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

NJ Department of Human Services

March 2015

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2015 AL Industry Training

Goals of Training

Provide an Overview of the following key areas:

1. Identification of clinical needs and eligibility
   - NJ's Clinical Assessment
   - Nursing Facility Level of Care
   - Options Counseling
2. Care Planning Process
   - Role of the MCO Care Manager
   - Plan of Care/General Service Plan
   - Collaboration
3. Referral Processes to establish eligibility
   - Clinical
   - Financial
4. Provider Resources

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 uses NJ FamilyCare Managed Care Organizations (MCOs) to coordinate all services.

- MLTSS can be provided in the following settings:
  - Private Home/Apartment
  - Subsidized Housing
  - Assisted Living Type Facilities
    - ALR
    - CPCH
    - ALP
    - AFC
  - Nursing Facility
  - Special Care Nursing Facility

interRAI Home Care Assessment Tool

- The Home Care is one of the interRAI assessment suite of tools designed by an international group of clinicians & researchers.

- The NJ Choice is a modified version of the interRAI Home Care, version 9.1. It is often referenced as the NJ Choice HC.

- The Home Care is one of a series of integrated assessment tools used to identify an individual's needs, strengths and preferences.

- It includes clinical assessment protocols(CAPS) which guide individualized care plans and services.

  - The POC is a person-centered process

NJ Choice HC Assessment Tool

All individuals seeking MLTSS must meet NJ's Nursing Facility Level of Care (NF LOC). The NJ Choice Home Care (HC) assessment tool is utilized to determine eligibility for NF LOC. The NJ Choice HC is a comprehensive assessment tool that captures information in the following areas:

- Demographics
- Cognition
- Communication and Vision
- Mood, Behavior, and Psychosocial well-being
- Functional Status and Continence
- Disease and Health Conditions
- Oral, Nutrition, and Skin Status
- Medications
- Treatments and Procedures
- Social Supports
- Environmental

NJ Choice HC Assessment Tool

- NJ Choice HC Assessment Tool – 8 page comprehensive assessment

- Narrative – documents overall picture of individual

- Service Authorization (OCCO, ADRC, PACE) – identifies level of care

- Clinical Assessment Protocols (CAPS)

- Interim Plan of Care (IPOC)/Consumer Planning Worksheet with Narrative – outlines Options Counseling and Service Options discussed

NJ Choice HC Assessment Tool

Who conducts the NJ Choice Assessment?

- Office of Community Choice Options (OCCO)

- Program of All-Inclusive Care of 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.

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OCCO vs. MCO Assessment – What's the difference?

- OCCO (or ADRC) conducts assessments for individuals not currently enrolled in NJ FamilyCare (New to Medicaid)
- 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

NJ Nursing Facility Level of Care (NF LOC)

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 is defined as three or more
- What is considered?
  - Deficits in **Cognition**
- The NJ Choice HC 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 <u>NOT</u> capacity.

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

- 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

ADL Definitions

- **Eating** – How the individual eats and drinks, includes intake of nourishment by all means. (e.g., feeding tube, total parenteral nutrition).
  - Does not include meal preparation , setup, or cutting food
- **Bathing** – How the individual takes a full-body bath or shower, including transfers in/out tub or shower and how each body part is bathed.
  - Does not include washing of back and hair
- **Dressing Upper Body** – How the individual dresses and undresses above the waist, including prosthesis, orthotics, fasteners, pullovers.
- **Dressing Lower Body** – How the individual dresses and undresses from the waist down, including prostheses, orthotics, belts, pants, skirt, shoes, fasteners.

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ADL Definitions (continued)

- **Transfer Toilet** – How the individual moves on/off the toilet or commode.
- **Toilet Use** – How the individual uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode, changes bed pad, manages ostomy or catheter, adjusts clothing.
- **Bed Mobility** – How the individual moves to and from a lying position, turns side to side, and positions body while in bed.
- **Transfers** – How the individual moves to/from bed, chair, wheelchair, standing position. Excludes to/from bath and toilet.
- **Locomotion** – How the individual moves between locations on the same floor (walking or wheeling - self-sufficiency once in chair). Includes indoor and outdoor

ADL – Level of Assistance

- **Independent**: No help, setup, or oversight in ANY EPISODE
- Independent**, Setup help only**: Article or device provided within reach, no physical assist or supervision in ANY EPISODE
- **Supervision**: Oversight, encouragement, or cueing
- **Limited assistance**: Individual is highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance
- **Extensive assistance**: Individual performed 50% or greater part of activity. Weight bearing assistance of 1 helper.
- **Maximal assistance**: Individual involved and performed less than 50%. Weight bearing assistance of 2+ helpers.
- **Total dependence**: Full performance of the activity by another during ALL EPISODES
- **Activity did not occur**: the ADL activity was not performed by the individual <u>or others</u> (regardless of ability) during entire period

Cognitive Deficits

- Areas assessed for NJ NF Level of Care:

  - 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

How is the assessment information used?

- Upon the completion of the NJ Choice assessment, the assessment data calculates trigger areas for consideration in the care planning process

- These calculations are Clinical Assessment Protocols (CAPS)

- The CAPS are available for the assessor to identify areas of need and strengths that will guide a discussion of the individual's preferences and goals

interRAI
Clinical Assessment Protocols
(CAPs)
Version 9.1

interRAI Clinical Assessment Protocols (CAPs)

The interRAI CAPs are designed to work with the interRAI assessment instruments. The instruments are research based, user friendly, reliable person centered assessment systems that inform and guide comprehensive care and service planning.

Clinical Assessment Protocols (CAPs)

- CAPs focus on
  - An individual's function and quality of life
  - Assessing the individual's needs, strengths, and preferences
  - Facilitate referrals when appropriate

  - **Provides the basis for an outcome-based assessment of the individual's response to care or services**
    - **Guides a plan of care**

Goals of Care for CAPs

- Resolve an identified problem;

- Reduce risk of decline; or

- Increase potential for improvement

- CAPS identify 2 types of people:
  - Those with a higher than expected likelihood of **declining** (NF population)
  - Those with an increased likelihood of **improving** (recent acute episode)

CAP Areas

- There are 27 individual CAPs that fall into 4 broad categories

  1. Functional Performance
  2. Cognition and Mental Health
  3. Social Life
  4. Clinical Issues

How is a CAP used?

- Once a CAP is identified, it is used to:
  - Outline clinical care guidelines and strategies to lead to positive outcomes
  - Guide a Plan of Care to resolve, reduce decline, or increase potential for improvement
  - Identify and provide a service
- The plan of care development is a person-centered, collaborative effort between the healthcare team, the individual, and his/her informal supporters that builds on the individual's strengths
- The plan of care process begins with Options Counseling

Options Counseling (OC)

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Options Counseling:
A National Initiative

- Driven by:
  - The Administration for Community Living (ACL) and
  - Centers for Medicaid/Medicare Services (CMS)

- ADRC Options Counseling Grants (Parts A & B)
  - Options Counseling Standards
    - Part A Grant Recipients goal is to finalize standards and develop certification program
  - Options Counseling Training
    - Part B Grant Recipients
    - NJ utilized Rutgers School of SW to assist in curriculum development

National Options Counseling Training and Certification Program Development

Standards

- Personal Interview
- Exploring Options/Planning
- Decision Support
- Collaboration with Individual to Develop Action Steps or Long Term Support Plan
- Access to Community Supports
- Follow-up

Job Duties

- Conduct One-to-One Person Centered Interview
- Develop Person Centered Plan
- Facilitate Streamlined Access to LTSS
- Ongoing Follow Up and Documentation

Competencies

- Knowledge
- Skills/Abilities

Training

- Build upon current best practice
- Design curriculum based on Standards, Job Duties and Competencies

Certification

- Creation of National Advisory Council for guidance and input
- Leverage existing national certification efforts

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Options Counseling - Defined

- 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.

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.

Conducting Options Counseling

- OC is conducted for all individuals assessed via the NJ Choice for NJ Medicaid Programs
  - Does not include those assessed for Medical Day Care only (see Slide 9)
- The NJ Choice HC Assessment, CAPs, individual preference and assessor's professional judgment will guide OC
  - Identification of needs and goals
  - Discussion of service options
  - Completion of Interim Plan of Care (IPOC)
- The CAPS are further utilized to guide the development of the Plan of Care for all MLTSS individuals.

Care Planning Process

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Services Included in ALR/CPCH

- Core package of AL services:
  - personal care, 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 ALP and AFC only
- Care Management provided by Managed Care Organization

Role of the
MCO Care Manager (MCO CM)

Individuals enrolled in MLTSS receive coordination of care through a Managed Care Organization Care Manager (MCO CM)

- The Care Manager shall be responsible for coordination of the individual's physical health, behavioral health, and long term care needs.
- They will visit the individual at least quarterly.
- Monitor services, as specified in the Plan of Care, quarterly.
- Meet with facility/program staff to revise POC as necessary.
- Complete a NJ Choice Assessment annually to determine continued clinical eligibility (NF LOC).

The MCO Plan of Care

- An agreement to ensure that the health and related needs of the individual are clearly identified, addressed, and reassessed.

- At a minimum, the POC shall be based upon:
    - ✓ Assessed ADL need,
    - ✓ The face-to-face discussion with the individual that includes a systematic approach of the individual's strengths and needs.
    - ✓ Recommendations from the individual's primary care provider (PCP), and
    - ✓ Input from service providers, as applicable.

- Identify:
    - unmet needs,
    - informal supports, and
    - individual's personal goals.

The MCO Plan of Care (continued)

- In addition to the required elements as defined in section 9.2.2.B of the MCO contract, the plan of care, at a minimum, shall document;
  - Each service to ensure that the frequency, duration or scope of the services accurately reflects the Member's current need and updates the plan of care as necessary.
  - Indicates whether the Member agrees or disagrees with each service authorization and signs the plan of care at initial development, when there are changes in services and at the time of each review (every 90 or 180 calendar days).
  - A copy of the plan of care shall be provided to the Member and/or authorized representative and maintained in the Member's electronic Care Management record.

AL Resident Service Plans

- § 8:36-7.1 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

§ 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

- Bill the individual for Room and Board and any applicable Cost Share in timely fashion

- Bill MCO 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 by:
  - Contacting Care Manager 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

Responsibilities of the Medicaid Assisted Living Provider

- Specify the responsibilities of the individual and provider in the Admission Agreement

- Refer private pay residents to OCCO for clinical assessment, using AL- 6 form, 3 months before spend down occurs

- Refer to the County Welfare Agency (CWA) 2 months before spend down occurs by providing CWA phone number and Medicaid checklist

AL/AFC Referral Form

- Policy updated February 11, 2011
- 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

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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 ($764.25 in 2015), AL provider instructs individual to apply for Medicaid at the local County Welfare Agency, within 2 months of spend down.

Provider Intent

- Form AL-1 (formerly Attachment A Form)

- Indicates intention to accept or not accept Medicaid reimbursement when the individual is clinically and financially approved

- OCCO staff will need Administrator or designee's signature on AL-1 form at the time of the assessment visit

Provider Accepts

➢ Facility Acceptance prompts OCCO to process the Waiver enrollment via the CP-5 form

➢ The facility and Care Management site are copied on the CP-5

Provider Doesn't Accept

➢ Facility is responsible for notifying individual and family of the decision

➢ Facility is responsible to facilitate a safe discharge

Financial Eligibility:
County Welfare Agency (CWA)

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ABD Cascading Programs for MLTSS

- Supplemental Security Income (SSI)
  - Individual with monthly income under $764.25 and $2,000 in resources

- Medicaid Only
  - Individual with monthly income under $2,199 and $2,000 in resources
  - Individual with monthly income over $2,199, a Qualified Income Trust is required and $2,000 in resources

Application for SSI Increase

- An individual whose income is insufficient to both pay for the Department's defined Room and Board and to retain the approved Personal Needs Allowance can apply to Social Security Administration Office for an SSI supplement

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

Determining Financial Eligibility

- If the total gross income is at or below 100% FPL (Federal Poverty Level) the individual can submit a self-attestation form, which states that they did not transfer any resource in the past five years. This allows the County Welfare Agency (CWA) to forgo the 5 year look back and process the case.

- If the individual does not sign this form, then the CWA must do the look back.

- Individuals whose income is over the 100% FPL cannot self-attest to transfers and must supply documentation for the look back period.

  - If Transfers of resources are discovered the penalty period starts when the individual is financially (income and resource) and clinically eligible.

Determining Financial Eligibility

- It is important that potentially eligible individuals contact the County Welfare Agencies and submit an application for Medicaid.

- 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.

- An individual can apply for Medicaid up to 2 months prior to spending down their resources.

- 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.

What should an individual bring with them when they apply for Medicaid

- The next slide is a listing of items an applicant should be gathering as verification for Medicaid. The County Welfare Agencies do have access to some electronic databases to verify information.

- Example- If an individual loses their Medicare card, the Agency caseworker can access a database and print out the information for the case record. There would be no need for the individual to contact the Social Security Office for a letter to verify the information.

Medicaid Program
Check List

This is the type of information that you will need to bring with you when applying for Medicaid. The more information you are able to provide the faster your Medicaid application can be processed.

1. Proof of Age:
One of the following documents should be provided to verify your age:
- ☐ US Passport
- ☐ Birth Certificate
- ☐ Driver's License
- ☐ Baptismal Certificate
- ☐ Other_____

2. Proof of Citizenship:
One of the following documents should be provided to verify your citizenship:
- ☐ US Passport
- ☐ Birth Certificate
- ☐ Naturalization Papers
- ☐ Alien Registration Card
- ☐ Voter's Registration Card
- ☐ Medicare Card
- ☐ Other_____

3. Marital Status:
One of the following documents should be provided to verify your marital status:
- ☐ Marriage Certificate
- ☐ Separation Papers
- ☐ Divorce Decree
- ☐ Spouse's Death Certificate
- ☐ Other_____

4. Income
In order to verify your **Income**, please provide <u>copies</u> of all that are applicable:

- ☐ Most recent pay stubs
- ☐ Social Security Award Letter
- ☐ Railroad Retirement Letter
- ☐ Temp. Disability Check or Award Letter*
- ☐ Pension Checks
- ☐ Unemployment Notification
- ☐ Workers Comp.Notification
- ☐ Support/Alimony Checks or Court Order
- ☐ VA Award Letter
- ☐ Reparation Payments
- ☐ Payments from Boarders
- ☐ SSI Award Letter
- ☐ Dividend Checks
- ☐ Federal Income Tax Returns including schedules:
  - ☐ Schedule C – Net Profit from Business
  - ☐ Schedule D – Capital Gains
  - ☐ Schedule E – Rental Real Estate
  - ☐ Schedule K-1- Partner's Share of Income
- ☐ Other_____

5. Financial Resources
To provide the most accurate picture of your **Financial Resources**, you must provide <u>copies</u> of all that is applicable:

- ☐ Checking Acct. Statements
- ☐ Savings Acct. Statements
- ☐ Stocks or Bonds
- ☐ Certificates of Deposit
- ☐ Amount of Cash on Hand
- ☐ List of Valuables (jewelry, etc.)
- ☐ IRA, 401K, 403B, Keogh Accounts
- ☐ Trusts or other Financial Instruments
- ☐ Money Market Accounts
- ☐ Annuities
- ☐ Deeds to Property Owned
- ☐ Property Proceeds
- ☐ Mortgages
- ☐ Prepaid Funeral Contracts
- ☐ Christmas/Vacation Clubs
- ☐ Credit Union Shares
- ☐ Burial Plot Information
- ☐ Funds set aside for Burial
- ☐ Special Needs Trusts
- ☐ Life Insurance Policies with Cash Value Statement
- ☐ Other_____

The following **Living Expenses** will be taken into account if the Medicaid recipient is placed in a nursing facility but the SPOUSE remains living in the community. Please provide copies of the following:

- ☐ Mortgage Statements
- ☐ Real Estate Tax Bills
- ☐ Rent Receipts
- ☐ Electric Bills
- ☐ Gas / Oil Bills
- ☐ Water / Sewer Bills
- ☐ Telephone Bills
- ☐ Connection Charges
- ☐ Home / Renter's Insurance
- ☐ Outstanding Loans
- ☐ Health Insurance Bills
- ☐ Unpaid Medical Bills (past 3 months)
- ☐ Other_____
- ☐ Other_____

CWA Contact Information

- Much information is available through the Department of Human Services website

- CWA listing is maintained at the following link:

  www.state.nj.us/humanservices/dfd/programs/njsnap/cwa/

Medicaid Reimbursement = 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

Billing before MLTSS start date occurs

- **For claims with service dates on or after July 1, 2014**, AL providers may 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 a MCO is pending. Eligibility from both a clinical and financial perspective **must** be completed for AL residents pending MCO enrollment **before** any FFS claims may be submitted to the State for payment.

FFS Payment Requirements

- AL providers with NJ Family Care newly eligible residents pending MCO enrollment shall notify the DMAHS Office of Provider Relations at mahs.provider-inquiries@dhs.state.nj.us and provide the following information:

  - Resident' name

  - Date of birth

  - Medicaid ID number

  - Date the individual became "clinically" eligible for AL services

  - Facility name

- Please <u>allow ten business days</u> after notifying DMAHS <u>before submitting FFS claims</u>. After ten business days, the AL provider may submit claims to Molina Medicaid Solutions.

Billing after MLTSS start date occurs

- Provider bills the individual directly for Room and Board and any cost share that is due.

- Provider bills the individual's MCO for services once MCO MLTSS start date has occurred.

Quality Assurance Eligibility

- Care Managers, at least annually, will re-evaluate MLTSS individuals to establish continued clinical eligibility criteria

- County Welfare Agencies, on an annual basis, will re-determine that individuals on the Waiver continue to meet the financial eligibility criteria

Quality Assurance
Service Provider

- Care Managers will review resident records and service logs as well as speak with MLTSS enrollees at least quarterly to verify that services have been provided (as agreed to by the Plan of Care)

- AL Providers will meet with the Care Manager to review the individual's POC and verification of services on a quarterly basis

Quality Assurance Licensing

- The Division of Health Facilities Evaluation and Licensing (HFEL) will survey licensed providers annually to ensure quality service delivery to Waiver enrollees

- Medicaid, or it's contracted agency, audits the files of MCO Care Managers for MLTSS individuals to aid in meeting the Quality Measures standards put forth by the Center for Medicare and Medicaid Services (CMS)

- Both Federal and State Funding and Program Administering Agencies (DHS and CMS) may perform fiscal audits as needed

Respite Care

- ALR, CPCH and AFC approved Medicaid providers may offer Respite to MLTSS and JACC individuals
  - Bill as per program requirements or instructions from MCO
- Single-page application to offer Respite for JACC individuals
- Respite must be requested and authorized by the individual's Care Manager
- Reimbursement is determined by the MCO for MLTSS individuals
  - JACC reimbursement is an all-inclusive daily fee of $100
- Bill per MCO or Patient Payment Liability instructions

Financial Accountability

- The contracted Managed Care Organizations (MCOs) are responsible for ensuring that all financial requirements for payment of services is followed.

- Questions on payments need to be addressed by the MCO.

- Cost share is being done by the County Welfare Agency (CWA) at the time of initial eligibility, upon annual redetermination, and for change in circumstances.

NJ FAMILY CARE MANAGED CARE PROVIDER RESOURCES

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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.

  http://www.state.nj.us/humanservices/dmahs/info/resources/hmo/

  - Contact phone number for Member and Provider Relations is listed
  - Link for MCO Member Manual is posted

NJ Family Care Managed Care Provider Reference Information

- Human Services website - MLTSS:
  http://www.state.nj.us/humanservices/dmahs/home/mltss_resources.html
  - Provider Frequently Asked Questions (FAQ) posted
  - Provider Education PowerPoints

- Molina –NJMMIS website: http://www.njmmis.com
  - Medicaid Newsletters posted-sample below
  - SUBJECT: Managed Long-Term Services and Supports (MLTSS)
    https://www.njmmis.com/downloadDocuments/24-07.pdf
  - SUBJECT: Fee for Service (FFS) Coverage of Assisted Living Programs and Managed Long Term Services and Supports(MLTSS)
  - https://www.njmmis.com/downloadDocuments/24-14.pdf

State Resource for Managed Care Providers
Office of Managed Health Care (OMHC)
Managed Provider Relations Unit

- The OMHC, Managed Provider Relations Unit addresses Provider Inquires and/or Complaints as it relates to MCO contracting, credentialing, reimbursement, authorizations, and appeals

- Conducts complaint resolution tracking/reporting

- Provides Education & Outreach for MCO contracting, credentialing, claims submission, authorizations, appeals process, eligibility verification, TPL, MLTSS transition and other Medicaid program changes

- Addresses stakeholder inquiries on network credentialing process, network access, and payment compliance

- Provider inquiries should be e-mailed to the **State Office of Managed Health Care** at: MAHS.Provider-Inquiries@dhs.state.nj.us

Provider Inquiries

- The Managed Care Provider Relations Unit will work with necessary staff at DMAHS, Molina, DOBI, other State Departments and/or HMO to address inquiry

- Prior to contacting the State directly, individuals should contact **Member** and/or **Provider Relations Office at the Managed Care Organization (MCO)**

- If matter is unresolved, state staff will review and assist as necessary

Provider Inquiry

Enrollment and claims payment questions should be addressed directly with the NJ FamilyCare Managed Care Organization (MCO) prior to contacting the Division of Medical Assistance and Health Services.		
Inquiries should be emailed to MAHS Provider-Inquiries at MAHS.Provider-Inquiries@dhs.state.nj.us		
Provider Name		
Date		
Representatives Name:		Phone: E:Mail
Member Information	Member's Name	
	Member's Medicaid Number	
	Member's Date of Birth	
Service Information	Service Type	
	Date of Service	
	MCO	
	Provider (if different than submitting provider)	
Inquiry Summary	Summary of Contact with NJ FamilyCare MCO	
Enrollment Information (if applicable)	Date of Admission to LTC Facility	
	PAS Date	
	PAS Action Code	
	Date of Financial Eligibility	
Other Information		

Provider and Member Resource Information

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
NJ State Health Insurance Assistance Program	1-800-792-8820