State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services

NEWSLETTER

Volume 24, No. 07 **July 2014**

TO: All Providers **– For Action**
For Managed Care Organizations – **For Information Only**

SUBJECT: **Managed Long-Term Services and Supports (MLTSS)**

EFFECTIVE: Effective for services provided on or after July 1, 2014

PURPOSE: To notify NJ FamilyCare (NJFC)-participating Waiver fee-for-service (FFS) providers of the transition of coverage responsibilities for certain long-term services and supports from the NJFC FFS program to the NJFC managed care program with the July 1, 2014 implementation of NJ FamilyCare Managed Long Term Services and Supports (MLTSS) program. Also, to announce the mandatory enrollment of NJFC ACCAP, CRPD, GO and TBI Waiver clients into MLTSS. Note: Community Care Waiver (CCW) clients will not be enrolled in MLTSS.

BACKGROUND:

The NJ FamilyCare Managed Long Term Services and Supports (MLTSS) benefit refers to the long-term care a person is determined to need, coordinated through a NJ FamilyCare managed care organization (MCO). MLTSS uses NJ FamilyCare MCOs, also known as health maintenance organizations (HMOs), to coordinate all services. Currently, NJ FamilyCare members have their acute and primary health care services and their home and community-based Waiver services coordinated by different care management agencies.

MLTSS enables a beneficiary to live in the community with long-term supports for as long as possible. MLTSS provides comprehensive services and supports, whether a beneficiary lives at home, in a Community Alternative Residential Setting (CARS) which includes assisted living resident, assisted living program, adult family care, community residential services and comprehensive personal care home, or in a nursing home.

ACTION:

(1) <u>Effective for services provided on or after July 1, 2014</u>, the following long-term services and supports shall be managed by NJFC MCOs:

- Personal Care;
- Respite;
- Care Management;
- Home and Vehicle Modifications;
- Home Delivered Meals;
- Personal Emergency Response Systems;
- Mental Health and Addiction Services; and
- CARS Nursing Home Care.

(2) Effective on or after July 1, 2014, participants in the Medicaid Waiver programs listed below shall be automatically enrolled in the MLTSS program through their current NJFC MCO:

- AIDS Community Care Alternatives Program (ACCAP);
- Community Resources for People with Disabilities (CRPD);
- Global Options for Long-Term Care (GO); and
- Traumatic Brain Injury (TBI) Waiver.

(3) Program of All-Inclusive Care for the Elderly (PACE) remains an option for an individual who is 55 years of age or older; able to live safely in the community with supports at the time of enrollment; and lives in a PACE provider service area. To enroll in PACE, individuals must call the PACE program. They may also receive information by calling 1-800-MEDICARE (1-800-633-4227/TTY 1-877-486-2048). There currently are four PACE organizations in seven counties that individuals may contact directly to request enrollment. The PACE organizations are listed on page 11 of this Newsletter. Individuals may also contact the local County ADRC.

For informational purposes, please find attached Frequently Asked Questions (FAQs) and responses compiled by the New Jersey Division of Medical Assistance and Health Services regarding the implementation of NJFC MLTSS. The FAQs are updated as necessary and are posted on the Department's website at
http://www.state.nj.us/humanservices/dmahs/home/Consumer_FAQs.pdf
http://www.state.nj.us/humanservices/dmahs/home/MLTSS_Provider_FAQs.pdf

If you have any policy questions regarding NJFC MLTSS, please contact the NJ FamilyCare – Member/Provider Hotline at 1-800-356-1561.

RETAIN THIS NEWSLETTER FOR FUTURE REFERENCE

State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services

FREQUENTLY ASKED QUESTIONS (FAQs) FOR PROVIDERS ON THE IMPLEMENTATION OF NJ FAMILY CARE MANAGED LONG-TERM SERVICES AND SUPPORTS

GENERAL INFORMATION

1. What is NJ FamilyCare Managed Long-Term Services and Supports (MLTSS)?

New Jersey Medicaid's Managed Long-Term Services and Supports (MLTSS) benefit refers to the long-term care a person is determined to need, coordinated through a NJFC health plan. MLTSS includes Personal Care, Respite, Care Management, Home and Vehicle Modifications, Home Delivered Meals, Personal Emergency Response Systems, Mental Health and Addiction Services, CARS and Nursing Home Care.

2. How does MLTSS differ from the current benefit of home and community-based services?

MLTSS uses NJFC health plans to coordinate all health care needs for enrolled members. Under the current benefit structure, NJFC members have their acute and primary health care services and their home and community-based services coordinated by different care management agencies.

3. What does MLTSS do?

MLTSS enables a beneficiary to live in the community with long-term supports for as long as possible. MLTSS provides comprehensive services and supports, whether a member lives at home, in an assisted living arrangement; in community residential services; or in a nursing home. By moving these care categories together into one program, NJFC members will see improved coordination of services.

4. How does someone qualify for MLTSS?

A person qualifies for NJFC MLTSS by meeting the following requirements:

- **Financial Requirements** – These include monthly income, as well as total liquid assets. For more detailed information on NJ FamilyCare financial eligibility go to: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/abd/
- **Clinical Requirements** – A person meets the qualifications for nursing home level of care, which means that s/he requires assistance with activities of daily living such as bathing, toileting and mobility.
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- **Categorical Requirements** – These refer to age (65 years or older) or disability (under 65 years of age and determined to be blind or disabled by the Social Security Administration or the State of New Jersey).

Refer to the Department of Human Services website for MLTSS FAQ's for Consumers: http://www.state.nj.us/humanservices/dmahs/home/Consumer_FAQs.pdf.

TRANSITION FOR WAIVER PROVIDERS

5. **With the transition of the GO, ACAAP, TBI, and CRPD Waivers into NJFC MLTSS beginning July 1, 2014, what will be the role of the current service providers?**

   - Effective July 1, 2014 the managed care organizations (MCOs) are responsible for coordinating their members' plans of care and payments for Waiver services.

   - All current providers must continue to provide the authorized services and hours identified in the participant's current plan of care beyond June 30th until the MCO care manager notifies the provider that a new plan of care has been 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.

6. **After the transition to NJFC 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 that are received by PPL/CAU prior to 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 need to be submitted to the members' MCO for payment instead of Molina Medicaid Solutions or the fiscal intermediary.

   - Claims for MLTSS-covered services submitted to Molina Medicaid Solutions with service dates on or after July 1, 2014 shall be denied payment due to a member's enrollment in managed care.

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

   - The individual MCO's will work directly with the providers regarding a member's plan of care. The provider's primary point of contact regarding a member's services will be the MCO care manager.

   - If providers are not currently in the MCO network, they must contact the individual plans regarding necessary steps to join the individual plan's provider network.

   - 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 must be in the plan's provider network to continue to provide services. Providers should contact each health plan for specific network requirements.

8. **What are the NJFC health plan contact numbers for providers and specifically for MLTSS?**

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 **WellCare of New Jersey**	**1-888-362-3368** **1-888-453-2534**	**1-888-362-3368** **1-888-453-2534 or 588-9769**

NJFC CONFIRMATION OF MLTSS MEMBER ELIGIBILITY

9. What is a provider's requirement in terms of confirming a member's eligibility in the NJFC program?

Providers must confirm a member's eligibility in the NJFC program monthly to ensure that a member is enrolled in the program. If a member has changed health plans, providers must contact the new health plan to request an updated authorization. Providers also must confirm that the member is enrolled with an active authorization for MLTSS to be eligible for payment by the health plan.

10. Why must a provider confirm a member's eligibility status in the NJFC program and/or the individual's enrollment in a health plan for MLTSS?

Providers must have assurances that any prior authorizations were provided by the correct health plan and that the correct health plan is being billed for the service that was provided. If a provider has inaccurate information and, as a result, bills incorrectly, the provider may not be able to file a claim in a timely manner and may not be paid for the service(s) provided.

11. How can a provider check a member's eligibility for NJFC coverage and/or the member's enrollment status with a NJFC health plan?

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

- 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.

- 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.

Providers who do not have a NJFC Provider ID must contact the individual Health Plans directly.

NJFC MCO PROVIDER NETWORKS AND MLTSS

12. 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:

1. offering an application when considering enrolling providers in network;
2. credentialing/re-credentialing providers;
3. establishing a contract with providers selected to be network providers and subcontractors;
4. creating an annual provider manual and preparing updates as necessary;
5. offering provider education and outreach;
6. providing access to call center staff to resolve payment issues; and
7. providing a process for claim and utilization appeals.

13. 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.

14. 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.

15. What steps do non-residential providers need to complete to be a provider with a health plan that administers the NJFC MLTSS benefit?

1. inquire if the health plan is accepting applications for service;
2. submit Application to the health plan;
3. complete the health plan's credentialing requirements; and

4. secure a contract with the plan when the plan and the provider have reached a contract agreement.

For additional information, go to
http://www.state.nj.us/humanservices/dmahs/info/resources/hmo/

MCO CONTRACT REQUIREMENTS/PARAMETERS RELATED TO NJFC MLTSS

16. 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.

17. What are the prior authorization requirements found in the Health Claims Authorization Processing and Payment Act (HCAPPA)?

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

18. What are the claims submission requirements found in HCAPPA?

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

19. What is the universal billing format for NJFC MLTSS?

- For paper claims:
  The 1500 claim form is submitted for Assisted Living (AL) facilities, HCBS service providers, and non-traditional providers, such as home improvement contractors, emergency response system providers, and meal delivery providers. The UB-04 claim form must be submitted for billing nursing facility (NF) and Skilled Care Nursing Facility (SCNF) claims.

- For electronic claims:
  Providers need to submit 837P claim transactions for AL facilities, HCBS service providers, and non-traditional providers, such as home improvement contractors, emergency response system providers, and meal delivery providers. The 837I claim transaction must be submitted for billing NF and SCNF claims.

20. What are the claims submission requirements for providers when there is coordination of benefits?

The managed care contract specifies the requirement for consistent timelines across all plans. Timeframes are consistent with the NJ Department of Banking and Insurance requirements for all medical services. Providers are to submit coordination of benefit claims within 60 days from the date of the primary insurer's explanation of benefits or 180 days from the claim service date, whichever is later.

21. What are the claims processing requirements for the health plans?

The managed care contract language specifies a requirement that a MLTSS claim should be processed by the plan within 15 days of a clean claim submission. For non-MLTSS claims, the plan contract language requires that claims be processed by the plan within 30 days of a clean claim submission.

22. What are the claim submission categories?

The claim submission categories are: initial, resubmission, denial, and appeal.

23. What is a claim resubmission?

A claim may be denied for a variety of reasons, so it is important for a provider to supply the plan with as much information as possible when resubmitting a claim. Some common reasons for a claim resubmission include: corrected claim; addition of prior notification/prior authorization information; and/or verification of a bundled claim.

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

If a member is enrolled in another health plan or casualty insurer, the NJFC plan is responsible for coordinating benefits to maximize the utilization of third party coverage and ensure that NJFC is the payer of last resort. The provider must follow the process established by each plan to submit claims.

25. What are the policies in place for "balance billing" MLTSS claims?

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 NJFC beneficiaries, refer to the NJ Division of Medical Assistance and Health Services' NJFC Newsletter Volume 23, No. 15, dated September 2013. All NJFC Newsletters can be accessed on line at http://www.njmmis.com/

26. What are the utilization management appeal parameters in the Health Claims Authorization Processing and Payment Act (HCAPPA)?

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

27. What are the health plan's responsibilities with regard to complaints, grievances and appeals?

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

28. Will a member continue to receive MLTSS during his/her appeal process or the NJFC Fair Hearing process?

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

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

29. How can a member request a Medicaid Fair Hearing?

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

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

AVAILABLE PROVIDER RESOURCES FOR NJFC MLTSS

30. Are there resources on the NJ Department of Human Services' website?

Yes. The managed care 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 NJFC health plan websites which also include phone numbers for the member and provider relations unit for each health plan.
http://www.state.nj.us/humanservices/dmahs/info/resources/hmo/

The link below will connect you to MLTSS Information for Consumers and Stakeholders

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

31. What are the MLTSS reference contacts at the NJ Department of Human Services?

Department of Human Services References	***Contact Information***
Division of Aging Services Care Manager Hotline	1- 866-854 - 1596
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

CHART OF NEW JERSEY LOCATIONS SERVED BY NJFC MCOs AND PACE

NJFC HEALTH PLANS

HEALTH PLAN	STATE COUNTIES
Amerigroup New Jersey, Inc.	**All counties except Salem**
Horizon NJ Health	**All**
United Healthcare Community Plan	**All**
WellCare Health Plans of New Jersey	**Essex, Hudson, Middlesex, Passaic and Union**
To enroll in a NJFC health plan, call 1-866-472-5338 (TTY: 1-800-701-0720	

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

NAME	SERVICE AREAS
LIFE at Lourdes	Most of Camden county
To enroll, call (856) 675-3355	
Lutheran Senior LIFE	Parts of Hudson county
To enroll, call (201) 706-2091	
LIFE St. Francis	Mercer and parts of northern Burlington county
To enroll, call (609) 599-5433	
Inspira LIFE	Parts of Cumberland, Gloucester and Salem counties
To enroll call (856) 418-5433	
For more information regarding PACE, call 1-800 MEDICARE (1-800-633-4227), (TTY: 1-877-486-2048), or visit http://www.medicare.gov/site-search/search-results.html?q=pace%20program%20of%20all-inclusive%20care%20for%20the%20elderly or www.npaonline.org on the web	