



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

NEWSLETTER

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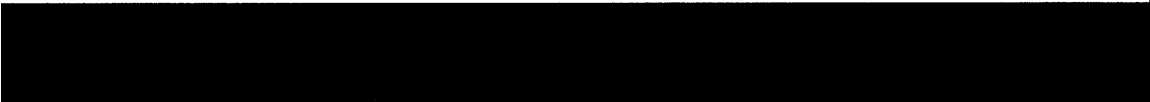
TO: All Medicaid Providers
 FROM: Division of Medical Assistance and Health Services
 DATE: July 17, 1995
 SUBJECT: The Medicaid Managed Care Program--New Jersey Care 2000

As you may know, certain Medicaid beneficiaries are enrolling in Health Maintenance Organizations (HMOs) that have a contract with the Division of Medical Assistance and Health Services. Under such plans, beneficiaries can obtain most of their health care through the HMO. The purpose of this newsletter is to inform you of the Medicaid Managed Care Program, how it is being implemented, what it may mean to your professional practice or business, and how you can identify HMO-enrolled Medicaid beneficiaries.

Background

Up to now, many Medicaid beneficiaries have had the opportunity to voluntarily join a Health Maintenance Organization that is available in their county. At present, nine (9) HMOs are licensed and approved to offer managed care services to Medicaid beneficiaries. These HMOs, with appropriate telephone numbers, are as follows:

HMO	Provider Phone Number	Customer Service Phone Number	Counties Operating In
First Option Health Plan	1-800-963-6286	1-800-555-2604	Cumberland, Gloucester, Essex
Garden State Health Plan	1-800-525-0047	1-800-525-0047	All counties <i>except</i> Cape May, Cumberland, Hunterdon, Monmouth, Ocean, Salem, Somerset
Harmony Health Plan	1-800-771-9875	1-800-771-9871	Essex, Hudson
HIP Health Plan of New Jersey	1-800-551-8083	1-800-688-5117	Bergen, Burlington, Camden, Gloucester, Hudson, Mercer, Middlesex, Union
Liberty Health Plan	1-800-425-0185	1-800-399-0499	Hudson
Medigroup South--dba--Mercy Health Plan of NJ on behalf of HMO Blue	1-800-682-9091	1-800-682-9090 1-800-656-3729	Camden, Essex, Hudson
Oxford Health Plan	1-800-233-5479	1-800-444-2413	Essex, Hudson
University Health Plan	1-800-564-6847	1-800-564-6847	Essex



HMO	Provider Phone Number	Customer Service Phone Number	Counties Operating In
US HealthCare	1-800-624-0756(Southern NJ) 1-800-852-0629 ext. 3695(Bergen, Passaic, Essex, Hudson and Union) 1-800-852-0629 ext.3861(Middlesex, Sussex, Monmouth, Warren, Ocean, Hunterdon, Somerset)	1-800-628-4758(English) 1-800-533-6615(Spanish)	Camden, Cumberland, Essex, Gloucester, Hudson

As additional HMOs are approved and licensed to serve Medicaid beneficiaries, we will alert you.

Enrollment in these HMOs totals over 100,000 members. The vast majority are covered under the Aid to Families with Dependent Children (AFDC) program, with the remainder covered under the Division of Youth and Family Services (DYFS) or Supplemental Security Income (SSI) categories.

Services currently provided by the HMOs generally include: primary and specialty care; inpatient and outpatient hospital services; emergency medical care; behavioral health services; laboratory and radiology services; prescription drugs; family planning; podiatry, chiropractor and optometry services; optical and hearing appliances; home health services; personal care assistant services; medical supplies and durable medical equipment; dental services; ambulance, MICU and invalid coach transportation services; prosthetics and orthotics; rehabilitation services; and hospice services. Some HMOs have limited the services they cover. In any event, services that are not covered under the HMOs are available and payable on a traditional fee-for-service basis. **Beneficiaries enrolling in an HMO do not lose any of their Medicaid benefits.**

What Changes are Being Implemented?

Effective June 1995, Medicaid began to implement major changes in the Managed Care program. There are two significant changes of which you need to be aware.

- All AFDC beneficiaries in Camden, Gloucester and Hudson counties will begin to be outreached for mandatory enrollment in an HMO. These beneficiaries will be given a limited time period to select an HMO that best meets their needs. After this period of time, assuming the beneficiary has not selected a plan, the Division will assign that beneficiary to an HMO. This process of outreach and enrollment will continue for approximately six (6) months. At that point in time, all AFDC clients in the specified counties will be enrolled in an HMO unless they have requested and qualify for an exemption. Additional details on exemptions are presented below. You should also note that while AFDC beneficiaries will be required to enroll in an HMO, Medicaid clients in other eligibility categories (e.g., SSI and DYFS) will not be required to join an HMO, but may voluntarily do so, with certain restrictions.

- There will be a standard benefits package that all Medicaid-participating HMOs will provide. This includes all Medicaid services not specifically excluded from managed care coverage. The benefits that will remain in the fee-for-service Medicaid program include:

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|--------------------------------------------------|-------------------------------------------------------------------------------|
| - behavioral health services | - psychiatric inpatient hospital |
| - personal care assistant services | - residential treatment center care |
| - medical day care | - intermediate care facility/mental retardation |
| - abortions (elective/induced) | - rehabilitation services in excess of 60 days per year |
| - inpatient hospital costs for organ transplants | - nursing facilities |
| - lower mode transportation | - services to beneficiaries participating in waiver or demonstration programs |

In order for an HMO to be approved to offer coverage to Medicaid beneficiaries under this new program, the HMO must demonstrate its ability to deliver the standard benefit package, using available providers in the community. The Division evaluates each HMO's ability to offer accessible services to the client population, and further determines the maximum number of beneficiaries that can be served by the HMO based upon the network of available providers. The HMO is then limited in the number of members it can enroll by the size and breadth of the provider network. HMOs are strongly encouraged to expand their networks of community-based physicians, and to enter into service arrangements with providers who have traditionally served Medicaid eligibles including community health centers, Federally Qualified Health Centers, community pharmacies, medical equipment suppliers, hospitals and other providers of medical services and supplies.

What Will Happen After This First Six-Month Enrollment Period?

In the fall of 1995, Medicaid AFDC beneficiaries in Essex County will begin to be outreached for mandatory enrollment. Again this process will continue for approximately six months.

The anticipated beginning dates for the phase in of the remaining counties will be:

Spring 1996: Atlantic, Bergen, Cumberland, Mercer, Middlesex, Monmouth, Passaic and Union

Fall 1996: Burlington, Cape May, Hunterdon, Morris, Ocean, Somerset, Salem, Sussex and Warren

How Will This Initiative Affect Your Practice/Business?

You have several ways in which you may continue to serve Medicaid clients:

- We encourage both you and our participating HMOs to explore all avenues to include your practice/business in the HMO networks which are being formed. In this way, Medicaid beneficiaries who have relied upon you can continue to utilize your services. HMOs must use credentialing criteria when reviewing applications from providers in a community. If you do not meet the HMO's credentialing standard, you are encouraged to contact the HMO to determine why and to work with the HMO to achieve its credentialing standard. As part of the process of becoming an HMO network provider, you can negotiate a rate of reimbursement with the HMO. The Division does not require the HMOs to pay a certain reimbursement rate to their network providers. The Division does, however,

require that the HMO pay all clean claims within 30 days. The Division does not mandate billing formats, however, most HMOs use standardized billing formats.

- Because some Medicaid beneficiaries will continue to obtain their health care services under the traditional fee-for-service system, you can still serve these patients and be reimbursed directly from the Medicaid program, through UNISYS the fiscal agent.
- There are some services that fall outside of the scope of the HMO's standard benefits package. These services, such as mental health and substance abuse treatment/services, will continue to need the current network of Medicaid providers.
- Patients that are new to the Medicaid system (those just being qualified as eligible) will need to rely on the fee-for-service system until their HMO memberships become effective.

Because HMOs typically restrict their networks to providers who have agreed to contract with them, services you provide to a Medicaid enrollee may no longer be covered. This could occur if you do not contract with or obtain authorization from the HMO in which the beneficiary is a member. **Therefore, it is imperative that you or your staff check the identification card of the Medicaid patient prior to the provision of any service, even if you have received prior authorization from a Medicaid District Office or Medicaid's Central Dental Services Unit.** This will avoid your claim being rejected by both the Division's fiscal agent, UNISYS, and the member's HMO.

How Can I Identify Whether The Patient Is Covered By An HMO?

Medicaid beneficiaries enrolled in HMOs will receive two (2) identification cards. One card will be issued by the HMO, and appropriate toll-free telephone numbers will be indicated on the card. These telephone numbers will allow you to inquire whether a service you perform will be covered, or needs a prior approval. These numbers should be staffed 24 hours a day, 365 days a year.

The second card will be the traditional Medicaid Eligibility Identification card. However, on the card, the words "ENROLLED IN HMO XYZ, 1-800-XXX-XXXX" will be imprinted. See sample Medicaid Eligibility ID card on the last page of this Newsletter. This card likewise will provide a toll-free telephone number of the HMO in which the beneficiary is a member to verify HMO membership. Questions about covered services may be referred to this number.

You are also strongly encouraged to use the Division's REVS automated system to verify a beneficiary's eligibility for Medicaid and enrollment in an HMO. The toll-free number is 1-800-676-6562 and it is available 24 hours a day, seven days a week.

A Word About Exemptions

Because we recognize that an HMO may not be in every Medicaid beneficiary's best interest, we have determined several situations whereby someone on Medicaid can request an exemption from the program. These exemptions include: pregnant women past the first trimester who have an existing relationship with an obstetrician; those who have chronic debilitating illnesses who are under the care of a physician; and individuals who are terminally ill or enrolled under the Hospice Program. Individuals covered in Waiver, Demonstration, Medically Needy or Home Care Expansion Programs will not be outreached for the mandatory program. Medicaid clients can request an exemption when being outreached to join a managed care plan.

Special Notice to Pharmacists

While many HMOs have contracting arrangements with a wide array of local pharmacies, your patient may be enrolled in an HMO with which you do not contract. Please be aware that under New Jersey's "Any Willing Provider" legislation, you have the right to enter into a contract with any HMO or Pharmacy Benefits Manager firm used by the HMO, providing that you accept the same reimbursement arrangements offered to other pharmacy providers and meet the HMO's credentialing/participation requirements. If your patient is enrolled in an HMO with which you do not contract, you may be asked to facilitate the transfer of appropriate records, including any active prescriptions, to a pharmacy provider within that HMO's network. This will assure that the patient will not suffer any delays in getting refills of needed medication.

Special Notice for Family Planning and Emergency Services

Beneficiaries will be informed that emergency and family planning services are not restricted under the waiver. Federal regulations require that under the waiver, the State must cover family planning supplies and services provided by any Medicaid provider who meets the regular Medicaid program requirements for family planning services. Even though the State contracts with HMOs to provide family planning services and supplies, a beneficiary may obtain these services either through the HMO or through a Medicaid-participating family planning provider. Family planning services rendered by a Medicaid participating provider who is not a part of the HMO network will be reimbursed by Medicaid on a fee-for-service basis.

Any Other Questions?

Should you have any questions about the information in this Newsletter, please call the **Medicaid Managed Care Hotline at 1-800-792-9745**. We thank you for your continuing commitment to the Medicaid program, and look forward to your continued participation.

