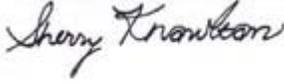


	MEDICAL ASSISTANCE BULLETIN COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC WELFARE	
	SUBJECT Implementation of the Family Care Network: A Primary Care Case Management Program for Children and Adolescents.	BY  Sherry Knowlton Deputy Secretary for Medical Assistance Programs
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PURPOSE:

To notify all providers of the implementation of The Family Care Network, a primary care case management program for Medical Assistance (MA) clients under age 21 in 60 counties.

SCOPE:

This Bulletin applies to all providers enrolled in the Medical Assistance (MA) Program.

SUMMARY OF IMPACT:

- The Program will be implemented gradually in 60 counties over the next two years. Berks, Bucks, Chester, Delaware, Lancaster, Montgomery and Philadelphia Counties are excluded.
- The program has already begun in York County. Erie, Washington and Westmoreland counties are scheduled for implementation in April and May 1994.
- MA providers that are primary care physicians, hospital outpatient clinics, independent medical clinics, rural health clinics and federally qualified health centers may enroll as Network providers.
- Network providers must also be certified as Early, Periodic, Screening Diagnosis and Treatment (EPSDT) providers. Eligible providers not yet participating as EPSDT providers may wish to enroll now. Call 1-800-892-1028 for more information about EPSDT enrollment.
- MA clients under age 21 will be required to enroll in the program. They will select or be assigned to Network providers. They may select Network providers from neighboring counties.
- If you are not enrolled as a Network provider, clients cannot select or be assigned to you as their primary care provider.
- Network providers will receive a case management fee of \$3 per month for each Network client assigned without being required to submit an invoice. This is in addition to usual MA fees.
- Network providers decide the number of clients to be assigned. The maximum Network patient load is 1,000 per physician and 5,000 per multi-provider site. Exceptions may be made to preserve patient/provider relationships and ensure access.
- Participation as a Network provider does not affect your other MA patient base. Network providers are encouraged to see family members of clients enrolled in the Network.
- Network providers must provide 24-hour access to comprehensive primary health care and make appropriate referrals.
- Existing MA fee-for-service rules and regulations apply.

- As in most managed care programs, once a client is enrolled, services obtained by self-referral will not be reimbursed by MA. Appropriate referrals will receive the usual MA fees.
- Verification of client/patient enrollment in the network is available through the Eligibility Verification System (EVS).

Please see the following for further details.

BACKGROUND:

The Omnibus Reconciliation Act of 1981 gave states the opportunity to obtain waivers of federal regulations to allow them to implement primary care case management programs for Medical Assistance (MA) clients. Clients enrolled in such programs are linked with specific primary care MA providers who deliver or coordinate their access to most services. Providers who agree to act as primary care case manager (PCCMs) are paid MA fees for the services they deliver and a monthly case management fee for coordinating the clients' access to other medical services.

When implemented in other states, primary care case management programs have resulted in increased access to primary and preventive care for MA clients and more cost-effective utilization of services. Most savings have been attributed to clients receiving more comprehensive preventive care, earlier and less costly treatment for illnesses, and use of primary care physicians rather than hospital emergency rooms for non-emergency medical care.

Over the last year, the Department has been working with the Medical Assistance Advisory Committee, its subcommittees, various provider organizations and client advocate groups, to design a primary care case management program which targets children and adolescents. This collaborative effort resulted in a program which includes the requirement that providers who agree to the primary care case managers also be responsible for providing Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) services.

On October 14, 1993, the Health Care Financing Administration (HCFA) approved the Department's request for a waiver to implement a primary care case management program in 60 counties for clients under age 21. The program is called the FAMILY CARE NETWORK.

The Department will use a contractor to administer the Family Care Network. Automated Health Systems, Incorporated (AHSI) administers the EPSDT Program for the Department and will also be responsible for administering the Family Care Network. AHSI will recruit, enroll and provide technical support for Family Care Network providers, assist clients in selecting their Family Care Network providers, process changes in provider/client assignments, compile and submit data to enable the Department to pay monthly case management fees to Family Care Network providers, notify providers of the clients enrolled in their panels, notify clients of their enrollment in the plan and issue membership cards to the clients. They will also use surveys to monitor client satisfaction with the program and will monitor quality and appropriateness of services and referrals provided by PCCMs by reviewing paid claims history, conducting on site visits and reporting results to the Department.

DISCUSSION:

Counties Excluded

Clients in Berks, Bucks, Chester, Delaware, Montgomery and Philadelphia Counties have been excluded from coverage by this program because they will be covered by the HealthChoices managed care expansion plan. Clients in Lancaster County have been excluded because a PCCM initiative for MA clients of all ages is under development there.

Provider Enrollment

MA providers who may enroll as case managers in the Network include: Physicians who provide primary health care, hospital outpatient clinics, independent medical clinics, rural health clinics and federally qualified health centers. Network providers must also be certified by the Department as EPSDT providers. Certified Registered Nurse Practitioners (CRNPs) and Physician Assistants (PAs) may not enroll as case managers in the Network. However, they may continue to provide services to clients enrolled in the Network by establishing protocols or referral arrangements with Network providers.

To enroll, providers are required to complete a Supplemental Provider Agreement by which they agree to the responsibilities of a Network provider. The responsibilities include but are not limited to the following:

- To provide 24-hour access;
- To provide comprehensive primary and preventive care;
- To authorize and arrange referrals;
- To conduct EPSDT exams to required intervals;

- To coordinate services with other providers; and,
- To advise clients of services available from other community-based service agencies.

We are using the paid claims file to identify providers who currently serve MA clients under age 21 in the 60 counties. At least one month prior to implementing the program in a county we contact these providers by mail and invite them to attend a briefing at a local site. The briefing provides a forum for providers to receive clarification about the program and to actually initiate enrollment as Network providers.

Since clients may select or be assigned to providers located in their county of residence or neighboring counties, providers from all counties are encouraged to enroll in the Network. If you currently serve MA patients under age 21 and you do not enroll as a Network provider, those patients will select or be assigned to another primary care provider when the program is implemented in their county. We urge you to enroll to preserve existing patient/provider relationships.

Providers interested in enrolling should contact the Network Administrator, Automated Health Systems, Inc. at 1-800-892-1028 for further information and to obtain a Supplemental Provider Agreement.

Patient Load

Network providers choose the number of Network clients they are willing to accept, up to a maximum of 1000 clients per individual provider, and 5000 per multi-provider site. The Department may grant exceptions to these limits if capacity to serve additional clients is established and/or access to a usual source of care may be jeopardized by the limit. These limits apply only to clients enrolled in the Network. Providers may serve other MA clients and are encouraged to serve other family members of clients enrolled in the Network.

Case Management Fees

Network providers are paid a monthly case management fee of \$3 for each Network client assigned to them. Network providers receive monthly lists of all clients assigned to them during the preceding month and for whom they are paid the \$3 monthly case management fee. Network providers will not have to submit invoices for the \$3 case management fee. AHSI will compile the information and submit it to the Department. The Department uses this information to issue payments. Case management fees will be paid monthly for the clients assigned to the Network providers during the preceding month. The monthly payment will be listed on the Remittance Advice Form as a gross adjustment.

Client Enrollment

Enrollment in the Program is mandatory and is handled automatically by the Department and the Network Administrator, Automated Health Systems, Inc. Once enrolled, clients select or are assigned to Network providers. MA paid claims history files are used to identify usual sources of care when assisting clients in selecting or assigning clients to Network providers. If a client's usual source of care has not enrolled as a Network provider, he or she will have to select a new primary care provider.

The Department mails special notices to households that include clients under age 21 who must enroll in the Network. Concurrently, the county assistance office begins to distribute the notice to new clients. The notice instructs the clients to call AHSI to learn about the Network and to select their Network provider. Clients have 30 days from the date of the notice to contact AHSI and select a Network provider. If they have not selected one by the 30th day, AHSI selects one and sends the notice of assignment, Network membership card and Handbook to the client. This process should result in initial enrollment of active clients being completed within 45 days after the notice is issued. Thereafter, Network membership is updated when new clients are enrolled or existing clients are disenrolled. Disenrollment could occur for a variety of reasons such as a client reaching age 21 or moving from a county covered by the program to one not covered.

Verifying Client Enrollment

Network providers receive weekly lists of the clients assigned to them or disenrolled for any reason. The lists also identify clients due or overdue for an EPSDT exam.

MA providers will be able to determine whether or not a client is enrolled in the Family Care Network and assigned to a Network provider when they verify eligibility through inquiry on the Eligibility Verification System (EVS). As with other managed care plans, the responses to EVS inquiries will include an alert that the client is enrolled in the Family Care Network. The toll-free telephone number of the Family Care Network will be included in all responses. If the EVS inquiry is made through a Point-of-Sale device or personal computer, the response will include the name and phone number of the client's Network provider. The clients will also receive Family Care Network membership cards which will include the name, address and telephone number of their Network provider. **The membership card is not proof of eligibility for MA coverage. Providers must use EVS to verify eligibility for MA.**

Services Requiring Referral

The Family Care Network is not a risk-based managed care plan. Network providers are paid the usual MA fees for the medical services they provide. If the Network provider refers one of his or her clients to a specialist for care and the specialist is an MA provider, the specialist will also be paid the appropriate MA fees for the services provided to the client. However, if a client self-refers to a specialist and services are provided by the specialist without the Network provider's referral, the MA program might not pay the specialist for the services and the client would be responsible for payment.

Once linked with a Network provider, the medical services to which a client may self-refer are limited. Clients are required to contact their assigned Network providers to obtain or arrange for most outpatient medical care. Their Network provider must arrange referrals when care from another provider is medically necessary. If clients self-refer to such services, the MA program might not cover the cost and the client would be responsible for payment.

When a referral is medically necessary, the client's Network provider will arrange an appointment with an appropriate MA provider for the required service. Network providers may contact the Network Administrator, Automated Health System, Inc., to request assistance in locating MA providers to whom referrals may be made. They have access to the Department's provider data base which contains the most current information about providers participating in the MA program.

The Network provider will complete a referral form which confirms the name of the provider, the date, time and location of the appointment and the reason for the referral. The Provider MA Identification number of the Network provider making the referral will also be included on the referral form. A copy of the referral form will be given to the client to be presented to the provider, at the time of the appointment. In addition, a copy of the referral form will be sent by the Network provider to AHSI. AHSI will then track the referral and contact the provider to confirm that the client kept the appointment.

Where time permits, AHSI will call the client to remind them of the appointment and to assist them with arranging transportation to the appointment. If the appointment is not kept, AHSI will notify the Network provider who will follow-up with the client to reschedule the appointment.

When a MA provider receives a referral from a Network provider for a client enrolled in the Family Care Network, the receiving provider must enter the name and MAID number of the Network provider on the MA invoice in the referring physician sections of the invoice. The Department will use this information to process claims for services provided to clients enrolled in the Network. Failure to include this information could result in a claim being rejected.

If a client linked with a Network provider self-refers to any of the following MA provider types, the provider should contact the client's Network provider to coordinate care and to arrange a referral if appropriate.

PROVIDER TYPE CODE	DESCRIPTION
01	Physician (including specialists)
04	Podiatrist
07	Chiropractor
10	Independent Med/Surg Clinic
11	General Hospital Outpatient Clinic
23	Home Health Agency
26	Rural Health Clinics/Federally Qualified Health Centers
43	Physical Therapist
49	Certified Nurse Practitioners.

Emergency Room Self-Referrals

If a client linked with a Network provider self-refers to a hospital emergency room and emergency room (ER) staff determine that the client's medical condition does not meet the criteria for emergency care, the client should be referred back to his or her Network provider to arrange for treatment. If the client insists that the ER provide treatment for a non-emergency condition, he or she must be advised that MA may not cover the cost. Later this year the Department will implement changes in the claims process that will result in the rejection of claims from ERs for non-emergency services provided to clients enrolled in the Network. Network providers may not refer clients enrolled in this program to ERs for non-emergency care. Network providers may not authorize ERs to provide non-emergency care to clients enrolled in this program.

Services Excluded From Referral

Clients listed with Network providers may still obtain some services from providers other than their Network providers without referral. Services that do not require a Network provider's referral include the following:

- Emergency Services;
- Ambulance Services;
- Inpatient Hospital Care;
- Inpatient Residential Treatment;
- Prescription Drugs or Medical Equipment;
- Dental Services;
- Eye Exams and Glasses;
- Family Planning Services;
- Obstetrical/Gynecological Services;
- Mental Health Services;
- Drug and Alcohol Treatment; or,
- Nursing Home or ICF/MR Care.

These services were excluded from the Network provider referral process because the Department already has activities in place that monitor utilization; because they are specifically exempt by federal regulation; because they are services not routinely available from a primary care physician and would always require referral placing a burden on the Network provider; or, the service is one generally accessed by clients in crisis and requiring a referral might deter clients from seeking treatment.

Although clients may obtain some services without referrals from their Network providers, all providers are expected to coordinate provision of care with the Network provider. Consultation prior to providing services is recommended to ensure continuity of care and avoid duplication of services.

Referral to Other Services

If a client needs transportation to medical care, the Network Administrator, Automated Health System, Inc., can assist in arranging it either through the county assistance office or a contracted MA transportation program service.

In the process of treating patients enrolled in this program, Network providers will identify conditions or circumstances for which assistance from community-based service agencies is appropriate. When this occurs, the Network Administrator, Automated Health Systems, Inc., can assist the Network provider in arranging a referral to the appropriate agency. Examples of such agencies include County Drug and Alcohol Treatment Centers, WIC nutritional programs for pregnant women and young children.

Services provided to clients enrolled in the Network are subject to all existing MA fee-for-service rules and regulations. The Department will continue to include them in its Quality Assurance reviews, providers will still be required to obtain prior authorization where applicable, co-payments will still apply as appropriate, etc.

Implementation

The Department will implement the Family Care Network gradually in the 60 counties over the next two years. Our goal is to enroll at least 72,000 children by July 1994. Enrollment will then continue until approximately 400,000 children in the 60 counties have been enrolled.

We will implement the program in each of the 60 counties when enough Network providers have enrolled to ensure adequate access to care for the MA clients. The waiver approved by HCFA established standard for adequate access to be one provider for every 1000 clients enrolled.

The program was implemented in York County in February 1994. Providers were enrolled as the notices were mailed to active clients at the beginning of February 1994. Initial enrollment of approximately 10,500 active clients was completed by mid-March. We have targeted the following Counties for the next two phases of implementation:

COUNTY	DATE
Erie Washington Westmoreland	April 1994
Cameron Lackawanna Luzerne Pike Susquehanna Wayne Wyoming	June 1994

Counties will be selected for subsequent phases as implementation progresses. Actual implementation dates will depend upon participation and enrollment of providers as PCCMs. Remittance Advice Alerts will be issued to all providers to inform them when the program is being implemented in a specific county.

Providers interested in enrolling as EPSDT screening sites and PCCMs are encouraged to contact AHSI for further information at the following address:

Automated Health Systems, Incorporated
300 Arcadia Court
9370 McKnight Road
Pittsburgh, PA 15237

1-800-892-1028 or (412) 367-3030

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Division of Outpatient Programs
P.O. Box 8046
Harrisburg, Pennsylvania 17105

Or call the appropriate toll-free number for your provider type.

Visit the Office of Medical Assistance Programs website at www.dpw.state.pa.us/omap.