NJ Department of Human Services

FREQUENTLY ASKED QUESTIONS (FAQs) FOR PROVIDERS
NJ FamilyCare MANAGED LONG TERM SERVICES AND SUPPORTS (MLTSS)
(Revised November 25, 2014)

Note: The sections highlighted below in yellow contain new information as of October 1, 2014.

TRANSITION FOR WAIVER PROVIDERS

1. **With the transition of Global Options for Long Term Care (GO), AIDS Community Care Alternatives Program (ACCAP); Community Resources for People with Disabilities (CRPD); and Traumatic Brain Injury (TBI) into MLTSS effective July 1, 2014, what is the role of the current service providers?**

- Effective July 1, 2014 the managed care organizations (MCOs) were responsible for coordinating their members' plans of care and payments for waiver services.
- However, previous waiver providers (for the programs mentioned above) shall continue to provide the authorized services and hours identified in the participant's current plan of care beyond June 30, 2014 until the MCO care manager notifies the provider that a new care plan of care is established for the participant. At that time, the MCO will either authorize the provider to continue providing services under MLTSS or will terminate the services rendered by the provider.

2. After the transition to MLTSS, what is the correct billing procedure for providers?

- The fiscal intermediary will continue to process payments for invoices with service dates prior to July 1, 2014, but they must be received by PPL/CAU before December 31, 2014. Any invoices with service dates prior to July 1, 2014 received by PPL/CAU after December 31, 2014 shall not be considered for payment.
- All payment invoices for MLTSS services rendered on or after July 1, 2014 for members in a MCO need to be submitted to the members' MCO for payment instead of Molina Medicaid Solutions or the fiscal intermediary.

3. What is the process for providers to submit claims if the member was enrolled in waiver but was not transitioned to MLTSS?

- Claims for waiver services submitted to Molina Medicaid Solutions with service dates on or after July 1, 2014 shall be denied payment because the former waivers were terminated on June 30, 2014 and transitioned into MLTSS effective July 1, 2014. However, Molina will process fee for service (FFS) claims for the service period of July, 1 2014 through August 31, 2014 and issue payment through a reprocessing effort for members who are not enrolled in MLTSS. The payment processing will be completed by December 31, 2014. Refer to the NJMMIS website for instructions regarding claim submission.

4. How will providers receive notification that the MCO has updated the member's plan of care?

- The individual MCOs will work directly with the providers regarding the member's plan of care. The provider's primary point of contact regarding the member's services will be the MCO care manager.
- If a provider is not currently in the MCO network, the provider must contact the individual plans regarding steps to join the individual provider networks.
- Providers may be paid through a single-case agreement with the health plan as part of the continuity of care plan for individual members, but they must be in the network to continue to provide services.

5. **If an individual is determined to be eligible for MLTSS what services are they eligible to receive?**

- Members enrolled in MLTSS are eligible to receive state plan medical services included in the Plan A Benefit Package as well as services included in the MLTSS Service package.

  http://www.state.nj.us/humanservices/dmahs/home/MLTSS_Service_Dictionary.pdf

6. **If an NJ FamilyCare member does not meet clinical eligibility for MLTSS are they eligible to receive home and community based services, if needed?**

   Member enrolled in Medicaid Plan A as part of their State Plan benefit are eligible for Home Health Care-Non-Rehab, Home Health Care-Rehab, Personal Care Assistant and Medical Day Care- Adult.

   Refer to https://www.njmmis.com/downloadDocuments/23-20.pdf for full description of State Plan services for NJ FamilyCare members.

FEE-FOR-SERVICE MEMBER TRANSITION TO MLTSS for CUSTODIAL FFS MEMBERS

1. **Explain the triggers which would cause a custodial fee-for-service (FFS) resident on Medicaid in a nursing facility (NF) or a specialty care nursing facility (SCNF) to move into MLTSS?**

- The triggers are as follows:

  a) A change in a resident's level of care, meaning the resident is transitioning from a NF to a SCNF; transitioning from a SCNF to a NF, or transitioning from a SCNF to a different kind of SCNF (i.e. behavioral to vent);
  b) A change in a NF/SCNF provider, meaning a resident was admitted to the hospital from the NF and subsequently discharged and admitted to a different NF; or the resident was transitioned from one NF to a different NF;
  c) New admission to MLTSS, meaning the individual is transitioning from the NF to the community and eligible for MLTSS; or is a new NF admission for NJ FamilyCare (NJFC);
  d) New individual to NJ FamilyCare (NJFC) and eligible for MLTSS, meaning the individual is newly eligible for NJFC and needs custodial care in a nursing home. (Note: A change from the Medically Needy program to NJFC Care will trigger enrollment into MLTSS if individual meets clinical eligibility criteria.)
  e) A change from rehabilitation to custodial care (regardless of when admission to the NF occurred), meaning that an individual's Medicare benefits are exhausted after July 1 and the individual is determined to need custodial care.
  Note: If a member is custodial FFS prior to July 1, 2014 and uses the Medicare benefit for an acute or skilled service this is not a trigger for change in a members Medicaid enrollment.

NURSING FACILITY RESIDENT DISCHARGE

1. **A nursing facility resident (NF) resident, who is Medicaid fee-for-service (FFS) was living in the NF before July 1, 2014, but is now transitioning into the community or another NF. How does the resident become enrolled in a NJ FamilyCare MCO to obtain MLTSS to either move into the community or another NF?**

   The Office of Community Choice Options (OCCO), Division of Aging Services (DoAS), Department of Human Services (DHS) continues to be responsible for the transition process of NF residents, who are FFS Medicaid, and are moving into the community or another NF. As part of the process, OCCO will conduct a new assessment on the NF resident with the NJ Choice assessment tool to determine the nursing home level of care. At this point, the NF resident will also receive Options Counseling to learn about his/her long term care options—MLTSS or the PACE program, and how to select a NJ FamilyCare MCO if MLTSS is chosen. OCCO then assists the resident in contacting NJ FamilyCare to choose the MCO and help the resident and/or family/responsible party with actually enrolling in a MCO. OCCO works directly with the NJ FamilyCare enrollment unit, which inputs the resident's MCO selection into the system.

2. **How is a service plan developed for NF resident's transition into a home and community-based setting if the individual does not have an MCO? Does OCCO take the lead on this process since the person is Medicaid FFS?**

   For FFS Medicaid NF residents, OCCO serves as the lead entity in the process. An OCCO Community Choice Counselor is responsible for identifying potential residents who are able to move in the community, assessing care needs and help in choosing a community setting, etc. Once initial planning has taken place and specific benchmarks are met, the member would need to be enrolled into an MCO during the next enrollment period. At this point, it is the MCO who then becomes responsible for the individual, participates in the discharge planning and develops his/her plan of care. The MCO's care manager participates in the Interdisciplinary Team (IDT) meeting to finalize the plan of care and discharge to the community setting. Once the NF transition IDT is convened, the MCO care manager assumes the lead for developing a plan of care and the transition/discharge planning. OCCO still continues to serve as the subject matter expert.

3. **A FFS Medicaid NF resident wishes to sign himself out of the facility against medical advice. The individual is capable of making this decision from a cognitive standpoint. What is the process?**

   The Office of Community Choice Options (OCCO), Division of Aging Services (DoAS), Department of Human Services (DHS) continues to be responsible for the transition process of NF residents, who are FFS Medicaid, and are moving into the community or another NF. But in this situation, there is little (if any) lead time to coordinate MCO/MLTSS enrollment and schedule an IDT. If the resident wants to move into a home and community based setting with MLTSS and the resident is unwilling to remain in the NF until OCCO is able to facilitate the process, then the individual must handle the process in a different manner. The individual will need to contact the Aging and Disability Resource Connection/County Welfare Agency and apply for MLTSS from the community. The individual will still need to enroll into an MCO to enroll in MLTSS.

4. **Does the LTC-2 form need to be generated and sent to OCCO when a NF resident in a NJ FamilyCare MCO has requested a transfer to another NF?**

   If the resident is already enrolled in an MCO, the MCO is always the primary point of contact for the provider. The MCO should be contacted to notify the health plan of a member's request to transfer. Upon admission to the new NF, the receiving facility would submit a LTC-2 form to OCCO. However, if the resident is FFS Medicaid, then the sending NF would have the resident/responsible party forward a letter to OCCO requesting a transfer to another NF: 1) OCCO would visit the resident in his/her current NF and complete the pre-admission screening process (PAS) that would trigger MLTSS enrollment; 2) OCCO would issue an transfer authorization letter; and, 3) upon admission, the receiving NF would submit a LTC-2 to OCCO so the provider number can be entered in the claims system to cover FFS until MCO/MLTSS enrollment occurs.

ELIGIBILITY for MLTSS

1. What criteria must an individual meet to be eligible for MLTSS?

To be eligible for MLTSS an individual must meet the following eligibility criteria:

1. Categorical Eligibility
    - Aged – 65 years old or older, or
    - Blind ***or*** Disabled – Under 65 years of age and determined blind or disabled by the Social Security Administration or the State of New Jersey.

2. Clinical Eligibility
    - A person meets the qualifications for nursing home level of care, which means that s/he requires limited assistance with a minimum of 3 activities of daily living (ADL) such as bathing, toileting and mobility or the consumer has cognitive deficits and ADL needs of supervision in greater than 3 ADL areas.

3. Financial Eligibility –Institutional Medicaid
    - Income[1]
        - Income for one person can be equal to or less than $2,163* per month (2014).
        - Income for a couple can be equal to or less than $4,326* per month (2014).
        - All income is based on the gross amount.
    - Resources
        - Resources must be at or below $2,000 for an individual and $3,000 for a couple.

In addition, the financial eligibility component includes a five-year "look back" to insure member meets requirements for Institutional Medicaid. Individuals in the Alternate Benefit Plan (ABP) determined to be medically frail are not required to meet the five-year look back requirements until they reach the age of 65 or are eligible for Medicare.

* Subject to annual change
[1]Note that for children applying for MLTSS and who meet the nursing home level of care, parental income and resources are not counted in determining financial eligibility.

FINANCIAL ELIGIBILITY DETERMINATION

1. Where do residents apply for Medicaid?

- Individuals must apply for Medicaid at the County Welfare Agency (CWA). The submission of an application with its supporting documents is required to determine financial eligibility.

2. Who do residential providers contact to insure that the member meets financial eligibility for MLTSS if member is currently approved for "community Medicaid"?

- Institutional Medicaid eligibility is required for MLTSS. Providers and the MCO should contact the CWA regarding a member's eligibility for Institutional Medicaid. Institutional Medicaid includes a five-year "look back" for assets.

3. **Who do residential providers contact if an individual is admitted to a facility pending Medicaid eligibility?**

- The CWA determines financial eligibility for Medicaid. If a residential provider has a release from the member, the provider can contact the CWA regarding a member's financial eligibility. If the provider does not have a release, the member and/or their representative should contact the CWA.

CLINICAL ELIGIBILITY DETERMINATION

1. Will the hospitals still be doing the Enhanced At-Risk Criteria Screening – (EARC-PAS) for hospitalized patients going to the nursing facility (NF) on NJ FamilyCare?

- Yes. The NF authorization process will be the responsibility of the NJ FamilyCare MCOs under MLTSS. The E_ARC tool will only be utilized for non-Medicaid participants and will serve as a 90-day temporary authorization.

2. **Who and what will determine where a MLTSS member is going to be placed in the continuum of care?**

- The NJ FamilyCare MCOs will have the acute and primary health care services and home and community-based services coordinated (care managed) for their members by an MLTSS care manager. The choice of services and setting is based on consumer preference and care needs.

3. If NJ FamilyCare will be converting the long-term care facility payments to the NJ FamilyCare MCOs, how will the care management take place?

- All MLTSS beneficiaries will have a care manager assigned to them by the MCO. The care manager will visit with NJ FamilyCare residents in long-term care facilities (only those who are admitted or become Medicaid eligible after July 1, 2014 and provide the following services):

    a) Evaluate the resident's service and care coordination needs on an annual basis and as your care needs change;

b) Help the resident to develop a plan of Care (POC);
c) Help the resident to select and arrange his/her services;
d) Work with the resident and his/her doctors to ensure that all needed medical and dental visits and screenings take place;
e) Assist with service problems or concerns, and
f) Assist with the managed care plan's participant rights.

4. How will the NJ Family Care MCO cover community services like cognitive rehabilitation and residential long-term care for patients discharged from post-acute facilities?

- The NJ FamilyCare MCO contract parameters outline the continuity of care requirements for members who will transition to MLTSS. The MCO care manager will evaluate service needs of all members and provide care coordination needs on an annual basis and as the care needs change.

5. What criteria does a member enrolled in NJ FamilyCare MCO need to meet in order to receive MLTSS services?

- Providers and/or members must contact the MCO for a clinical assessment for members enrolled in a NJ FamilyCare MCO. In addition, the CWA must be contacted regarding the financial eligibility requirements. A member must meet the following criteria to receive MLTSS services:

    - Clinical: person meets the qualifications for nursing home level of care, which means that s/he requires assistance with a minimum of three activities of daily living such as bathing, toileting and mobility. The MCO will complete NJ Choice and forward to the Office of Community Choice Options (OCCO) for review and approval.
    - Institutional Medicaid Eligibility: Financial Eligibility for MLTSS includes a higher income and five–year "look back" of assets. The CWA completes financial determination.

6. **What entity will handle the Pre-Admission Screening Process for new members to NJ FamilyCare MLTSS?**

- The Office of Community Choice Options (OCCO) in the Division of Aging Services, Department of Human Services (DHS) will conduct the Pre-Admission Screening (PAS) process for individuals, who are new to NJ FamilyCare, and seeking clinical eligibility for MLTSS. The MCO will conduct the PAS for its members seeking clinical eligibility, which will then be reviewed and authorized by OCCO. All MLTSS members, regardless of their living arrangements, will receive annual re-evaluations by their MCO. The re-evaluations will be reviewed and authorized by OCCO.

MLTSS MEMBER ELIGIBILITY CONFIRMATION

1. Why must a provider confirm a member's eligibility status in NJ FamilyCare and/or the individual's enrollment in a NJ FamilyCare MCO for MLTSS?

- Providers must have the information on an individual's NJ FamilyCare status to be sure that the prior authorization is obtained from the correct entity so that the billing is submitted to the correct payer. If a provider has inaccurate information and, as a result, bills incorrectly, the provider may not be able to file in a timely manner and will lose reimbursement.

2. What is a provider's requirement in terms of confirming a member's eligibility in NJFamilyCare?

- Providers must confirm a member's NJ FamilyCare eligibility on a monthly basis to ensure that the member remains enrolled in the program. If a member has changed MCOs, providers must contact the existing health plan for an updated authorization. Providers also must confirm that the member is enrolled in an MCO with an active authorization to receive MLTSS.

3. How can a provider check a member's eligibility status in NJ FamilyCare and/or the member's enrollment in a NJ FamilyCare MCO for MLTSS?

- There are two methods available for providers to verify a beneficiary's eligibility status:

  a) The first option is to access REVS or the Recipient Eligibility Verification System if the provider is a NJFC fee-for-service provider. The provider may call 1-800-676-6562 to verify an individual's NJFC eligibility and, at the same time, confirm if the individual has Medicare Parts A and B coverage. REVS may also be used to access health plan membership information.

  b) The State has a second option to verify eligibility using the internet, which is referred to as eMEVS or the Electronic Medicaid Eligibility Verification System. This System is supported on a secure area of the www.njmmis.com website. A provider may visit www.njmmis.com and select the link on the left side of the page called "Contact Webmaster." The provider will complete a screen to request a username and password in order to access eMEVS. When using eMEVS, a provider has the option of entering a Card Control Number from the Health Benefits Identification (HBID) card; the beneficiary's Social Security Number or Name. EMEVS displays a formatted eligibility response on the computer, which a provider can view quickly and print for their records.

- Any provider with an active login ID and password may access the web portal. However, a provider may only verify a member's NJFC eligibility for service dates that fall within that provider's NJFC provider eligibility period. For example, if a provider is eligible to participate in NJFC as a valid provider between 01/01/13 and 12/31/13 and the service date for a member is 01/01/14; the provider would not have access to that member's eligibility information since the service date to be verified is outside of that provider's NJFC provider eligibility period.

MLTSS MEMBER ENROLLMENT AND ELIGIBILITY INFORMATION

1. **Can an Assisted Living (AL) resident who already is enrolled in one NJ FamilyCare MCO change to a different MCO due to the transition of AL services to MLTSS? Is this a good cause situation? What happens if, for some reason, the AL is not part of the network of the MCO the resident is enrolled in?**

- There will be several opportunities after the July 1, 2014 transition date to MLTSS to change to another MCO. Residents can call NJ FamilyCare at 1-866-472-5338 (TTY 800-701-0720) for more information.
- All NJ FamilyCare MCO beneficiaries can change their MCO to another MCO during the annual Open Enrollment Period, which takes place October 1 – November 15 annually.
- In addition, if a member has good cause, he/she can call NJ FamilyCare at 1-866-472-5338 (TTY 800-701-0720) at any time to ask about changing his/her MCO to another MCO.
- The NJFC MLTSS MCO contract has two-year *Any Willing Provider* and *Any Willing Plan* (AWP) provisions for Assisted Living (AL), Community Residential Services (CRS), Nursing Facility (NF) and Special Care Nursing Facilities (SCNF) providers.

2. **Who is doing the semi-annual recertification?**

- Level of care determinations will be conducted annually by the MCO for MLTSS participants.

3. **Is there a 60-day waiting period for MLTSS services?**

- Under MLTSS, there is not a 60-day waiting period before a person can access MLTSS. The delay in receiving MLTSS services is due to the timing of the financial/clinical eligibility process and the cutoff date (25th of each month) for assigning a new member to an MCO. For example: A person is determined to be clinically eligible on May 5th, then determined financially eligible on May 18th and is entered into the eligibility system on May 20th. Because the enrollment date was before May 25th, the person can begin to receive services June 1st. If the enrollment date had been May 29th, the enrollment date was after May 25th, therefore enrollment into MLTSS could not begin until July 1st.

4. **Are there still a Medicaid Track 1 and Track 2 in NFs and what is the impact on enrollment in MLTSS?**

   Members approved and enrolled in an MCO for MLTSS will not have Track 1 and Track 2 designation, since an MLTSS individual has met NF LOC and financial eligibility for an institutional setting. However, the Track 1 and Track 2 designation will be used for individuals who have not been enrolled in MLTSS.

5. **Will a SCNF be able to request an exemption from enrollment in MLTSS for an individual on NJ FamilyCare who is in a brain injury special unit?**

- Medicaid eligible individuals who are admitted to a SCNF prior to July 1, 2014 will be exempted from MLTSS for a period of up to two years. Medicaid individuals admitted to a SCNF after July 1, 2014 will be enrolled into MLTSS.

6. **If a NJ FamilyCare member needs to stay in a SCNF beyond Day 30, will the MCO automatically disenroll the patient?**

- The 30-day limit goes away for new residents on NJ FamilyCare admitted after July 1, 2014, or for those who switch from another payer to NJ FamilyCare after July 1.

7. **An individual is admitted to a trauma center and started his/her application for NJ FamilyCare while hospitalized. The patient is then transferred to another hospital for rehabilitation. NJ FamilyCare is later approved and a NJ FamilyCare number is assigned. Will the NJ FamilyCare MCO be assigned while the patient is still in the hospital?**

- While the individual is hospitalized, there will be no changes made to his NJ FamilyCare status. Any changes will be made after the individual is discharged from the hospital.

8. **An individual is admitted to a trauma center and started his/her application for NJ FamilyCare while hospitalized. The patient is then transferred to a long-term care facility for rehabilitation. NJ FamilyCare is later approved and a NJ FamilyCare number is assigned. Will the NJ FamilyCare MCO be assigned while the patient is still in the long-term care facility?**

- Yes, the member will be enrolled in a NJ FamilyCare MCO when the member is discharged from the hospital.

9. **An individual is admitted to a sub-acute rehabilitation facility for a traumatic brain injury. The individual's application for NJ FamilyCare is pending and not yet approved. What entity provides the pre-authorization for admission to SCNF if there is no NJ FamilyCare MCO yet involved?**

- OCCO is responsible for determining if an individual meets the clinical requirements for NJ FamilyCare MLTSS by using the NJ Choice assessment tool when members Medicaid eligibility is pending.

10. **An individual already is on NJ FamilyCare before a traumatic event. The individual is admitted to a sub-acute rehabilitation facility. Before the transition to MLTSS, this individual would have been dis-enrolled from NJ FamilyCare on Day 31. Will this policy change with the transition to MLTSS on July 1, 2014?**

- The 30-day limitation on NJ FamilyCare coverage ends after July 1 with the move to MLTSS. As a result FamilyCare member's long term care is managed by the MCO that the individual is enrolled.

MLTSS PATIENT PAY LIABILITY/COST SHARE

1. Who will calculate cost share/patient pay liability (PPL)?

- The County Welfare Agency (CWA), on behalf of the State of New Jersey, will calculate the cost share for individuals applying for Institutional Medicaid.

2. How will the cost share/patient pay liability be communicated to AL and NF providers?

- The CWA will enter the cost share amount in the Medicaid eligibility system and send notification to the NF or AL provider. In addition, the notification will be sent to the member and/or the member's designee. The cost share amount will be included in claims submitted to the MCO.

3. How will the CWA process the statement of income form in a timely manner and switch residents from Community Medicaid to Institutional Medicaid?

- The State has introduced a new electronic PR (previously PA-3L) form which streamlines the process and improves accuracy. The CWA staff will enter cost share information into the Medicaid Eligibility system.

4. How is the patient payment liability going to be collected?

- Cost share/patient payment liability (PPL) will be collected by the NF and/or AL provider. The MCO's process to account for cost share and payment to facilities will be outlined in the individual MCO contract with providers.

6. How are the members cost share communicated to MCO?

- The capitation payment from the State for the individual members to the MCO will be reduced by the State based on the individual member's cost share/PPL.

- The MCO will communicate with the provider as to the amount of PPL and the process which the MCO will use for billing.

7. How will retroactive cost share/patient pay liability be communicated to MCO?

- The capitation payment from the state for the individual members to the MCO will be adjusted based on the retroactive cost share/patient pay liability. The MCO will work directly with the provider to account for the retroactive cost share.

8. Is a new NJ FamilyCare resident in AL responsible for turning over his/her monthly income immediately upon enrollment into an MCO?

- The month of admission is excluded for current AL residents. Beginning in the second month after admission, however, the MLTSS member will be responsible for his/her patient pay liability (PPL) minus the allowable deductions for room and board, medical expenses (i.e. Medicare Part B) and other personal needs allowance (PNA).

9. Is a new NJ FamilyCare resident in a NF responsible for turning over his/her monthly income immediately upon enrollment into an MCO?

- NF residents without a month of admission disregard will have to turn over income for the first month of enrollment.

MCO PROVIDER NETWORK AND MLTSS

1. What are the health plan's responsibilities in regard to establishing a provider network?

- Each health plan has specific responsibilities when contracting with providers, including:

a) offering an application when considering enrolling providers in network;
b) credentialing/re-credentialing providers;
c) establishing a contract with providers selected to be network providers and subcontractors;
d) creating an annual provider manual and preparing updates as necessary;
    a. offering provider education and outreach;
e) providing access to call center staff to resolve payment issues; and,
f) providing a process for claim and utilization appeals.

2. How do health plan's contract with providers?

- The health plan will establish written agreements and/or contracts with providers selected to service enrolled members. Templates for provider contracts are reviewed and approved by the NJ Division of Medical Assistance and Health Services (DMAHS) and the NJ Department of Banking and Insurance before they are distributed to providers to ensure regulatory and contract compliance

3. What do the Any Willing Provider (AWP) and Any Willing Plan (AWP) provisions mean for residential providers?

- The NJFC MLTSS MCO contract has a two-year *Any Willing Provider* and *Any Willing Plan* (AWP) provisions for providers in these categories: Assisted Living (AL), Community Residential Services (CRS), Nursing Facility (NF) and Special Care Nursing Facilities (SCNF).

- The AWP provisions include any New Jersey-based NF, SCNF, AL or CRS providers. It also includes any long-term care pharmacy that applies to become a network provider. The pharmacy must comply with the Pharmacy

Benefit Plan (PBM) provider network requirements; and accept the terms and conditions of the health plan provider contract, or terms for network participation.

- If the health plan wishes to have any New Jersey-based NF, SCNF, AL or CRS join its network, the providers will be instructed to complete an application form.

4. What steps does a non-residential provider need to complete to be a provider with an MCO that administers the MLTSS benefit?

1. Inquire if the MCO is accepting applications for service;
2. Submit application;
3. Complete credentialing requirements, and,
4. Secure a contract if the MCO and provider reach a contract agreement.

5. What are the MCO contact numbers for Provider Relations and MLTSS?

- The following are the special Provider Relations department numbers at each MCO:

NJFC Health Plan	Provider Relations	MLTSS Contacts
Amerigroup New Jersey, Inc.	**1-800-454-3730**	**1-800-454-3730**
Horizon NJ Health	**1-800-682-9091**	**1-877-765-4325**
UnitedHealthcare Community Plan	**1-888-362-3368**	**1-888-702-2168**
WellCare of New Jersey	**1-888-453-2534**	**1-888-453-2534 or 588-9769**

The contact information for each NJFC MCO is also available on the DHS web-site at http://www.state.nj.us/humanservices/dmahs/info/resources/hmo/

NJ FamilyCare MCO CONTRACT PARAMETERS FOR MLTSS PROVIDERS

1. What federal/state regulations govern the payment of claims and the issuance of prior authorizations under the NJFC managed care contract?

Existing law was amended and supplemented by L. 2005, c. 352 (Chapter 352) – the Health Claims Authorization, Processing and Payment Act (HCAPPA). As of July 11, 2006, health plans must have processes and procedures for providers regarding the handling of claims; claims payment appeals; prior authorization processes; utilization management; appeal rights and obligations; and information about clinical guidelines and claim submissions.

2. What are the prior authorization parameters in the Health Claims Authorization Processing and Payment Act (HCAPPA)?

- As mandated in the HCAPPA, prior authorization decisions for non-emergency services need to be made within 14 calendar days. Prior authorization denials and limitations must also be provided in writing.

3. What are the claims submission parameters in the HCAPPA?

- In compliance with HCAPPA, claims are considered timely if they are submitted within 180 days of the date of service.

4. What claims submission requirements must MCOs follow to meet NJ FamilyCare Contract parameters?

The MCOs must capture and adjudicate all the claims submitted by providers and comply with NJ FamilyCare's data reporting requirements. The MCOs must ensure the coordination of benefits by exhausting all other payment sources before NJ FamilyCare pays. The provider must follow the process established by each plan to submit claims.

5. What is the universal billing format for MLTSS?

For paper submissions:

- Providers need to use the "1500" form 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 "UB-04" form for NFs and SCNFs.

For electronic submissions:

- Providers need to use the "837 P" form 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" form for NFs and SCNFs.

6. What are the claims submission requirements of providers if there is an explanation of benefits?

- The MCO contract specifies consistent timelines across all plans. Timeframes are consistent with DOBI for all medical services.
- Providers are to submit Coordination of Benefits (COB) claims within 60 days from the date of the primary insurer's Explanation of Benefits (EOB) or 180 days from the dates of service, whichever is later.

7. What are the claims processing requirements of the MCOs?

- The MCO contract language specifies that an MLTSS service claim should be processed by the MCO to the provider within 15 days of a clean submission. For non-MLTSS services, the MCO contract language specifies that claims should be processed by the MCO to the provider within 30 days of a clean submission.

8. What are the claims submission categories?

- The claim submission categories are as follows:
    1. Initial
    2. Claim resubmission
    3. Claim denial
    4. Claims Appeal.

9. What is a claim re-submission?

- A claim may get denied for a variety of reasons, so it is important for a provider to supply the MCO with as much information as possible when re-submitting a claim. Some common reasons for a claim re-submission include: corrected claim, adding of prior notification/prior authorization information and verification of bundled claim.

10. How does the coordination of benefits work for MLTSS members?

- If a member has another health or casualty insurer, the MCO is responsible for coordinating benefits to maximize the utilization of third party coverage and ensure that NJ FamilyCare is the payer of last resort. The provider must follow each MCO's process for submitting claims.

11. What are the policies on "balance billing" with MLTSS for providers?

- 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 the service does not meet criteria referenced in NJAC 10:74-8.7(a).
- For more information on the issue of balance billing and the limitations regarding the billing of NJ FamilyCare beneficiaries, refer to the Division of Medical Assistance and Health Services' *Medicaid/NJ FamilyCare Newsletter:* Volume 23 No. 15, which is dated September 2013. All NJ FamilyCare newsletters are posted on http://www.njmmis.com/

12. What are the Utilization Management Appeal parameters in the HCAPPA?

- An appeal or "adverse benefit decision" is included as part of the MCO contract for any member and/or provider who is not satisfied with the MCO's policies, procedures, a decision made by the MCO, or disagrees with the MCO as to whether a service, supply, or procedure is a covered benefit, is medically necessary, or is performed in the appropriate setting.

13. What is the MCO function with regard to complaints, grievances and appeals?

- An MLTSS member has three stages to appeal an adverse benefit determination by an MCO for medical services plus the option to ask for a Medicaid Fair Hearing.
- For non-medical services, the MLTSS member has two stages of appeal plus the option to ask for a Medicaid Fair Hearing.
- A member can file a complaint or grievance or a representative, such as a family member or a provider, can file on the member's behalf with the member's written consent.

14. Will the member continue to receive MLTSS during his/her appeal process or the Medicaid Fair Hearing process?

- During all stages of the appeal process or the Medicaid Fair Hearing process, services will continue while the appeal is being reviewed. However, the following conditions must apply:

    1. The appeal is filed on time;
    2. The appeal involves a previously authorized course of treatment;
    3. The services were ordered by an authorized provider, and,
    4. For those who requested a Medicaid Fair Hearing, continuation of benefits must be requested in writing within 20 days of the date of the denial letter.

15. What is the process to request a Medicaid Fair Hearing?

- A beneficiary or a provider on the beneficiary's behalf (with his/her written consent) can request a Medicaid Fair Hearing at any time during the appeal process.
- The Medicaid Fair Hearing Unit is available at 609-588-2655. The adverse decision letter must be mailed to the address below:

    Division of Medical Assistance and Health Services
    Fair Hearing Section
    P.O. Box 712
    Trenton, NJ 08625-0712

MLTSS CONTRACT PARAMETERS FOR RESIDENTIAL PROVIDERS

1. What are the covered services included in the per diem rates for NFs, SCNFs and AL facilities?

- The State has agreed that the default rate for NF, SCNF, AL and CRS during the AWP period ending June 30, 2016 will be the higher of: (a) the rate set by the state as of April, 2014 with the possibility of an increase each fiscal year for inflation, dependent upon available appropriation; and, (b) the negotiated rate between the contractor and the facility. This does not preclude volume based rate negotiations and agreement between the contractor and these providers. If a negotiated rate cannot be agreed upon, the rate will default to the state rate. A statement will be added to the verbatim language for provider agreements section in the MCO contract for AWP providers.

- The DHS can also confirm that the MCO contract language regarding AL programs is inclusive of all AL programs including comprehensive personal care and AL programs; therefore, we do not believe additional contract language is necessary.

2. Are there exclusions for specialty items, such as special beds and wound vacuums, in the provider contracts with the MCOs?

- The state confirms that the established managed care rates for long term care facilities and assisted living providers are the fee-for-service per diem rates currently in effect, and includes those additional contracted services that will be provided under MLTSS for the AWP period ending June 30, 2016. There is nothing in the MCO contract that would preclude some or all providers and the MCOs to mutually agree to enter into global payment arrangements before the AWP period concludes.

3. How will "bed hold" days be handled under MLTSS?

- The reporting requirements for bed hold are outlined in individual MCO contracts with the residential providers. In the MLTSS Service Dictionary and on the UB-04 and 8:37I, bed hold days do not have an reimbursement value but they will be reported on a claim.

4. Does the provider bill for "bed hold" on the UB-04 when a resident is hospitalized or does the resident need to be discharged when going to a hospital under MLTSS?

Bed hold information will be reported in the parameters of the MCO contract with providers; in the MLTSS Service Dictionary and on the UB-04 lite and 8:37I. Bed hold days do not have an reimbursement value but they will be reported on a claim.

5. How will remittance advices for Long Term Care be handled under MLTSS?

- The long-term care facilities will need to follow each MCO's guidelines.

6. How will the number of monthly Medicaid days be reported post MLTSS implementation? Will it differ for residents on MLTSS versus those residents on fee-for-service Medicaid?

- The long-term care facilities will need to continue to report their census through the Medicaid MMIS.

7. Will pharmacy services remain the same for the NFs and SCNFs?

- Pharmacy service procedures will depend on the contracts which the NJ FamilyCare MCOs have with each long-term care facility.

8. How will the provider bill for Room and Board in the long-term care facilities under MLTSS?

- Room and Board will continue to be collected by the long-term care facilities. The MCO payment to facilities will be outlined in the MCO contract with providers.

9. *How are therapeutic leave days handled under MLTSS?

- Therapeutic leave days will not be paid, but they will be reported.

OPERATIONS

1. Can each MCO provide an outline of its authorization process for the NFs, ALs and SCNFs and provide written information?

- The MCO provider manual will outline the process for authorizing MLTSS services.

2. Will clearinghouses be required for providers to use to submit claims to the NJ FamilyCare MCOs?

- The individual MCOs will outline the process for claim submissions.

3. Will the turn-around documents used by the NFs and SCNFs remain the same under MLTSS?

- The LTC-2, "Notification from Long Term Care Facility," form will continue to be submitted to OCCO. The form will be revised to reflect MLTSS.

4. How often do the long-term care facilities need to provide documentation under MLTSS to the MCOs?

- The answer depends on a variety of factors, including the individual resident's clinical needs and the MCO's care model. The MLTSS contract parameters between the MCOs and DHS outlines the standards to be followed for all MCOs.

5. Is supplementation in AL still allowed?

- Yes, it is allowable to pay for the cost difference between a private room and a double room. However, the supplement would be considered income to the member and may impact his/her Medicaid financial eligibility.

6. Will pharmacy remain the same for AL?

- The prescriptions will be filled according to the NJ FamilyCare MCO program's formulary (list of medications) and policies. For specific information regarding prescription coverage, the resident will need to contact the Member Services department phone number on the back of his/her MCO Member ID card.
- Medicare Part D benefits are not affected if the resident remains in traditional Medicare and a Medicare Part D Drug Plan, and is enrolled in a NJ FamilyCare MCO.

7. Please explain how the MCOs will coordinate behavioral health services for MLTSS residents of ALs, NFs, and SCNFs under MLTSS?

- The NJ FamilyCare MCOs will cover behavioral health services for MLTSS like they will handle other specialty care for their members in long-term care facilities who will need to visit specialists, i.e. podiatrists, pulmonologists and oncologists.

8. How often will the care managers from the MCOs meet with NF and SCNF residents enrolled in MLTSS?

- The timing of care management meetings with long-term care facility residents will depend on a variety of factors, including the individual resident's clinical needs, the MCO's care model and the MLTSS contract parameters between the MCOs and DHS.
- The contract stipulates a minimum of every 180 days for NF and Non-pediatric SCNF and every 90 days for Pediatric SCNF.

9. Does the NF have to have a contract with hospices that have a contract with the MCOs their residents are enrolled?

- The hospice provider must have an agreement/contract with the NJ FamilyCare MCO to offer hospice services.

10. How will claim adjustments be handled for NJ FamilyCare residents? Will claim adjustment forms be specific to each MCO? Will they be available online? Does the provider use claim adjustment forms to communicate the changes in resident income and leaves of absence?

- The individual MCOs will outline the process for claims submissions and adjustments.

11. Please explain the transition for AL residents. When will the contract between the MCO care managers and facilities begin?

- The AL residents transitioned to an MCO care manager on July 1, 2014. The timing of care management meetings with AL residents depends on a variety of factors, including the individual resident's clinical needs, the MCO's care model and the MLTSS contract parameters between the MCOs and DHS. The MCO care managers are responsible to continue all services and conduct telephonic outreach until a face-to-face visit and assessment are conducted no later than 180 days from July 1, 2014.

12. Providers are currently required to bill Medicare first to prove that Medicare is the primary payer for a dual eligible beneficiary? Does the process stay the same with MLTSS in that a provider must include a Medicare denial with the bill to the MCO?

If the beneficiary is dually eligible

a. Medicare must be billed, prior to NJ FamilyCare, if the service is covered by Medicare:

b. Medicare balances may be billed to the NJ FamilyCare MCO if the Medicare benefit is exhausted

The individual MCOs will outline the documentation required when a member is dually eligible.

RESOURCES FOR NJ FAMILYCARE PROVIDERS OF MLTSS

1. Are MLTSS resources available on the NJ Department of Human Services' website?

- Yes. The MCO contract is posted on line at http://www.state.nj.us/humanservices/dmahs/info/resources/care/
- The following link will connect you to the individual NJ FamilyCare MCO websites. Also included are phone numbers for the Member and Provider Relations units at the MCOs. It is http://www.state.nj.us/humanservices/dmahs/info/resources/hmo/.
- The following link includes MLTSS Information for Consumers and Stakeholders:

  http://www.state.nj.us/humanservices/dmahs/home/mltss_resources.html

2. **Who are the MLTSS contacts at DHS?**

DHS	***MLTSS Contacts***
Division of Aging Services Care Management Hotline	1- 866-854-1596
Division of Disability Services Care Management Hotline	1-888-285-3036
NJ FamilyCare Member/Provider Hotline	1-800-356-1561
NJ FamilyCare Health Benefits Coordinator (HBC)	1-800-701-0710
NJ FamilyCare Office of Managed Health Care, Managed Provider Relations	MAHS.Provider-inquiries@dhs.state.nj.us