Overview of Managed Long Term Services and Supports (MLTSS)

NJ Department of Human Services
Division of Aging Services
Division of Medical Assistance and Health Services
October 2021

NJ 1115 Comprehensive Medicaid Waiver

- Allows NJ to develop Medicaid programs that differ from the standard federal Medicaid program.
- Enables NJ to expand Medicaid eligibility and coverage options for people who needed home and community based services but they were not eligible for Medicaid due to income.
- Gives NJ broad authority to modify rules for efficiency while providing quality care.
- Protects consumer choice and independence.

NJ FamilyCare Managed Care

- NJ FamilyCare managed care delivers coordinated health care services and supports through a network of providers.
- Managed care works like a health care supermarket to deliver all of an individual's Medicaid benefits through one organization.
- All Medicaid beneficiaries are enrolled in managed care through self-selection or auto-enrollment.
- Individuals choosing Program of All-Inclusive Care for the Elderly (PACE) enroll in one of 6 PACE Organizations.
- PACE provides both Medicare and Medicaid coverage to most participants.

Financial Eligibility: County Welfare Agency (CWA)

- Overview:
  - Application process
    - Income and Resources
    - Documents and Verifications
  - QIT links to Resources
  - Post-eligibility Treatment of Income
  - Redeterminations

Application Process

- It is important that potentially eligible individuals contact the County Welfare Agencies and submit an application for Medicaid.
- An individual can apply for Medicaid up to 2 months prior to spending down their resources.
- The County Welfare Agency has 45 days to process a case for an individual 65 years or older and 90 days for an individual in need of a disability determination.
- Applicants must supply documents in a timely manner. If they are having difficulty in obtaining documentation, then they should contact the Agency to ask for an extension of time. It is important that the applicant and the Agency keep an open line of communication.

Income and Resources

- If an individual is deemed clinically eligible for an institutional level of care, they qualify for a higher income standard. In 2021 that institutional income standard is $2,382 per month. Their resources must be less than $2,000.
- According to federal regulations the CWA must do a five year look-back for transfers of assets for less than fair market value. If a transfer is found, the CWA will impose a penalty period which begins when the individual is found to be otherwise eligible.
- If the total gross income is at or below 100%FPL ($1,074 per month in 2021) the individual can submit a self-attestation form, which states that they did not transfer any resources in the past five years. This allows the County Welfare Agency (CWA) to forgo the 5 year look back and process the case.
- Individuals whose income is over the 100% FPL cannot self-attest to transfers and must supply documentation for the look back period.

ABD Cascading Programs for MLTSS

- Supplemental Security Income (SSI)
  - Individual with monthly income under $825.25 and $2,000 in resources
- Medicaid (Institutional)
  - Individual must have clinical eligibility
  - Individual with monthly income under $2,382 and $2,000 in resources
  - Individual with monthly income over $2,382, a Qualified Income Trust is required for the excess income

Qualified Income Trust (QIT) Resources

- QITs are for individuals with income in excess of $2,382 per month and less than $2,000 in resources.
- Must meet clinical eligibility for NF level of care
- QITs are financial devices used in conjunction with the Medicaid Only eligibility rules and have replaced the Medically Needy program for individuals in nursing facilities.

For more information on QITs , please see the following link which includes the QIT Template, Blank Letter, and FAQs:
http://www.state.nj.us/humanservices/dmahs/clients/mtrusts.html

If you have additional questions you may call Office of Eligibility at: (609) 588-2556.

Application for SSI Increase for AL Residents

An individual whose income is insufficient to:

1) Pay for the Department's defined Room and Board and
2) Retain the approved Personal Needs Allowance

Can` apply to the Social Security Administration Office for an SSI supplement

Application should be made upon admission to "lock-in" eligibility date

Medicaid Online Application

https://www.nj.gov/humanservices/dmahs/clients/medicaid/abd

All of the NJ FamilyCare Aged, Blind, Disabled Programs have just one application called the NJ FamilyCare Aged, Blind, Disabled Program Application. Click below to apply.

NJ FAMILYCARE

Affordable health coverage. Quality care.

APPLY ONLINE

If you need help filling out the application or have questions, please call 1-800-356-1561.

Additional ways to apply

You can also print the application below, then complete it and mail it in. An in-person interview at the County Welfare Agency is not required to apply. If you prefer to have help applying, call your local County Welfare Agency. They can help you.

The application process may require additional forms to be completed. The supplemental Designated Authorized Representative and Spouse Information forms must be submitted with your application, if applicable to your situation.

Get Adobe Reader

Download Adobe Acrobat Reader in order to correctly view and print PDF files.

See below to print individual components of the ABD Application:

- NJ FamilyCare Aged, Blind, Disabled Program Application
- NJ FamilyCare Aged, Blind, Disabled Program Application (Spanish)
- Designated Authorized Representative Form This is a supplemental form if you want to designate an Authorized Representative that will be responsible for the application and the eligibility process.
- Spousal Information FormThis supplemental form is completed if a married couple is seeking eligibility through the Aged, Blind, Disabled Programs. It must accompany the Aged, Blind, Disabled Application above.
- Area Agency on Aging (AAA) FormThis is an optional form. The AAA offers other services and supports that could benefit the aged or disabled applicant. This form, when completed, gives permission to refer the applicant's information to the local AAA for their follow up. (This form prints best on legal paper).

Applicants' Income, Resources, & Documentation

The NJ FamilyCare Eligibility Determining Agency (EDA) **verifies your information**. If the EDA cannot electronically verify your personal information, you may be asked to provide proof of identity, age, citizenship and/or marital status. The EDA may also ask for documentation that will **prove what you own, how much income you receive, where this income comes from, and how much you spend on living expenses.**

During the eligibility determination process, the information you provided will be verified. If there is missing information, you will receive a letter. **Failure to respond timely to these letters will cause your application to be denied.**

Income You Receive

Income can come from different sources such as a paycheck, pension, or interest from an investment account. Listed below are examples that can prove your income.

- Income Statement from Employer/Pay Stubs
- Pension Information
- Unemployment Benefit Statement
- Child Support Order
- Self-Employment Tax Return
- VA Explanation of Benefits
- Interest
- Proof of Rental/Royalty Income
- Social Security Award Letter
- Retirement Account Statement
- Dividends
- Income from Trust Funds
- Annuity Payments
- Workman's Compensation/ Disability
- SSI Payments

Your Living Expenses

How much money do you (and your spouse) need to live in the community each month? The expense of maintaining your house or renting an apartment can account for a large part of your monthly income. The following are examples of expenses to include with your application:

- Rent Payments
- Telephone Bills
- Water / Sewer Bills
- Health Insurance Bills
- Mortgage Statements
- Gas /Oil Bills
- Real Estate Tax Bills
- Electric Bills
- Renter / Home Owner Insurance

What You Own

Ownership is not limited to homes and automobiles - it can include cash values of life insurance policies or annuities, trust funds, and many other things. Provide documentation with your application of any of the following items that you own or owned during the past five years:

- Cash on Hand
- Bank Accounts
- Deeds to all Property Owned
- Certificates of Deposit (CDs)
- Promissory Notes
- Annuities
- Mortgages
- Equipment/Inventory
- Automobile/Registrations
- Other Vehicles (Boat, Trailer, etc.)
- Holiday/Vacation Club Accounts
- Property Tax Statements
- All Life Insurance Policies
- All Trusts or other Holding Instruments
- Special Needs Trusts
- ABLE Accounts
- Retirement Accounts (403B)
- Individual Retirement Accounts (IRAs)
- Business/Real Estate Partnership Papers
- Burial Accounts/ Funeral Trusts
- Credit Union accounts
- Stocks or Bonds
- Deed to Burial Plots
- Land/Mineral Rights
- Keogh Accounts (401K)
- Contracts
- Mobile Home

Your Other Documents

- Copy of health insurance card(s) – front and back
- Designated Authorized Representative Form
- Copy of any settlements
- Power of Attorney
- Guardianship
- Third Party Signator
- Court Pleadings

Post-eligibility Treatment of Income

- After an individual is determined eligible for MLTSS (clinical and financial), their information is entered into a Personal Responsibility form (PR-1 or PR-2) web application that calculates their cost of care (cost share).
- Cost Share calculations are determined by federal regulations at 42 CFR §435.725.
- Copies of the PR forms are sent by the CWAs to the NF/SCNF/AL facilities and to the Medicaid recipient and/or their representative(s).
- The post-eligibility order of income exemptions on the PR-1 include but are not limited to the following categories in the following order: Personal Needs Allowance (PNA); Community Spouse Maintenance Allowance; Family Deductions; and Health Insurance Premiums.

Redeterminations

- Medicaid financial eligibility redetermination are completed every 12 months by the CWAs.
- It is important for NFs to inform the CWAs when a Medicaid eligible resident moves to their facility or from their facility in order to ensure their eligibility continues.
- When a redetermination packet is sent to a facility, it is important for the Medicaid recipient and/or their representative to receive the packet and complete the required documentation in a timely manner. Failure to do so may result in a period of ineligibility.

CWA Contact Information

- Please contact your CWA for more information on the Medicaid financial eligibility process for MLTSS.
- CWA listing is maintained at the following link:
  www.state.nj.us/humanservices/dfd/programs/njsnap/cwa/

Clinical Eligibility

Nursing Facility Level of Care

Pre-Admission Screening

Nursing Facility Level of Care (NF LOC)

- NF LOC clinical eligibility is required for all long term services and supports including:
  - Nursing Facility – custodial care and Medicaid pending
  - Special Care Nursing Facility (SCNF) – Behavioral, TBI, AIDS, Huntington's, Ventilator, Pediatric, Neurologically Impaired
  - Assisted Living and Community Residential Services (ALR, ALP, CPCH, TBI)
  - Home and Community Based Services (MLTSS)
  - Jersey Assistance for Community Caregiving (JACC)
- The Division of Aging Services, Office of Community Choice Options (OCCO) is the designated entity to determine NF LOC for individuals seeking long term services and supports through a standardized assessment process
  - Frequently referred to as the Preadmission Screening (PAS) process
- Clinical eligibility is required for some individuals seeking NJ FamilyCare programs with higher income standards.

NF LOC Defined

Clinical eligibility criteria for an individual to meet NJ NF LOC in accordance with N.J.A.C. 8:85-2.1 requires that individuals are **"dependent in several activities of daily living. Dependency in ADLs may have a high degree of variability."**

- Several ADLs is defined as three or more
- Dependent refers to hands-on care needs
- What else is considered?
  - Deficits in **Cognition**
- The NJ Choice is a comprehensive assessment which assesses more factors than ADLs and Cognition which are all considered in the care planning process

Activities of Daily Living (ADL) Assistance Criteria

The NJ Choice assesses self care performance in each ADL within the last three days of the assessment period. ADL self performance measures what the individual actually did, or was not able to do, within each ADL. Measures an individual's performance NOT capacity.

- The individual must require at least limited assistance or greater assist in three eligible ADLs with no cognitive deficits

OR

- The individual must require at least supervision or greater assist in three eligible ADLs with cognitive deficits

ADLs Eligible for NJ NF LOC

- Eating
- Bathing
- Dressing upper and/or lower body
- Transfer toilet and/or toilet use
- Bed mobility
- Transfers
- Locomotion
  - includes both indoor and outdoor mobility

Cognitive Deficits Eligible for NJ NF LOC

- Cognitive Skills for Daily Decision Making
  - Making decisions regarding tasks of daily life
- Short-Term Memory
  - Ability to remember recent events
- Making Self Understood
  - Ability to express or communicate requests/needs and engage in social conversation

What type of authorization is needed?

Individuals seeking Medicaid coverage for LTSS require assessment and/or authorization dependent upon their insurance coverage:

Authorization	Entity Responsible	Who is Eligible
Enhanced At Risk Criteria (EARC)	Acute Care Hospital Discharge Planner (with Authorization by OCCO)	• Medicaid Eligible without MCO • Potentially Medicaid Eligible
Clinical Assessment/Pre-Admission Screening (PAS)	OCCO (on-site assessment)	• Medicaid Eligible without MCO • Potentially Medicaid Eligible
NJ Family Care MCO Authorization (with or without MLTSS assessment)	MCO	• NJ Family Care MCO Enrollees • MLTSS MCO Enrollees

Individuals who do not expect to become Medicaid eligible during their stay do not require any of the above. They may require authorization dependent upon their non-Medicaid insurance coverage.

Enhanced At Risk Criteria (EARC)

EARC is a screening tool utilized to establish clinical eligibility for Nursing Facility placement or Ventilator SCNF placement for non-MCO individuals identified as needing Medicaid coverage during the NF stay.

- EARC is completed by a Certified NJ Acute Care Hospital employee (Discharge Planner, Care Manager, etc.)
- EARC allows the NF or Ventilator SCNF to bill NJ Family Care Fee for Service (FFS) for up to 90 days.
- EARC is valid for one admission only. It is not transferrable.

Enhanced At Risk Criteria (EARC)

- NF/SCNF Provider is responsible for submitting the LTC2, Notice of Admission, to OCCO within 2 days of admission.
- If the individual continues in the NF past 60 days and is not MCO enrolled, Provider is responsible for requesting clinical eligibility from OCCO.
  - Both clinical and financial eligibility must be present for FFS payment
- Upon completion of financial eligibility for Medicaid, a NJ Family Care MCO will be selected or auto-assigned.
  - Upon enrollment, the MCO is responsible for authorization of NF placement and any other Medicaid services including assessment for Managed Long Term Services and Supports (MLTSS).

Clinical Assessment Tool

The NJ Choice is a standardized tool used to establish clinical eligibility for LTSS. The clinical assessment is conducted by:

- Office of Community Choice Options (OCCO)
- Program of All-Inclusive Care for the Elderly (PACE) Organizations
- Aging & Disability Resource Connections (ADRC)
  - 3 designated counties-Warren, Gloucester & Atlantic
- NJ Family Care Managed Care Organizations (MCO)

Assessments conducted by entities other than OCCO are reviewed and Authorized by OCCO.

OCCO vs MCO Assessment
What's the Difference?

- OCCO (or ADRC) conducts assessments for individuals not currently enrolled in NJ FamilyCare (New to Medicaid, JACC)
- MCOs are conducting assessments for individuals already enrolled in NJ FamilyCare and who request or may benefit from MLTSS
- OCCO Reviews the MCO assessment and makes a determination
  - Authorized for MLTSS
  - Not Authorized - requires OCCO to conduct an in-person reassessment, at which point a final determination is made – Approved/Denied.
- MCO conducts yearly reassessment with OCCO review for continued MLTSS clinical eligibility
- MCO also utilizes the NJ Choice to determine eligibility for Medical Day Care services which is a State Plan benefit outside the MLTSS program

Options Counseling for Long Term Services and Supports

Options Counseling for LTSS

- An interactive decision-support process whereby individuals, family members, and/or significant others are supported in the context of the individual's needs, preferences, values, and individual circumstances, as identified by the in-depth care needs assessment and individual's expressed goals.
- Includes discussion on the available services and options available to meet the individual's needs in the least restrictive environment and setting of choice
- Options Counseling is required and provided by numerous NJ entities during the screening and assessment process including:
  - ADRC/AAA
  - Division of Aging Services
  - Division of Developmental Disabilities
  - Division of Disability Services
  - Managed Care Organizations
  - Programs of All Inclusive Care for the Elderly

Conducting Options Counseling (OC)

- OC is conducted for all individuals assessed via the NJ Choice for NJ Medicaid Programs
- The NJ Choice assessment, individual preference and assessor's professional judgment will guide OC
  - Identification of needs and goals
  - Identification of preferred setting of care
  - Discussion of service options
  - Documentation of service option preferences

Person-Centered Planning

- Focuses on the preferences and needs of the individual.
- Empowers and supports the individual in defining the direction for his/her life.
- Promotes self-determination and community involvement.
- Assists in identifying the least restrictive environment in which the individual can maintain their highest level of independence

Program of All-Inclusive Care for the Elderly (PACE)

- PACE is available for individuals who are:
  - Aged 55 or older
  - Able to live safely in the community at the time of enrollment
  - Require nursing facility level of care
  - Reside in a PACE service area
- The PACE organization coordinates and provides all services including care in a NF or AL as identified through an interdisciplinary team model (IDT)
- Six PACE organizations now are in ten counties.
  - DoAS is the state administering agency responsible for oversight
  - PACE expansion statewide is anticipated over the next several years

Role of the PACE IDT Team

- Each PACE participant's care is coordinated by an interdisciplinary team of professionals
- The participant's plan of care usually integrates home care services along with visits to the PACE center for medical care, rehab, social activities, and meals
- Services include all Medicare, Medicaid and those deemed medically necessary
- PACE provides a continuum of care which may include assisted living or nursing facility care as the individual's needs change

PACE Service Areas

AtlantiCare LIFE *(Atlantic and Cape May Counties)*

Beacon of LIFE *(Monmouth County)*

Inspira LIFE *(Cumberland, Gloucester and Salem Counties)*

LIFE St. Francis *(Mercer County; some areas of Burlington County*

Lutheran Senior LIFE *(Hudson County - some exclusions)*

Trinity LIFE *(Camden County; some areas of Burlington County)*

PACE Expansion

Pending Service Areas include:

- Ocean County – 2021 opening
- Essex County – 2022 opening
- Union County - TBD
- Burlington County – RFA closed in July 2021.

The Department will be initiating Requests for Application (RFA) for all remaining unserved counties over the next several years.

NJ FamilyCare – MLTSS Program

- Managed Long Term Services and Supports (MLTSS) refers to the delivery of long-term services and supports through New Jersey Medicaid's NJ FamilyCare managed care program. MLTSS can be provided in the following settings:
  - Private Home/Apartment
  - Subsidized Housing
    - Assisted Living Program (ALP)
  - Assisted Living Facilities
    - Assisted Living Residences (ALR)
    - Alternate Family Care (AFC)
    - Comprehensive Personal Care Home (CPCH)
  - Nursing Facility (NF)
  - Special Care Nursing Facility (SCNF)
  - Community Residential Services (CRS)

Role of the MLTSS Care Manager (CM)

Individuals enrolled in MLTSS receive coordination of care through a Managed Care Organization Care Manager

- Responsible for coordination of the individual's physical health, behavioral health, and long term care needs.
- Required to make face to face visits quarterly (community) or bi-annually (nursing facility).
- Monitor services and update Plan of Care as necessary.
- Complete a NJ Choice Assessment annually to determine continued clinical eligibility (NF LOC).

Exclusions to MLTSS

Fee-for-service (FFS) Medicaid beneficiaries

- Living in NF/SCNF as of 7/1/2014, classified as "NF/SCNF Exempt"
- Currently fewer than 4,000 beneficiaries
- Members that experience a trigger event enroll with an MCO; trigger events include:
  - Change in NF/SCNF Provider
  - Seeking transition from NF/SCNF to Community

PACE participants

Certain Medicaid programs

- Not all Medicaid programs offer MLTSS as a benefit

Managed Long Term Services and Supports (MLTSS): A Focus on Assisted Living

Services Included in ALR/CPCH

- Core package of Assisted Living (AL) services:
  - Personal care assistance (PCA), chore, attendant care, laundry, medication administration, social activities, skilled nursing, on-going assessment, health monitoring, and transportation for medical appointments, directly or through arrangement with an outside provider
- Regular array of Medicaid State Plan services (Health Insurance) with certain exceptions:
  - No PCA, NF, or Medical Day Care
  - MLTSS Service of Social Day Care is allowed in Assisted Living Program (ALP) and Adult Family Care (AFC) only
- Care Management provided by Managed Care Organization or PACE Interdisciplinary Team

AL Resident Service Plans

- As per N.J. Admin. Code § 8:36-7.1(c), Initial assessments and resident service plans:

  (c) The general service plan shall include, but not be limited to, the following:

  1. The resident's need, if any, for assistance with activities of daily living (ADL);
  2. The resident's need, if any, for assistance with recreational and other activities; and
  3. The resident's need, if any, for assistance with transportation.

AL Health Care Assessment

As per N.J. Admin. Code § 8:36-7.2, Health care assessment and health service plan:

- (d) Each health care assessment shall include evaluation of the following:
  - Need for assistance with "activities of daily living";
  - Cognitive patterns;
  - Physical functioning and structural problems;
  - Continence;
  - Special treatment and procedures;

Health Service Plan (HSP)

- (e) Based on the health care assessment, a written health service plan shall be developed. The health service plan shall include, but not be limited to, the following:
  - Orders for treatment or services, medications, and diet, if needed;
  - The resident's needs and preferences for himself or herself;
  - The specific goals of treatment or services, if appropriate;
  - The time intervals at which the resident's response to treatment will be reviewed; and
  - The measures to be used to assess the effects of treatment.

- (g) The facility shall make reasonable effort to have documentation of services provided by outside health care professionals entered in the resident record.

Commonalities POC & GSP/HSP

MCO POC

- ✓ Assessed ADL need,
- ✓ Ensure that the frequency, duration or scope of the services accurately reflects the individual's current needs
- ✓ Update the plan of care as necessary, at least annually
- ✓ Input from service providers, as applicable.

AL GSP /HSP

- ✓ Assess the resident's need, if any, for assistance with activities of daily living (ADL);
- ✓ HSP shall be reassessed at least quarterly and more often on an as-needed basis
- ✓ Documentation of services provided by outside health care professionals

Responsibilities of the Medicaid Assisted Living Provider

- Specify the responsibilities of the individual and provider in the Admission Agreement
- Identifying spenddown for Medicaid
  - Initiating a referral to OCCO for clinical eligibility 3-6 months before full spenddown via AL-6 form
  - Ensuring a Medicaid application is being initiated 3 months before full spenddown
- Identifying the insurance type
  - FFS
  - MCO

Responsibilities of the Medicaid Assisted Living Provider

- Request prior authorization and MLTSS enrollment for MCO enrollees
- Bill the individual for Room and Board and any applicable Cost Share in timely fashion
- Bill MCO/PACE per diem only for days when individual was present minus any cost share
  - Cost share is not pro-rated during the individual's absence
- Keep individual's room available for at least the calendar month of discharge when individual is temporarily absent, or until they voluntarily leave the facility

Responsibilities of the Medicaid Assisted Living Provider

- Work closely with the individual's MCO Care Manager/PACE IDT by:
  - Ensuring prior authorization is obtained
  - Contacting about any issues and status changes of the individual
  - Observed change in assessed needs, i.e., Health Assessment
  - Communication is key to a beneficial working relationship

- Understand, deliver, and coordinate the services between POC and GSP

Referral of a Private Pay Resident for MLTSS Approval

- The Provider completes the AL/AFC Referral Form and faxes it to the Regional OCCO Office when the resident's financial resources are estimated to be within three months of spend down. Resident is permitted to retain $2,000
  - A security deposit is considered a resource
- Provider gives a PA-4 (Physician Certification) to the resident to be completed by his or her health care provider
- If the individual's income exceeds SSI level ($825.25 in 2021), AL provider instructs individual to apply for Medicaid at the local County Welfare Agency, within 3 months of spend down.

AL/AFC Referral Form

- The AL/AFC Referral Form (AL-6) is used to refer an individual to OCCO for a determination of clinical eligibility for the Medicaid Waiver
- The AL/AFC Referral Form prompts a clinical assessment while the financial eligibility is being processed
- The AL/AFC Referral Form is used for private pay residents and those from the community that the facility or program intends to accept or admit once the individual has been clinically and financially determined eligible for the Medicaid Waiver
- The processing of the AL/AFC Referral Form does not constitute enrollment in MLTSS nor does it guarantee residency for the applicant at the referring AL/AFC facility

Respite Care in AL

ALR, CPCH and AFC approved Medicaid providers may offer Respite to MLTSS, JACC and Statewide Respite participants

MLTSS:

- Ensure AL notification to MCO upon enrollment
- Respite must be authorized by the MCO Care Manager
- Bill as per MCO processes

JACC:

- JACC-1 and JACC-6 forms must be completed
- Respite must be requested and authorized by the individual's Care Manager
- JACC reimbursement is an all-inclusive daily fee

Statewide Respite Care Program:

- Contract with county Statewide Respite Coordinator
- Obtain approval and rate from coordinator

AL Room & Board Supplementation

42 CFR §441.310(a)(2)

- Prohibits making Medicaid payments for room and board costs when a Medicaid participant lives in an Assisted Living setting (i.e., ALR, CPCH, Assisted Living Program in Subsidized Housing, or Adult Family Care setting).
- **Since payment is made by the individual and not the state, it can be supplemented by a third party.**
- DoAS will no longer collect AL Room and Board Supplementation forms

Managed Long Term Services and Supports (MLTSS): A Focus on Nursing Facility

MCOs and NF Benefits

- All new Medicaid beneficiaries are enrolled into a NJ Family Care MCO
  - There may be a FFS period in advance of MCO enrollment
- NF/SCNF services are a covered state plan benefit for NJ Family Care members
- The NJ Family Care MCO is responsible for authorization and payment of individuals from the date of admission through discharge regardless of MLTSS status
  - No cost share applies during non-custodial stays (up to 180 days)
- NF Custodial Care is defined as non-rehabilitative with no reasonable expectation of discharge. Once a NJ Family Care member reaches this level, an assessment for MLTSS should be initiated by the MCO.
  - Individuals receiving DDD services with a goal to return to the community do not enroll in MLTSS

Managed Care Organization Contract

The NJ Family Care Organizations enter into a contract biannually with the Department of Human Services, Division of Medical Assistance and Health Services. 4.1.2 of the MCO Contract outlines all covered benefits under NJ FamilyCare, including Nursing Facility.

4.1.2 BENEFIT PACKAGE A. The following categories of services shall be provided by the Contractor for all Medicaid and NJ FamilyCare A, B, C, D and ABP enrollees, except where indicated. See Section B.4.1 of the Appendices for complete definitions of the covered services.

- 26. Nursing Facility Services/Special Care Nursing Facility (NF/SCNF) – shall be a covered benefit for all Medicaid/NJ FamilyCare A Members, and NJ FamilyCare ABP Members. The Contractor shall be financially responsible for all Nursing Facility/Special Care Nursing Facility services for NJ FamilyCare A Members and NJ FamilyCare ABP Members from the date the Member enters the Nursing Facility/Special Care Nursing Facility to the date of discharge. Medicaid members requesting MLTSS for custodial care or community transition services must receive the Screen for Community Services and if applicable, be assessed and determined to meet nursing facility level of care as per Article 9 requirements.

Assessment of MLTSS Needs for MCO Members in Nursing Facilities

The NJ Choice is conducted to determine MLTSS eligibility for members in a Nursing Facility when the below guidelines are met:

- Individual has received at least 20 days of rehabilitation under any payer source.
- Upon the 21st day, discharge planning discussions and identification of long term care needs should begin if not already initiated. Options Counseling is an ongoing process that can occur at any time and should begin upon hospitalization.
- The MCO will prescreen for MLTSS eligibility
- The NJ Choice Assessment should be initiated after the 20th day for the following individuals:
  - Members seeking discharge to the community and identified as potentially meeting MLTSS eligibility criteria upon discharge.
  - Members seeking long term nursing facility services **and** have been identified as approaching their rehab discontinuation date (within the next 7 days).
  - Members may stay as short-term for up to 180 days if their intent is to return to the community.

Assessment of Special Care Nursing Facility (SCNF) placement

N.J.A.C 8:85-2.21 Special care nursing facility (SCNF)

(a) A special care nursing facility (SCNF) is a standalone facility or separate and distinct unit within a nursing facility which has been approved by both CMS and the Department of Health to provide care to New Jersey Medicaid beneficiaries who require intensive nursing facility services beyond the scope of a conventional nursing facility as defined in N.J.A.C. 8:85-2.2

- MCO members require prior authorization
- The MCO will conduct clinical assessment for MLTSS as appropriate
- For individuals FFS or pending Medicaid, OCCO will conduct the clinical assessment to determine MLTSS eligibility

Pre-Admission Screening Resident Review (PASRR)

PASRR Level I screening and Level II determination (if applicable) is a federal requirement for all individuals seeking nursing facility admission regardless of payer source.

A Level I negative screen indicates an individual does not require specialized services through the Division of Mental Health and Addictions (DMHAS) or the Division of Developmental Disabilities (DDD) and they may enter a nursing facility.

A positive Level I screen requires a Level II determination prior to admission to a NF.

- Individuals expected to stay fewer than 30 days may receive a physician exemption
- It is the responsibility of the NF to identify those who stay beyond the 30 days and refer for the Level II Resident Review prior to the 40th day from admission

PASRR

The NF is responsible to keep all Level I screens and Level II determinations in the resident medical record

The State is in the process of evaluating reporting mechanisms and quality audits to ensure compliance

LTC-2 Notification of Admission

The Notification of Admission Form (LTC-2) is used to notify OCCO of admission for current or potentially eligible Medicaid beneficiaries.

- The LTC-2 prompts a clinical assessment while the financial eligibility is being processed for those who are in the application process and not yet MCO enrolled
  - EARC is designed to eliminate the need for an on-site PAS upon admission to a NF
- Individuals who are MCO enrolled:
  - Check off "Notice of Admission" for Type of request
  - Check off "MCO" in Section I and indicate which MCO
  - Do not fill out Section IV (Request for PAS)
    - The MCO is responsible for the Authorization and Assessment
- The LTC-2 serves as the facility's identification of need for Medicaid Billing and notification to the State in accordance with regulation N.J.A.C. 8:85
  - Email is the preferred delivery method of LTC-2
  - Faxing – save the fax confirmation sheets with the cover page photo as proof of submission
  - An online portal is in development for implementation in late 2021/early 2022

New Jersey Department of Human Services
Division of Aging Services
NOTIFICATION FROM LONG-TERM CARE FACILITY
ADMISSION OR TERMINATION OF A MEDICAID BENEFICIARY

Type:
- ☐ Request PAS
- ☐ Notice of Admission
- ☐ Notice of Termination
- ☐ Notice of Transfer

I. PATIENT INFORMATION

1. Name: _____ (Last) _____ (First)
2. Social Security No.: ___ - ___ - ___
3. Sex: ☐ Female ☐ Male
4. Date of Birth ___ / ___ / ___
5. HSP# (Medicaid) Case No. if applicable: _____
Confirmed By (CWA): _____ ☐ NJ Family Care ☐ MLTSS ☐ MCO _____

II. PROVIDER INFORMATION

1. Provider Number: _____
2. LTCF Name: _____
3. Address: _____
4. City, State, Zip: _____
5. Provider Phone #: _____
6. ☐ SCNF: _____

III. PASRR STATUS (COMPLETE FOR ALL NEW ADMISSIONS)

1. Date of PASRR Level I ___ / ___ / ___
2. Outcome of PASRR Level I Screen – For Positive Screens Check all that Apply
   - ☐ Negative
   - ☐ Positive: ☐ MI ☐ ID/DDD ☐ MI and ID/DDD ☐ 30-Day Exempted Hospital Discharge ☐ Categorical
3. If Positive, Date of PASRR Level II Evaluation: ___ / ___ / ___
   Outcome of PASRR Level II Evaluation - Client Needs Specialized Services: ☐ Yes ☐ No

IV. REQUEST FOR PAS

☐ Private to Medicaid	☐ SCNF to NF	☐ Transfer
☐ PAS Exempt >20 Days	☐ NF to SCNF	☐ E-ARC PAS
☐ Medicare to Medicaid	☐ Out of State Approval Admission	☐ Other:

V. ADMISSION INFORMATION

1. Admission Date: ___ / ___ / ___
2. Date of PAS, if applicable: ___ / ___ / ___
3. Admitted from: ☐ Community/Boarding Home ☐ Psychiatric Hospital
   - ☐ Private to Medicaid - Anticipated Medicaid Effective Date: ___ / ___ / ___
   - ☐ Hospital ☐ Other LTCF ☐ Other _____
4. Name of Hospital/LTCF: _____ Admission Date: ___ / ___ / ___
   Address: _____
5. If admitted from Hospital/LTCF, give the name/address of previous residence (Hospital Name and Address or Home Address): _____

VI. TERMINATION INFORMATION

1. Discharge Date: ___ / ___ / ___
2. Discharged to:
   - ☐ Home-Community (including relative's home)/ County of residence: _____
   - ☐ Facility Name: _____ County of NF: _____
   - ☐ Other (specify): _____ County of Residence: _____
   Telephone Number of Discharge Site: _____
3. Death (Date): ___ / ___ / ___ ☐ In LTCF ☐ In Hospital

VII. CERTIFICATION: The facility certifies that the patient will reside only in those areas of the facility which are certified for participation in the New Jersey Medicaid Program at the level of care authorized for this patient by the New Jersey Medicaid Program. The facility also certifies that upon discharge to a hospital, the patient's room/bed will be reserved for the full period of time covered by the New Jersey Medicaid Bed Reserve Policy. If nursing facility bills Medicaid for long term care services, the person signing this form certifies that the facility has a valid PAS on file. **This form completed by:**

Name: _____ Phone Number: _____

LTC-2 Notification of Admission

- **Northern Regional Office** – csessexltcfo@dhs.nj.gov
  - Bergen, Essex, Hudson, Morris, Passaic, Sussex, Warren
- **Central Regional Office** – csmiddlesexltcfo@dhs.nj.gov
  - Hunterdon, Middlesex, Monmouth, Somerset, Union
- **Southern Regional Office** - csatlanticltcfo@dhs.nj.gov
  - Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Ocean, Salem

Nursing Home Supplementation

42 U.S. Code §1396(a) - State plans for medical assistance

- The amount of payment made under subchapter XVIII of this US Code stipulates that the amount of payment under the State plan shall be considered to be payment in full for the service.
- There is no Medicaid cost sharing for NF care, the state's payment is payment in full. **As the resident does not directly pay the room and board fee, supplementation is not allowed. The cost of services, as well as room and board are paid by the state.**

Transition to the Community

NF MDS Section Q

Under Section Q of the Minimum Data Set (MDS), nursing facilities must ask residents directly if they are interested in learning about the possibility of returning to the community and speaking to someone from the Local Contact Agency.

The Division of Aging Services (DoAS), Money Follows the Person Team is the Local Contact Agency.

Q0500 Return to Community MDS Assessment Guidelines

- Q0500.B. – resident is asked if he/she would like to speak to someone about the possibility of returning to community.
- Family, significant other, guardian or legally authorized representative are consulted if resident is unable to communicate preferences.
- Q0600.0.-3. – referral made to LCA, YES or NO response
  - Q0600.2. YES – make LCA referral
  - Q0600.0. NO – resident and care planning team decide that contact is not required – OR –
  - Q0600.1. NO – referral not made for some reason even though resident and care planning team decide that the LCA needs to be contacted
  - If responding NO, there should be documentation why referral was not made

Custodial Care vs Discharge to Community

- NF Social Workers are responsible for identifying discharge plans for their residents. This is an ongoing process as the individual's needs change.
- MCOs are responsible for a NF to Community Transition plan to proactively address the discharge needs of members placed in a NF/SCNF.
- The State's goal is to maintain individuals in the least restrictive setting to meet their long term care needs.
- Individuals in need of custodial care should be assessed for MLTSS.
- Individuals seeking discharge to the community may or may not be eligible for MLTSS.

NF Transitions

In coordination with the NF Social Worker, OCCO or the MCO is responsible for assisting in the transition of individuals to less restrictive settings as requested/identified.

- Money Follows the Person Liaisons from OCCO collaborate for:
  - Money Follows the Person (MFP) Transitions for Medicaid beneficiaries
  - Discharge planning for non-MCO residents
- NJ Family Care MCOs collaborate for:
  - Discharge planning for MCO members

NF Transitions

Upon identification of a discharge plan to the community, a NJ Choice assessment is conducted to determine eligibility for MLTSS.

- If no Medicaid or MCO enrollment, OCCO will conduct the assessment
  - If the individual is Medicaid eligible, the MLTSS eligibility will trigger MCO enrollment
  - An IDT will be scheduled with the MCO, OCCO, and the NF upon MCO enrollment
    - An IDT is not mandatory prior to discharge, but Medicaid services may not be easily accessible upon discharge
- If MCO enrolled, the MCO Care Manager will conduct the assessment
  - The IDT will be scheduled with the MCO and the NF
    - MFP OCCO staff will participate if MFP
    - A person centered care plan will be created and services arranged upon discharge

What is Money Follows the Person (MFP)/I Choose Home NJ (ICH)?

The Money Follows the Person Demonstration Project is a nationwide initiative created by the Federal Government. NJ's MFP Program is called I Choose Home NJ.

- Helps low-income seniors and individuals with disabilities transition from institutions to the community that meet the following criteria:
  - Sign an informed consent;
  - Reside in an institution for 90 consecutive days or more;
  - Eligible for Medicaid 1 day prior to transition;
  - Transition to a "qualified residence";
  - Is eligible for MLTSS on day 1 of discharge
- Savings resulting from individuals residing in the community allows states to develop more community based long term care opportunities.

MFP/ICH Transitions

- The Division of Aging Services, Office of Community Choice Options has an MFP Associate Project Manager and 6 dedicated MFP/ICH Liaison positions.
- The OCCO/MFP team are the Division's subject matter experts on Nursing Facility Transitions.
  - The MCOs have Housing Specialists who also are experts on transition and housing resources
- The MFP team conducts Options Counseling for Section Q referrals, follow up on NF residents interested in transitioning, and conduct in-services for Nursing Facilities.

Overview of MLTSS Provider Responsibilities

- Providers Requirement to confirm Member Eligibility and Enrollment
- Claims Submission
  - Coordination of Benefits
  - Timely Filing

Provider's Requirement to Confirm NJ Family Care Eligibility

- Providers must confirm NJ Family Care Eligibility each month to ensure that member is currently enrolled
- Provider must confirm that member is enrolled in Health Plan and that they have an active authorization
- If Member has changed MCO, provider must contact existing Health Plan regarding authorization update

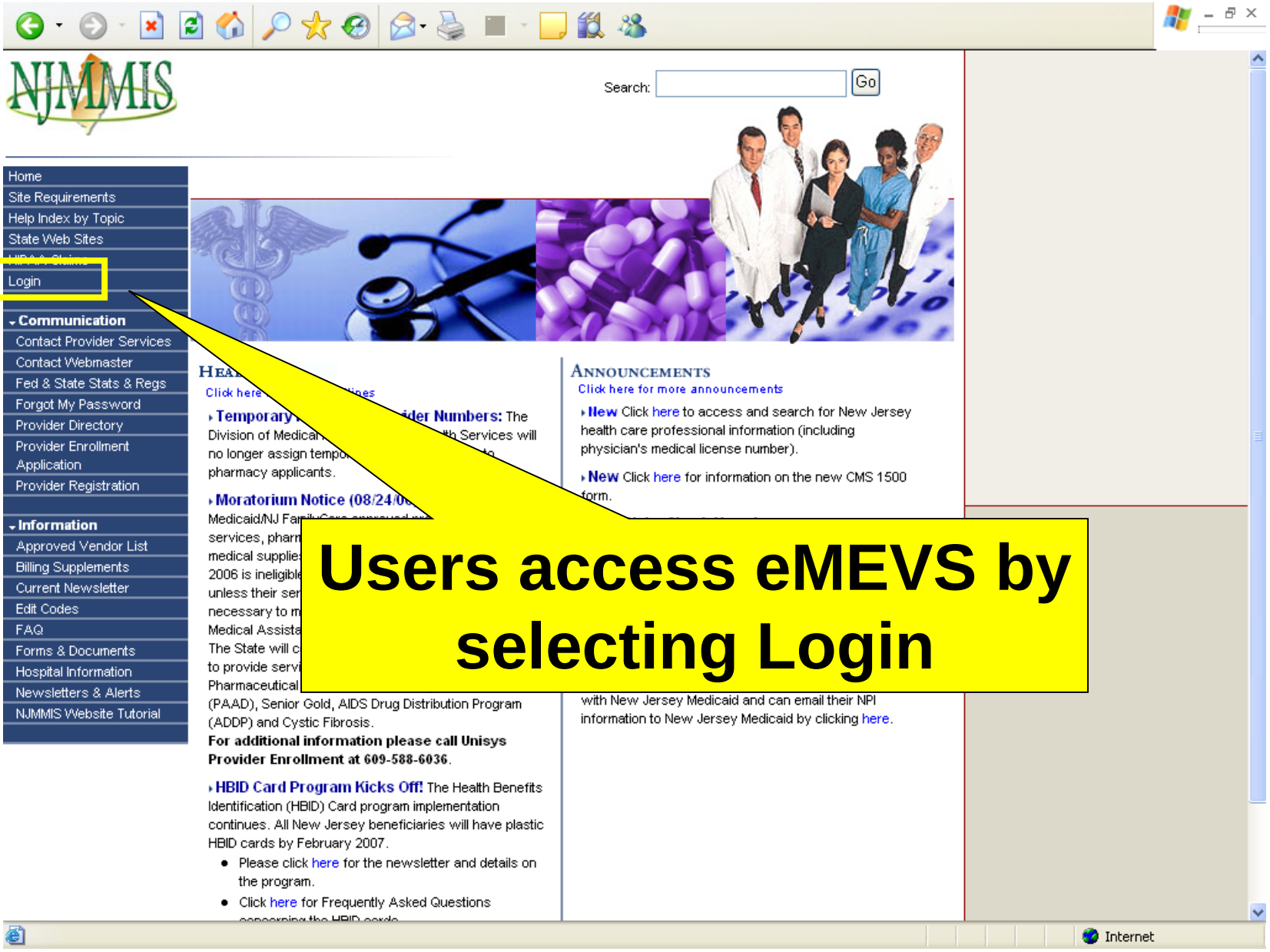
Options to Confirm Eligibility

- NJ Family Care FFS Service Enrolled Providers
- NJMMIS-E-MEVS
- Providers not enrolled as NJ Family Care Fee for Service Provider must access individual Health Plan site for confirmation

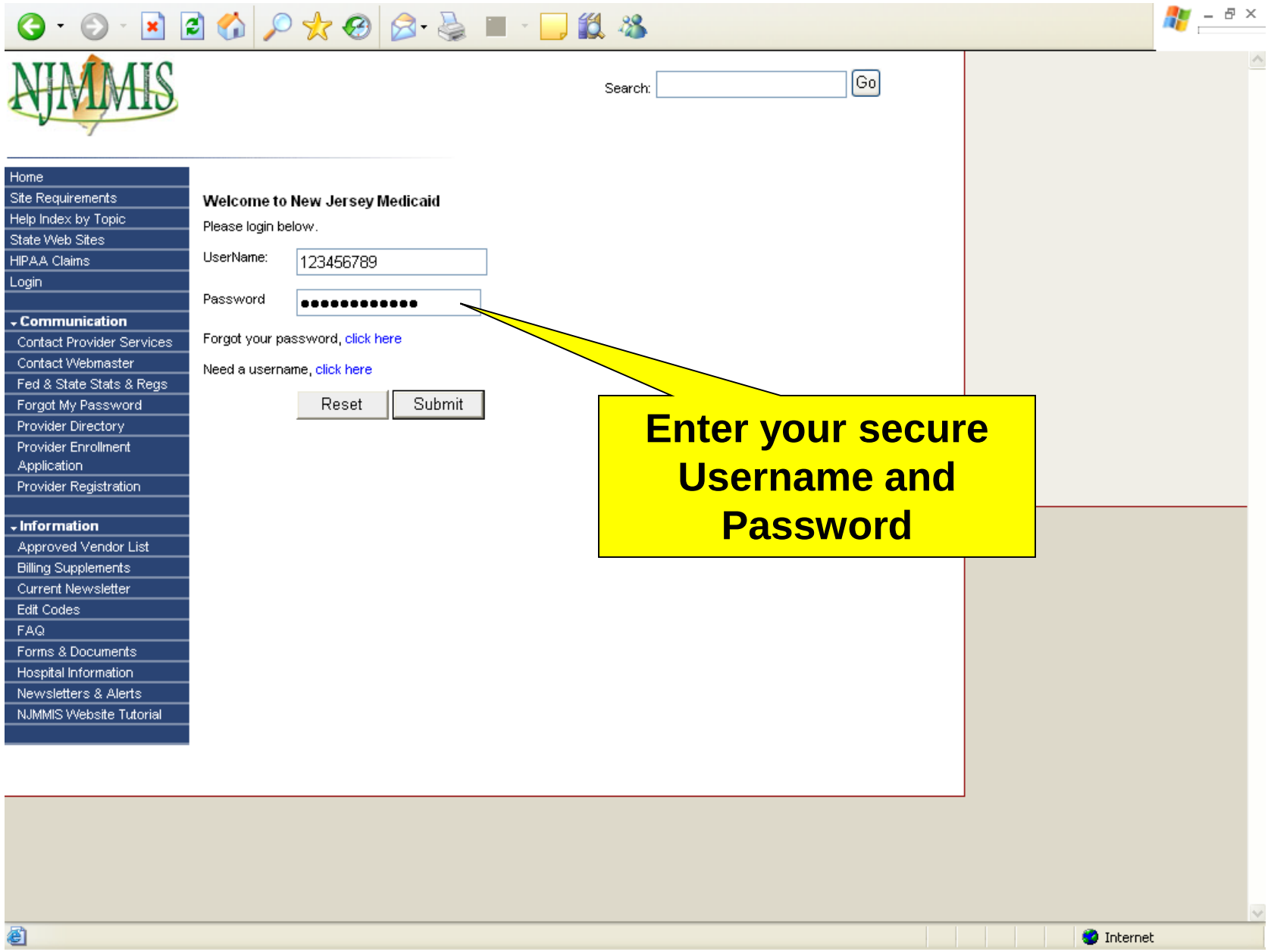
Note: Members will only be displayed in Health Plan site if enrolled in specific Health Plan

eMEVS

- Providers access eMEVS through "Login" on the NJMMIS website www.njmmis.com
- In order to login, individual must have a secure username and password
- Users ids and passwords are requested through Provider Registration link on the NJMMIS navigational bar on main screen.



Users access eMEVS by selecting Login


NJMMIS
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Home
Site Requirements
Help Index by Topic
State Web Sites
HIPAA Claims
Login
Communication
Contact Provider Services
Contact Webmaster
Fed & State Stats & Regs
Forgot My Password
Provider Directory
Provider Enrollment Application
Provider Registration
Information
Approved Vendor List
Billing Supplements
Current Newsletter
Edit Codes
FAQ
Forms & Documents
Hospital Information
Newsletters & Alerts
NJMMIS Website Tutorial
Welcome to New Jersey Medicaid
Please login below.
UserName:
123456789
Password
Forgot your password, click here
Need a username, click here
Reset
Submit
Enter your secure Username and Password
Internet

NJMMIS

Search: Go

- Home
- Site Requirements
- Help Index by Topic
- State Web Sites
- HIPAA Claims
- Log Off

Communication
- Contact Provider Services
- Contact Webmaster
- Fed & State Stats & Regs
- Forgot My Password
- Provider Directory
- Provider Enrollment Application
- Provider Registration

Information
- Approved Vendor List
- Billing Supplements
- Current Newsletter
- Edit Codes
- FAQ
- Forms & Documents
- Hospital Information
- Newsletters & Alerts
- NJMMIS Website Tutorial

Secured Options
- CCF
- Clear Claim Connection
- eMevs
- NPI
- Report Distribution
- Request Judge Run

Welcome [redacted] to njmmis.com. You have been authenticated.

ID will appear

Access to eMEVS

Headlines

Temporary Pharmacy Provider Numbers: The Division of Medical Assistance and Health Services will no longer assign t… pharmacy applica…

Moratorium No… Medicaid/NJ Family… services, pharmac… medical supplies, … 2006 is ineligible f… unless their service… necessary to meet specia… Division of Medical Assistance … rvices. The State will co… ccept pharmacy applications to provide s… beneficiaries enrolled in Pharma… Assistance for the Aged and Disable… (P… Senior Gold, AIDS Drug Distribution Program (… DP) and Cystic Fibrosis.

For additional information please call Unisys Provider Enrollment at 609-588-6036.

HBID Card Program Kicks Off! The Health Benefits Identification (HBID) Card program implementation continues. All New Jersey beneficiaries will have plastic HBID cards by February 2007.

- Please click here for the newsletter and details on the program.
- Click here for Frequently Asked Questions concerning the HBID cards.
- Click here to review the HBID Provider Overview.

Announcements

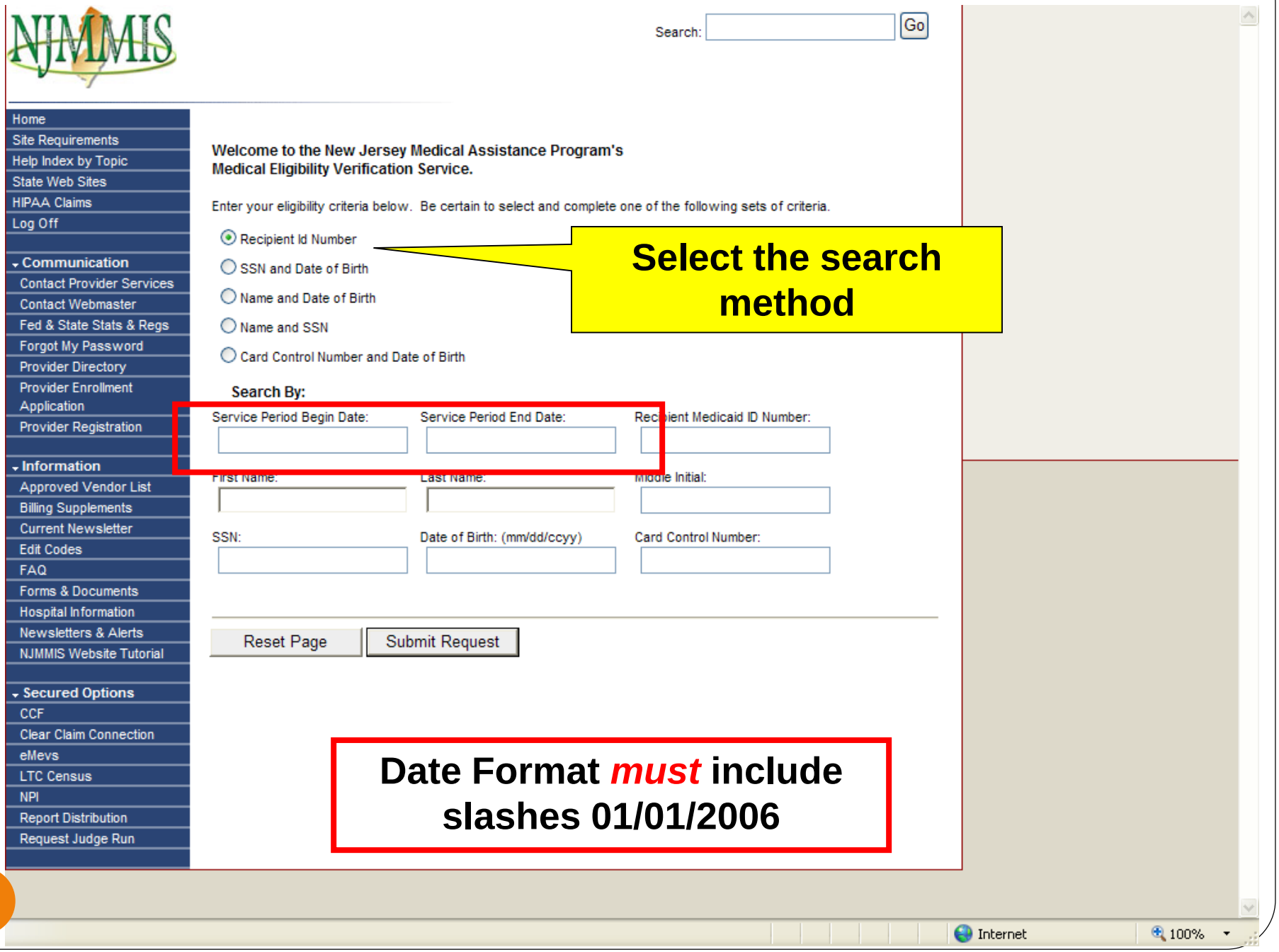
New Click here for information on the new CMS 1500 form.

…ews! Click here for …est information/messages.

…s National Provider Identifier (NPI) …iders may continue to use New …er numbers on all health care …v Jersey Medicaid for payment. …d via future newsletters regarding when the only provider identifier that will be accepted is the NPI. Providers still must register their NPI with New Jersey Medicaid and can email their NPI information to New Jersey Medicaid by clicking here.

New Providers have the ability to include their NPI on their HIPAA 837 transaction. Click here for corresponding Submitter Letter.

Internet 100%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Site Requirements
Help Index by Topic
State Web Sites
HIPAA Claims
Log Off
Communication
Contact Provider Services
Contact Webmaster
Fed & State Stats & Regs
Forgot My Password
Provider Directory
Provider Enrollment Application
Provider Registration
Information
Approved Vendor List
Billing Supplements
Current Newsletter
Edit Codes
FAQ
Forms & Documents
Hospital Information
Newsletters & Alerts
NJMMIS Website Tutorial
Secured Options
CCF
Clear Claim Connection
eMevs
LTC Census
NPI
Report Distribution
Request Judge Run
Welcome to the New Jersey Medical Assistance Program's Medical Eligibility Verification Service.
Enter your eligibility criteria below. Be certain to select and complete one of the following sets of criteria.
Recipient Id Number
SSN and Date of Birth
Name and Date of Birth
Name and SSN
Card Control Number and Date of Birth
Select the search method
Search By:
Service Period Begin Date:
Service Period End Date:
Recipient Medicaid ID Number:
First Name:
Last Name:
Middle Initial:
SSN:
Date of Birth: (mm/dd/ccyy)
Card Control Number:
Reset Page
Submit Request
Date Format must include slashes 01/01/2006
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Benefits of Checking Eligibility Each Month

- eMEVS records Provider queries electronically
- eMEVS record may provide documentation for Provider if eligibility was updated after provider confirmed monthly eligibility and claims are denied based on updated eligibility.
- **Note: If provider does not check Eligibility DHS can not assist with claims resolution that involve eligibility changes**

E-MEVS Displays Important Data

- Medicaid Eligibility Data
  - Termination Date –displayed if members eligibility scheduled to term month eligibility is verified
  - Termination Code Descriptions
- MCO Name –Begin Date
- Special Program Code
- Eligible Services
- Medicare Part A-Data
- TPL Information
- Cost share –
  - PR -1 Nursing Facility
  - PR -2 Assisted Living
  - Community PR is not displayed (PR 3)

E-MEVS Display of Termination detail month prior to termination

If the Member's Eligibility is terminating month of inquiry date, the date and an Eligibility Termination message will be displayed for the following Provider Types

- 20 - Physician
- 35 – Assisted Living
- 37 – Managed care
- 44 – Home Care/CSOC/DDD Supports/CCW
- 51 - Transportation
- 73 – Case management
- 80 – LTC facilities
- 92 – Adult day health services

E-MEVS Display

The eligibility terminating message will display as follows:

- Coverage will end on mm/dd/yyyy
- Due to: "termination code description"

(see list on next slide)

E-MEVS Termination Code Descriptions

00 - Recipient record closed due to death with potential of recoverable assets

01 - Recipient did not show up for a re-determination appointment

02 - Recipient voluntarily disenrolled from the New Jersey Family Care program

03 - Recipient record closed because he/she lives out of state.

04 - Recipient record closed due to duplicate eligibility segment (updated by DMAHS staff only)

05 - Recipient record closed due to death - no assets

06 - Recipient record closed due to transfer to another county

07 - Recipient record closed due to transfer to another program

08 - Recipient record closed due to ineligibility

09 - Recipient record closed for other reasons

10 - Eligibility was terminated due to newly added private comprehensive TPL coverage

11 - Recipient failed to pay their share of the insurance premium payment for Family Care

12 - HCFA program cap has been reached

13 – Recipient failed to comply with Premium Support Program stipulations

14 – Eligibility terminated due to lack of managed care enrollment

15 – recipient in LTCF

18 – Reasonable Opportunity Period is ending

19 – Continuation of benefits ending

20 – Medicaid Expansion recipient terminated due to Medicare

23 – Lives out of State per PARIS Match

50 - Eligibility segment terminated due to change of Program Status Code

Emevs- Display
Demographic /Eligibility detail
Display is for time frame specified and may required month by month few to determine changes

Search By:

Service Period Begin Date: 10/01/2021	Service Period End Date: 10/21/2021	Recipient Medicaid ID Number: 123456789
First Name:	Last Name:	Middle Initial:
SSN:	Date of Birth: (mm/dd/ccyy)	Card Control Number:
State Bureau Identification (SBI):		

Reset Page | Submit Request | Print Result

Results as of 10/22/2021 4:58 PM:

Last Name: [redacted] First Name: [redacted] Middle Initial:
Submitted Recipient Id #: [redacted] Eligible: Yes
Date of Birth: 12/20/1[redacted] SSN:
Card Control Number:
Submitted SBI:
Submitted Begin Date: 10/01/2021 Submitted End Date: 10/21/2021
Hospice Message:

Medicaid Eligibility Data: **Title XIX Medicaid** **Anticipated LIS Level:** **2**

Begin Date: 3/1/2021 End Date: 10/21/2021
Recipient Id # for Billing: [redacted]
Message: NJ FAMILYCARE PLAN A, CLICK TO REFER TO NJMMIS.COM FOR NEWSLETTERS VOL.8 NO.7, VOL.23 NO.20; COVERED FOR SUBSTANCE USE DISORDER TREATMENT, CLICK TO REFER TO NEWSLETTER VOL.26 NO.06; PROGRAM 120

Eligible Services:

1-Medical Care	33-Chiropractic	35-Dental Care
45-Hospice	47-Hospital	48-Inpatient Hospital
50-Outpatient Hospital	86-Emergency Services	88-Pharmacy
98-Physician Visits	AL-Vision	MH-Mental Health
UC-Urgent Care		

SEE MEDICAID SPECIAL PROGRAM DATA (IF ANY) FOR ADDITIONS/LIMITATIONS TO THE SERVICES ABOVE.

Anticipated changes to eligibility display to include description of termination reason.

PSC	Begin Date	End Date	County of Res	Term Code	Term Description
120	03/01/2014	06/30/2015	02	08	CASE RECORD CLOSED DUE TO INELIGIBILITY

Emevs- Display
Medicaid Managed Care/Medicare
Special Program Code Data
Note: SPC data is critical for Cost Share deductions by MCO

Termination Message:
County of Supervision: 012 County Name: Middlesex

Medicaid Recipient Lockin Data:

Lockin Begin Date: Lockin End Date:
Message:

Medicaid Special Program Data:

Begin Date: 6/1/2021 End Date: 10/31/2021
Message: ENROLLED IN MLTSS. CLICK TO REFER TO NJMMIS.COM FOR NEWSLETTER VOL.25 NO.11, VOL.24 NO.07
Special Pgm Code: 62

Medicaid Managed Care Data:

MCO Name: HORIZON NJ HEALTH MCO Phone Number: 8006829091
Begin Date: 6/1/2021 End Date: 10/31/2021
MCO Patient ID Number: [redacted] Plan Code: 086
Message: EFFECTIVE 10/01/2018, ADDITIONAL SUBSTANCE USE DISORDER AND MENTAL HEALTH SERVICES WITH CERTAIN EXCEPTIONS ARE COVERED BY MCO, CLICK TO REFER TO NEWSLETTER VOL.28 NO.04.

Medicare Part A Data:

Begin Date: 12/1/1986 End Date: 12/31/9999
Medicare ID (MBI): [redacted]

Medicare Part B Data:

Begin Date: 12/1/1986 End Date: 12/31/9999
Medicare ID (MBI): [redacted]

Medicare Part D Data:

Start Date: End Date:
Contract Number: Plan Id:
Name: Policy Number:
Group Number: NJ Insurer Code:
Copay Level:

Commercial Third Party Coverage Data:

The MCO information is displayed if member is enrolled in and MCO

Emevs- Display
Third Party Liability/ Cost share Information

Medicare Part A Data:

Begin Date:	12/1/1986	End Date:	12/31/9999
Medicare ID (MBI):	1A83U50WT91		

Medicare Part B Data:

Begin Date:	12/1/1986	End Date:	12/31/9999
Medicare ID (MBI):	1A83U50WT91		

Medicare Part D Data:

Start Date:		End Date:	
Contract Number:		Plan Id:	
Name:		Policy Number:	
Group Number:		NJ Insurer Code:	
Copay Level:			

Commercial Third Party Coverage Data:

Begin Date:	12/1/2006	End Date:	10/31/2021
Policy Number:	[redacted]	Group Number:	[redacted]
Carrier Name:	[redacted]		
Message:	THE BENEFICIARY HAS COVERAGE WITH ANOTHER INSURER. CONTACT THE INSURER FOR DETAILS ON COVERAGE OR BENEFITS		

Commercial Third Party Coverage Data:

Begin Date:	6/1/2018	End Date:	10/31/2021
Policy Number:	[redacted]	Group Number:	[redacted]
Carrier Name:	[redacted]		
Message:	THE BENEFICIARY HAS COVERAGE WITH ANOTHER INSURER. CONTACT THE INSURER FOR DETAILS ON COVERAGE OR BENEFITS		

PR1/PR2 Data:

Begin Date:	5/1/2021	Available Income:	[redacted]
PR1/PR2 Indicator:	PR2		

Cost Share Data:

Begin Date:	10/1/2021	Cost Share:	[redacted]
PR1/PR2 Indicator:	PR2		

Available income and cost share are displayed – Cost share is systemically reduced from MCO cap when SPC and PR amount are aligned:

SPC 61- PR 1

SPC 62- PR-2

Note SPC – 60 will not result in cost share deduction from MCO.

Claims Processing

Medicaid Reimbursement is Payment in Full

- Medicaid Reimbursement is payment in full for all services defined in the Plan of Care (POC)
- There is no supplementation of services
- Providers cannot bill, nor can the provider accept additional funds for increased levels of care
- Families cannot pay the per diem rate to facilities when the individual is absent from the facility

FFS Billing Before MLTSS Start Date

- Service delivery is dependent on enrollment and eligibility requirements.
  - Some services can only be billed for under MLTSS
  - Some services can be billed for under managed care without MLTSS (FFS)
  - PACE covers services authorized by the interdisciplinary team; there is no FFS
- Eligibility from both a clinical and financial perspective **must** be completed for residents **before** any eligible FFS claims may be submitted to the State for payment.
- NF: Submits claims through the NJMMIS system
- AL providers (excluding ALP): Submit claims to request fee-for-service (FFS) reimbursement for AL services provided to those Medicaid beneficiaries determined MLTSS eligible based on **both** a clinical and a financial eligibility determination, but their enrollment in an MCO is pending.

FFS Payment Requirements

- AL providers (excluding ALP) with NJ Family Care newly eligible residents pending MCO enrollment shall notify the DMAHS Office of Provider Relations at mahs.provider-inquiries@dhs.nj.gov provide the following information in an excel report:
  - Resident' name
  - Date of birth
  - Medicaid ID number
  - Date the individual became "clinically" eligible for AL services
  - Facility name
- Please allow ten business days after notifying DMAHS before submitting FFS claims. After ten business days, the AL provider may submit claims to Molina Medicaid Solutions.

AL Billing After MLTSS Start Date Occurs

- Provider bills the individual directly for Room and Board cost share that identified in the PR2
- Provider bills the individual's MCO for services once MCO MLTSS start date has occurred
- The cost share will automatically be deducted from the MCO payment if an SPC 62 is assigned to the member.
  - The MCO is responsible for identifying and changing the living arrangement code
- Contact the MCO directly if the SPC 62 is not displayed and /or there is an issue with cost share deduction once enrolled in MCO
- Assignment of an SPC 60 will not automatically deduct cost share from the MCO's Cap. Providers must contact the MCO to update SPC. Provider should contact DMAHS if outreach to MCO has not resulted in update within 30 days. ***mahs.provider-inquiries@dhs.nj.gov***

Claims Process for Nursing Facility: FFS Periods

- Ensure LTC2 submissions has been made to OCCO
- Ensure clinical eligibility determination is on file with OCCO
- Submit claims to NJMMIS
- NJMMIS error codes to be reported to OCCO via the Request for Billing Assistance Form (RFBA)

Claims process Nursing Facility: MLTSS Members

- Collect individual Room and Board and any applicable Cost Share from MLTSS members (PR-1)
- Contact CWA regarding cost share calculation for MLTSS members
- Keep room available for 10 days if individual is hospitalized report bed hold
- Follow individual MCO billing guidelines for members with relevant cost-share

Universal Billing Format for MLTSS Services (Electronic Submission)

- Providers need to use the 837 P for AL facilities, HCBS service providers, and non-traditional providers such as home improvement contractors, emergency response system providers, meal delivery providers and more.
- Providers need to use the 837 I for NFs and SCNFs.

Claim Submission Requirements

- MCO claims are considered timely when submitted by providers within 180 days of the date of service as per (HCAPPA) P.L. 2005, c.352

Claim Submission Requirements: Primary Insurance

- If member has primary insurance, providers are required to submit Coordination of Benefits (COB) claims within 60 days from the date of primary insurer's Explanation of Benefits (EOB) or 180 days from the dates of service, whichever is later.
- For additional information, refer to the attached COB guidance:
  - https://www.state.nj.us/humanservices/dmahs/home/Coordination_of_Benefits_Guidance.pdf

Balance Billing

- A provider shall not seek payment from, and shall not institute or cause the initiation of collection proceedings or litigation against a beneficiary, a beneficiary's family member, any legal representative of the beneficiary, or anyone else acting on the beneficiary's behalf unless service does not meet criteria referenced in NJAC 10:74-8.7(a).
- Balance Billing details are also outlined in NJ Family Care Newsletter: Volume 23 No. 15 (*September 2013*)
- Limitations Regarding the Billing of NJFC beneficiaries
- All Medicaid/NJ Family Care newsletters posted on: http://www.njmmis.com

NJ Family Care Managed Care Provider Resources

NJ Family Care Managed Care Provider Reference Information

- Below is the link where the NJ FamilyCare MCO contract is posted: **http://www.state.nj.us/humanservices/dmahs/info/resources/care/**
- The link below will provide connection to individual MCO sites.
- https://nj.gov/humanservices/dmahs/clients/medicaid/hmo/index.html
  - Contact phone number for Member and Provider Relations is listed
  - Link for MCO Member Manual is posted

DMAHS Provider Relations Inquiry Process

Provider and/or Member contact DMAHS:

- Provider must submit claim detail to DMAHS Office of Managed Health Care (OMHC)
- Provider's submission must indicate that Medicaid guidelines were followed and MCO was contacted prior to outreach to OMHC, including:
  - eligibility
  - request for prior authorization
  - timely claim submission
  - timely appeal submission
- Member should submit copy of balance bills to DMAHS, DMAHS will contact MCO

All submissions should be sent to: mahs.provider-inquiries@dhs.nj.gov

DMAHS Provider Relations Inquiry Process

- OMHC completes inquiry on behalf of the provider upon receipt of detail indicating that MCO contract guidelines were followed.

- OMHC will review and follow-up with MCO on behalf of the Provider if initial response does not meet contract guidelines. All inquiries sent to MCO are logged into a SharePoint database.

Provider & Member Resource Information

NJ FamilyCare Member/Provider Hotline	**Medicaid member and provider eligibility claims and quality inquiries** **1-800-356-1561**
County Welfare Agencies (CWA)	Financial Eligibility Cost Share http://www.nj.gov/humanservices/dfd/programs/njsnap/cwa/
Medicaid Provider Communications	Division of Medical Assistance and Health Services Home Page www.state.nj.us/humanservices/dmahs/home
Office of Community Choice Options (OCCO)	Member clinical eligibility not MCO Enrolled Regional office contacts http://www.state.nj.us/humanservices/doas/home/directory.html