

# Qualified Income Trust Overview



STATE OF NEW JERSEY  
DEPARTMENT OF HUMAN SERVICES  
DIVISION OF MEDICAL ASSISTANCE & HEALTH SERVICES

# What is a Qualified Income Trust (QIT)

- The Omnibus Budget Reconciliation Act of 1993 established the provisions for Qualifying Income Trusts (QIT)
- New Jersey seeks federal approval for individuals in need of long-term care to use these trust devices in order to attain Medicaid eligibility for the following living arrangements:
  - Home -based living (HB); Assisted Living (AL); Nursing Facilities (NF)
- Described in the Social Security Act at 1917 (d)(4)(B)
- This type of trust can only include income dollars
- Income over the Medicaid limit is deposited into the trust account and is not counted towards Medicaid eligibility
- The income that is deposited into a QIT account is subject to the cost share and other post-eligibility expenses such as a Personal Needs Allowance (PNA)

# Required Trust Provisions

- Must contain only income dollars  
(no resources)
- Must be irrevocable
- New Jersey must be the first remaining beneficiary of funds upon the death of the Medicaid recipient
- Must have a trustee (not the Medicaid recipient) to take care of administrative obligations

# Trust Rules and Operations

- All income including that income placed in the Trust can only pay the post-eligibility treatment of income and cost share according to federal regulations at 42 CFR 435.725 and 435.726.
- Post-eligibility deductions are made using all monthly income.
- Any income left over after these post-eligibility payments must remain in the Trust.
- At the time of death, the funds remaining must be paid to the State of NJ up to the cost of funds expended on Medicaid.

# Establishment of a QIT

- A QIT must be established and funded in the month of the desired eligibility date.
- QITs may be established for an individual by a lawyer, however, it is not a requirement.
- DMAHS posted a QIT template on its website that may be used by individuals.
- All QITs are subject to the review and approval of Medicaid eligibility staff.

# Post-eligibility Treatment of Income

Order of expenses deducted from monthly income:

- Personal Needs Allowance - \$35\* for NF

OR

- Maintenance Needs Allowances

\$ 871.05\*- room and board plus an additional \$107.00\* for AL

\$2,163.00\*- living at home (must be spent each month or considered a resource the following month)

- Community Spouse Maintenance Allowance = \$1,966.24\* minus spouse's income
  - Shelter Allowance = Shelter cost minus \$589.88\*
  - Utility allowance is \$491.00\* per month only if utilities are paid
- Allowance for uncovered, state approved medical expenses and health insurance premiums
- Cost Share: Will be paid by the trustee directly to the Nursing Facility and the Assisted Living Facility or for those residing at home, the trustee will pay it directly to DMAHS

\*dollar amounts reflect 2014 standards

# Medicaid Eligibility Resource Limits

- Resource limits are \$2,000 for an individual and \$3,000 for a couple.
- Individuals who will be moving from the Medically Needy program to Medicaid Only using a QIT will need to be aware that their resource limit will decrease from \$4,000 for an individual and \$6,000 for a couple.

# QIT Implementation Process

- Public Notice
- State Plan Amendment (SPA)
- QIT Medicaid Communication
- DMAHS Website information on QITs
- FAQs with consumer email access
- QIT Template
- Preparing training for stakeholders-end of Oct.



# Additional Information and Help

- You can find FAQs and additional information regarding the establishment of a QIT and the QIT template on the DMAHS website at:  
<http://www.state.nj.us/humanservices/dmahs/clients/mtrusts.html>
- Any additional questions may be emailed to DMAHS staff : [MAHS.QIT@dhs.state.nj.us](mailto:MAHS.QIT@dhs.state.nj.us) The questions submitted will be added to the FAQ section of the website.

*Informational Update:*

# **NJ FamilyCare Expansion Enrollment**

# Expansion Basics

## Timeline

- Oct. 2013 – Applications Started
- Jan. 2014 – Expansion Population Benefits Started

## Who's Eligible?

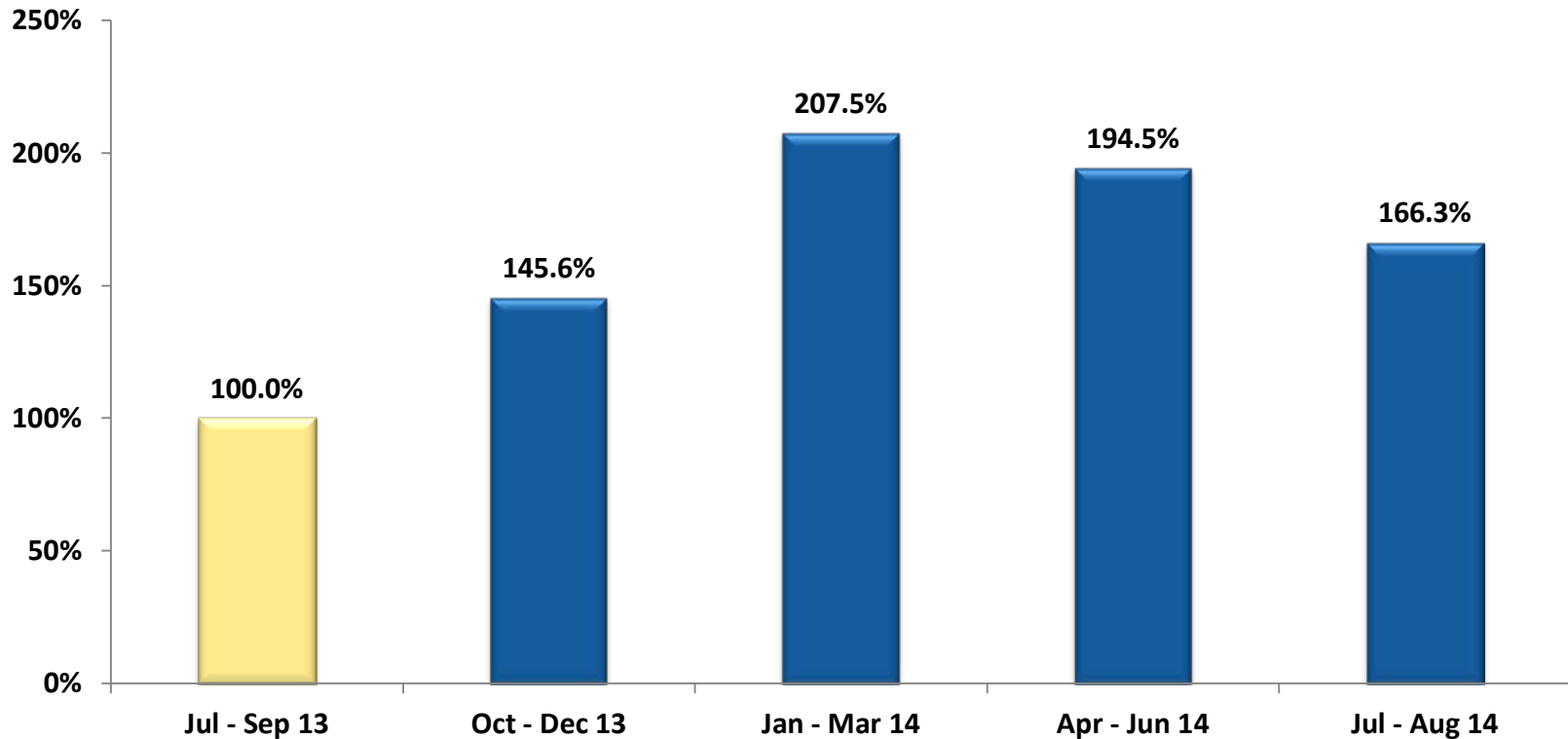
- All adults earning up to 133% of federal poverty level (\$26,321 per year for a family of three)
- Those previously eligible also expected to enroll due to federal law's "individual mandate"

## Who pays?

- Federal government pays 100% of expansion population's benefits through 2016
- Federal share slowly tapers to 90% by 2020

# Xerox Call Center Volume

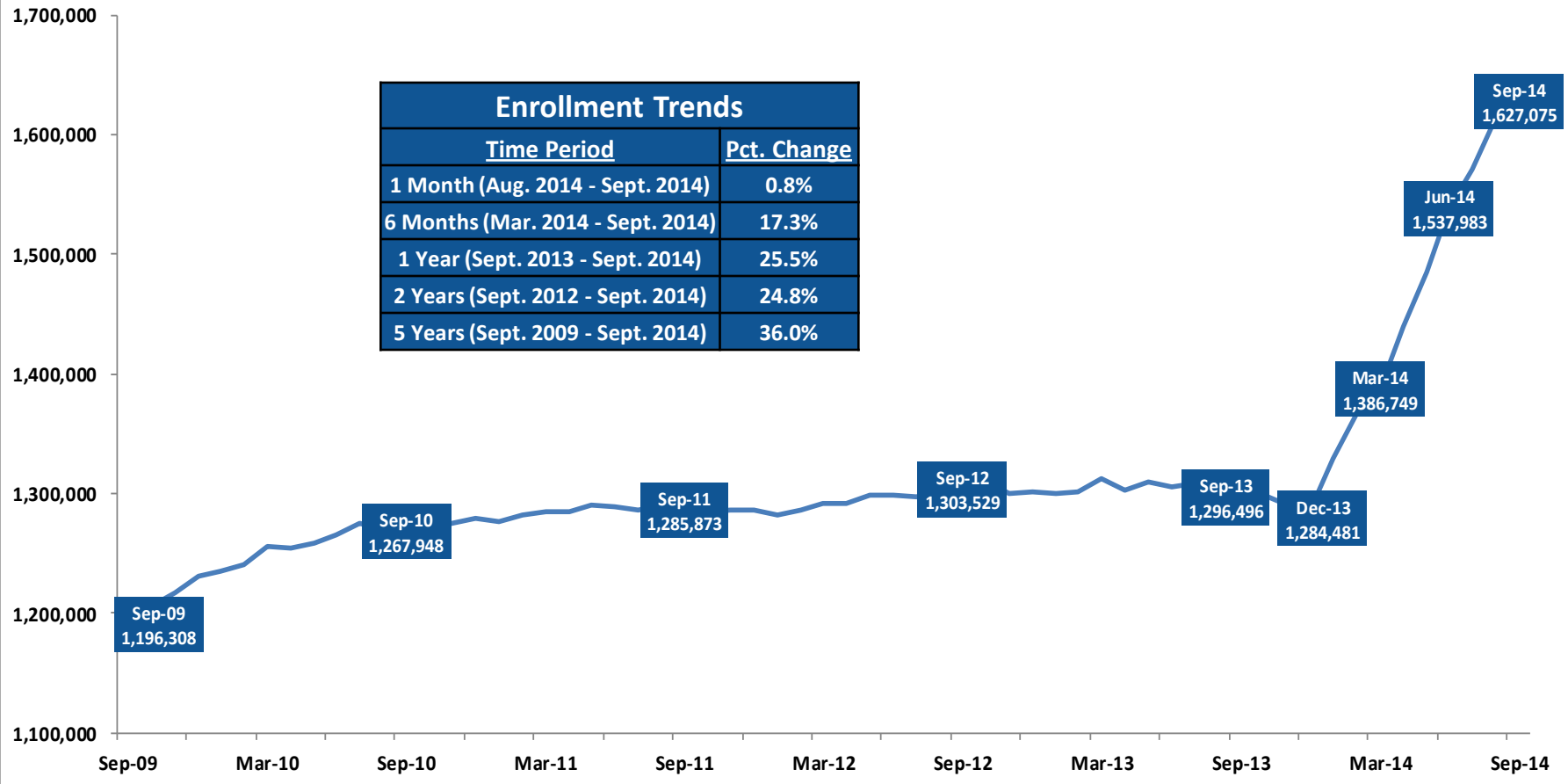
Call Volume as Percent of Baseline (Jul - Sep 2013)



Source: Xerox, New Jersey's Health Benefits Coordinator

# Overall Enrollment

Total NJ FamilyCare Recipients, Sept. 2009 – Sept. 2014



Source: Monthly eligibility statistics released by NJ DMAHS Office of Research available at <http://www.nj.gov/humanservices/dmahs/news/reports/index.html>

Notes: Includes all recipients eligible for NJ DMAHS programs at any point during the month

# September 2014 Expansion Summary

**Enrolled Adults Maintaining Eligibility  
Due to Expansion**

**159,915\***

**Newly Eligible Adults**

**279,560**

**Previously Eligible Children & Parents**

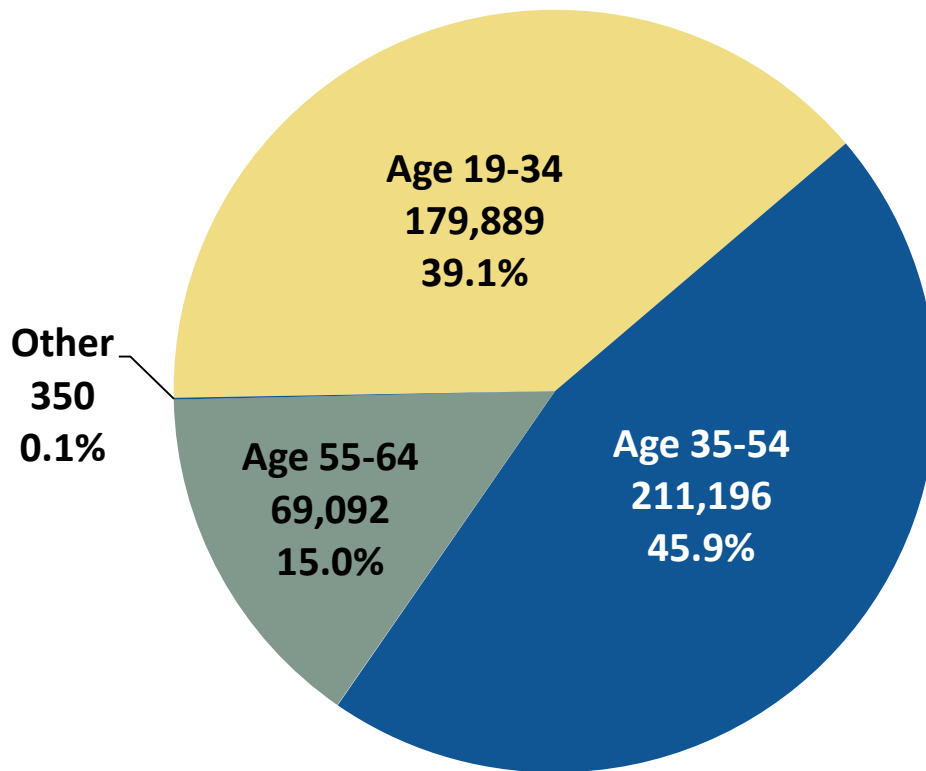
**66,571**

\* Total recipients "flipped" to Expansion eligibility categories in January 2014 = 176,369

Source: Monthly eligibility statistics released by NJ DMAHS Office of Research available at <http://www.nj.gov/humanservices/dmahs/news/reports/index.html>; Dec. eligibility recast to reflect new public statistical report categories established in January 2014

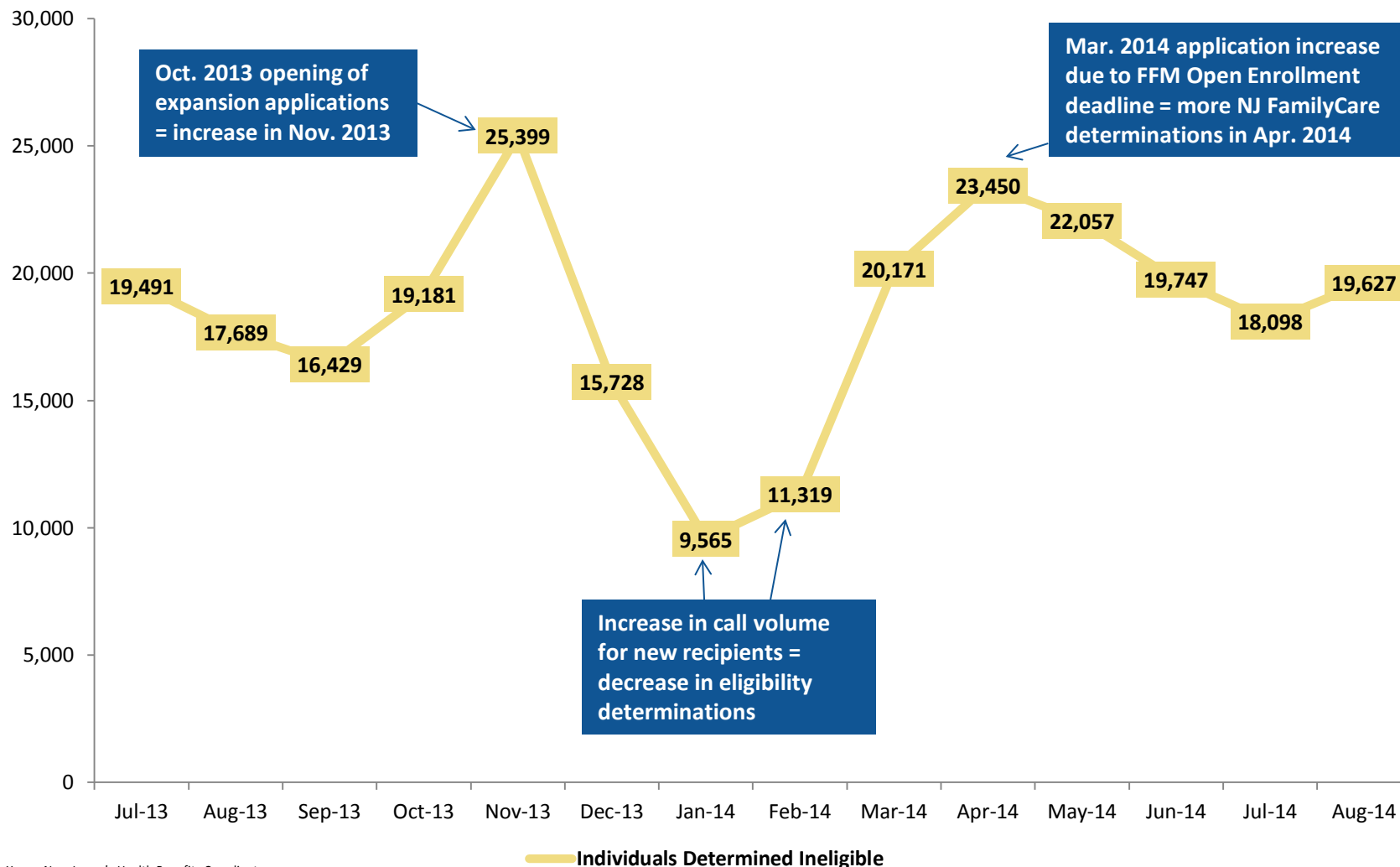
Notes: Net change since Dec. 2013; a small number of "Newly Eligible Adults Enrolled in NJ FamilyCare" were eligible for the former "General Assistance Medicaid Waiver" prior to 1/1/14; 3,537 adults were disenrolled in Dec. 2013 and were not subsequently found eligible by the federally facilitated marketplace prior to 1/1/14

# Expansion Population (Sept. 2014) by Age Group



Source: NJ DMAHS Shared Data Warehouse Snapshot Eligibility Summary Universe, run for 9/1/2014.  
Notes: Expansion Population is composed of 'ABP Parent Up To 133% FPL' and 'Other Adult Up To 133% FPL'

# Individuals Determined Ineligible



Source: Xerox, New Jersey's Health Benefits Coordinator



# SNAP Streamlined NJ FamilyCare Enrollment

May 2013 CMS guidance allows states to streamline the NJ FamilyCare enrollment process for certain Supplemental Nutrition Assistance Program (SNAP, formerly food stamps) recipients

The streamlined process includes the use of data from existing government databases and other means-tested programs, such as SNAP, to expedite and simplify eligibility determinations

New Jersey is one of 6 states using the streamlined enrollment process for its SNAP recipients (Ark., Calif., Ill., Ore., WV)

CMS authority for this process is effective through December 2015

# SNAP Enrollment Process for NJ FamilyCare

**21,083 Uninsured, Single Adult SNAP Recipients Identified**

- Ages 19- under 65
- Verified US citizen
- Valid Address
- No eligibility past month

**Express Applications Mailed between 5/28 and 6/11**

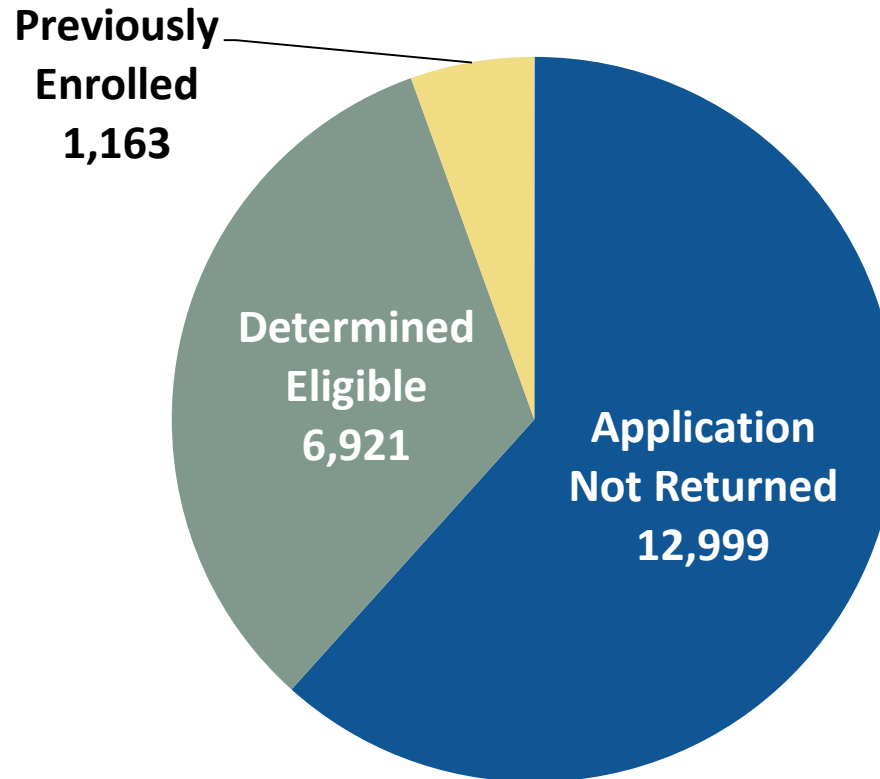
- English/Spanish
- Cover letter
- Shortened Application
- Postage Paid Envelope

**Enrolled by Xerox**

- Receipt of applications affirming enrollment in NJFC with choice of health plan
- Applications processed by Xerox

# NJ FamilyCare SNAP Enrollment

## SNAP Recipient Mailing Results



Source: Xerox, New Jersey's Health Benefits Coordinator

Note: Applications received through 9/15/14

# Presumptive Eligibility

## Definition

NJ FamilyCare enrollment allowing individuals presumed to be eligible to temporarily access healthcare services on a FFS basis pending a full eligibility determination

## NJFC Process

Individuals are screened by state certified presumptive eligibility coordinators, usually at FQHCs/hospitals; online applications are sent to the State for expedited processing

## Effective 1/1/14

Federal law made Presumptive Eligibility available to adults in expansion populations. Previously, only children and pregnant women were eligible for this program

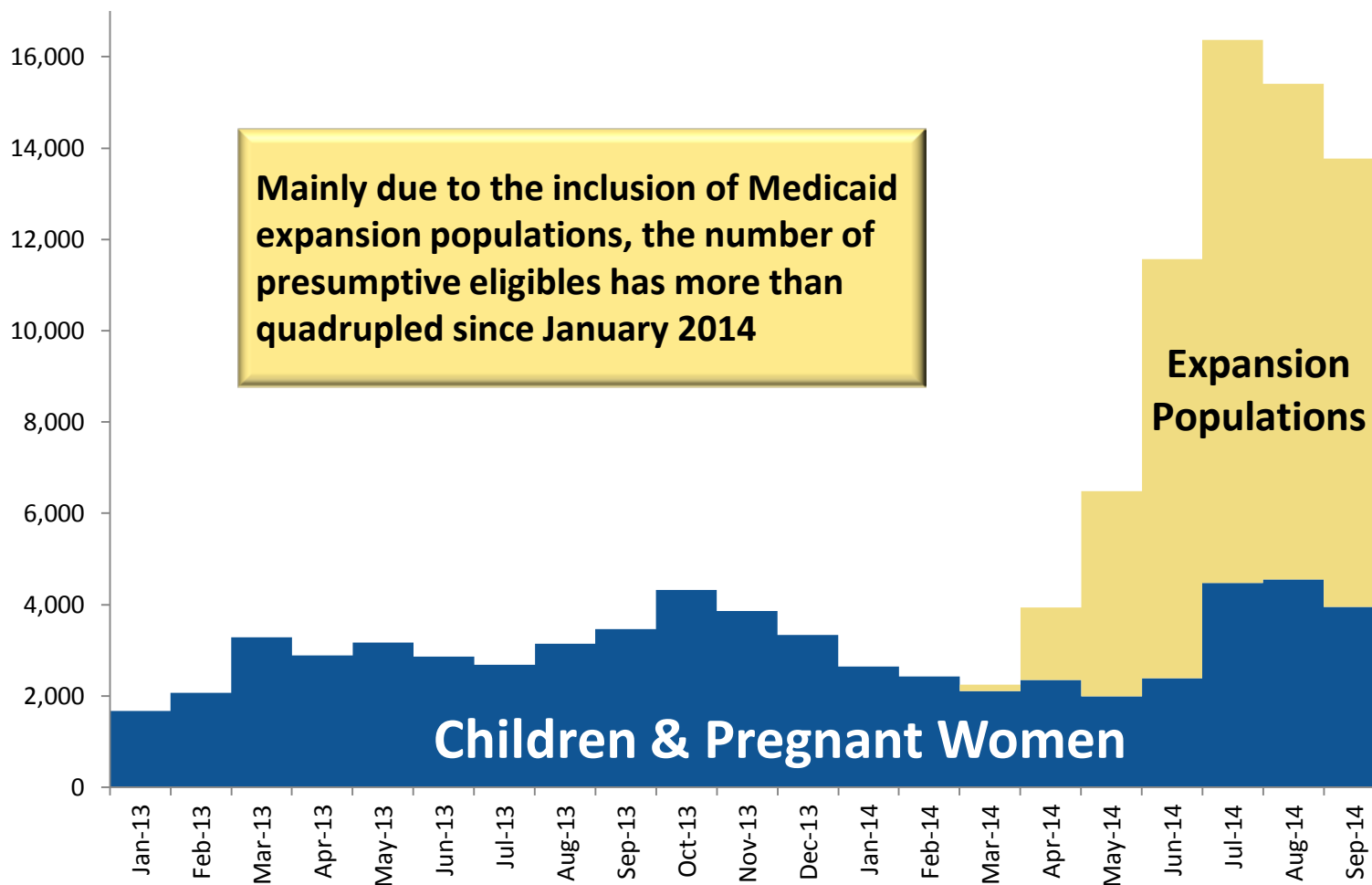
# States Providing Presumptive Eligibility

State	CHIP	Medicaid
California	Yes	Yes
Colorado	Yes	No
Connecticut	No	Yes
Illinois	Yes	Yes
Iowa	Yes	Yes
Kansas	Yes	Yes
Massachusetts	Yes	Yes
Michigan	Yes	Yes
Missouri	No	Yes
Montana	Yes	Yes
New Hampshire	No	Yes
New Jersey	Yes	Yes
New Mexico	Yes	Yes
New York	Yes	Yes
Ohio	Yes	Yes
Wisconsin	No	Yes

**New Jersey is one of 11 states that makes presumptive eligibility available to its entire medical assistance population**

**New York and Massachusetts are the only regional states that match NJ's presumptive eligibility policies**

# Presumptive Eligibility Enrollment



Source: NJ DMAHS Shared Data Warehouse Snapshot Eligibility Summary Universe, accessed 10/1/2014.  
 Notes: Expansion Population is composed of 'ABP Parent Up To 133% FPL' and 'Other Adult Up To 133% FPL'

***Informational Update:***

**Managed Long Term  
Services and Supports**

# Implementation of Managed Long Term Services and Supports (MLTSS)

Presentation to the Medical Assistance Advisory Council

October 6, 2014

Nancy Day  
Director, Division of Aging Services  
NJ Department of Human Services



# MLTSS Care Management: Post Go Live

- 11,138 1915 c waiver participants were transferred from 100+ community-based care management agencies to 4 Managed Care Organizations.
- DoAS database provided MCOs with demographic information, identified high risk members, authorized services/hours, and provider agencies.
- DoAS database will serve as a benchmark for QA audits to monitor changes in members' new plans of care.

# Re-evaluations for Former Waiver Participants

- Contract requires MCOs to maintain continuity of care for all former waiver participants until a face-to-face assessment is completed.
- Contract requires MCOs to conduct face-to-face comprehensive assessments for high risk members within 90 days and the remaining members within 180 days.
- Upon approval of assessment, MCO care manager must complete the new Plan of Care within 30 days.

# MCO Re-evaluation Assessments

- July 1,983
- August: 2,542
- September (9/22): 1,424
- **Total MLTSS Submitted: 5,949**
  
- Focus is on High Risk individuals who require reassessment within the first 90 days of implementation
  - All plans on target to complete high risk pool prior to 90 days

# MLTSS Plans of Care

- Person-centered approach
- Collaborative process between the member, family and MCO care manager to develop goals and build on members' strengths
- Formal & informal supports
- Informed by the NJ Choice assessment and options counseling

# Implementation Strategy

- Weekly calls between DHS and MCOs
- Weekly calls between the Office of Community Choice Options and Care Management Supervisors
- Webinars – focused topics

# MLTSS Claims Processing by MCOs

Data as of September 18, 2014

Submitted	Paid	Denied	Pending	Discrepancy
93,828	69,430	12,035	12,363	0

# Top Reasons for Claim Denials by MCOs

- Primary carrier information required
- Definite duplicate claim
- Disallow is not allowed under contract
- Explanation of benefit (EOB) needed from commercial carrier
- Incorrect billing
- Place of service
- Multiple procedure reduction
- Procedure or modifier not in fee schedule

# Top Questions on Member Calls to MCOs

- The MCOs handled a total of 29,674 calls on MLTSS as of September 24, 2014
- The majority of calls centered on these issues:
  - Benefits;
  - Primary care providers/specialists;
  - ID cards;
  - Care management inquiries: appointments, etc., and
  - Durable medical equipment questions.



# Member Calls to DHS Hotlines

Low call volume captured at these DHS hotlines:

- ADRC
- NJ FamilyCare
- MLTSS quality
- Division of Medical Assistance & Health Services, Office of Quality Assurance
- Division of Aging Services

# MLTSS Provider Issues and Remediation

**Issue:** MLTSS billing code and unit of service for speech therapy was incorrect.

- **Fix:** Joint effort by MCOs (and their coding experts) and DHS to correct code detail for speech therapy and review all therapy codes to ensure consistency, billing and timely claims payment. The MCOs have re-educated the providers and are paying correctly submitted claims.

**Issue:** Eligibility verification for enrollment in NJ FamilyCare and MCOs.

- **Fix:** DHS and the MCOs have been partners in addressing concerns and initiating systemic changes to ensure a seamless transition for members who are enrolling in MLTSS.

# The Bottom Line

## Case

- 84-year old woman on NJ FamilyCare lives at home alone with no family and is hospitalized.
- She is depressed because she doesn't feel she is capable to return home and therefore wants to go into nursing home.

## MLTSS

- MCO visits her in hospital and determines she is eligible for MLTSS.
- MCO arranges for the member to receive medical day care, homemaker services and behavioral health care services.

## Success

- The woman is now able to live in her own apartment with supportive services, attends medical day care and is in a better mental state.
- It is because of MLTSS that the nursing home diversion is possible.

***Informational Update:***

**Personal Care Assistant  
Assessment Tool**

# Purpose

Purpose of the beta test:

- Identify accuracy of determination of beneficiaries' PCA needs
- Evaluate the time necessary to complete the PCA evaluation
- Identify consistency among evaluators
- Identify if tool documents individuals' needs
- Determine if tool needs refinement

# Beta Test Guidelines

- Test for a minimum of 30 days
- Must be used for all cases: initial, reassessments and change of condition
- MCOs may limit the Beta test to designated staff provided their caseload is representative of a cross section of populations served by the MCO
- Must be administered face-to-face in the home
- MCOs may elect to authorize hours using their existing PCA tool after completing the Beta tool
- MCOs will provide copies of all completed PCA evaluations including the Beta tool and existing tool, if utilized, to the State

# Beta Test Levels of Assist

- No Assist/Independent
- Supervision (oversight/cuing)
  - Minimally impaired- cuing in new or specific situations
  - Moderately impaired- repeated reminders
  - Severely impaired- never, rarely makes decisions
- Limited Assist (non-weight bearing support)
- Extensive/Max Assist (weight bearing support)
- Total Dependence

# ADLs Reflected Using Beta Tool

	Records	Limited	Max	Total
Hours				
>40	2	0	0	14
31-40	40	34	99	100
25-30	44	139	71	26
21-24	41	161	41	10
11-20	167	413	71	23
1-10	101	202	36	5

5 records in 11-20 group had supervision only



# Findings

- **Low acuity with high IADL scoring**
  - Did not have any ADL needs noted or needed supervision of bath only
- **High scoring missing a clear explanation of need**
  - Excessive times reported such as 90 minutes for grooming of hair without further justification
- **Variation between current MCO tool and the State's Beta tool**
  - Inconsistency between level of acuity between tools
- **Scoring errors**
  - Math errors
  - Scoring for inappropriate fields such as soiled linen change when continent
- **Differentiation between assessors**

# Next steps for implementation

## Timeline:

- Update tool and instructions – September 2014
- Provide MCO training on tool/instruction updates – October 2014
- MCOs use new tool for all members – Begin November 2014
- Analyze use of tool during Nov/December 2014 – January 2015  
(note: MCOs continue to use this tool for all members)
- Revise tool/instructions (if necessary) based on analysis – January 2015
- All MCOs use the new, revised tool – February 2015

***Informational Update:***

**Administrative Services  
Organization/  
Managed Behavioral Health  
Organization**

# ASO/MBHO RFP

- RFP to procure a vendor for the ASO/MBHO developed collaboratively by DMHAS and DMAHS
- Procurements for the State require the following:
  - Review by DHS executive staff and interdivisional/interdepartmental partners
  - Review by Department of Banking and Insurance (DOBI)
  - Review by DHS Central Office Procurement
  - Review by Office of Information Technology (OIT), Office of Management and Budget (OMB), and the Office of the State Comptroller (OSC)
  - RFP transmitted to Department of Treasury, Division of Purchase and Property (DPP)
- RFP published/posted by DPP
- Responsive bidder identified
- Once the ASO/MBHO vendor is identified, there will be a 4-6 month readiness review to ensure the vendor's ability to fulfill contract obligations.

# Behavioral Health Home (BHH) State Plane Amendment (SPA)

- The Behavioral Health Home (BHH) State Plan Amendment (SPA) was submitted to CMS in July 2014 for Bergen County.
- Currently this BHH SPA is in review with CMS and we have submitted response to their inquiries
- Once approved, the SPA will be approved for Bergen County beginning July 1, 2014.
- The BHH service in Bergen County has already been approved to be included in the ABP benefit for the Expansion population

# Behavioral Health Home SPA

- There are two separate BHH SPAs for Bergen County, one for children and one for adults.
- The adult SPA is targeted to serve individuals with Serious Mental Illness *and* high service utilization
- The Children’s BHH SPA is targeted to serve children who are in the CMO and have a chronic medical illness.

# Behavioral Health Home SPA

- The plan for future BHHs is to roll out the service county by county
  - Bergen – 3rd quarter of calendar year 2014
  - Mercer – 4<sup>th</sup> quarter of calendar year 2014
  - Adult and children SPAs will be submitted jointly
  - DMHAS and DMAHS will measure outcomes and impact on costs
  - Other counties to follow as state appropriations are made available.

# Psychiatric Emergency Rehabilitative Services (PERS) SPA

- The PERS State Plan Amendment (SPA) was submitted to CMS for approval for the State Medicaid Plan.
- The PERS service has already been approved to be included in the ABP benefit for the Expansion population.
- Currently the SPA for the Medicaid State Plan is in review with CMS and the State has submitted formal responses to their inquiries.



# Psychiatric Emergency Rehabilitative Services (PERS) SPA

- If approved, PERS services will be eligible to be billed for the Medicaid population beginning July 1, 2014.
- DMAHS published guidance (on NJMMIS.com) released in August, 2014, on billing of the PERS service for the ABP and once approved, for the Medicaid population.
- The PERS service is designed to cover the current designated screening centers and affiliated emergency screening services.