



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

NEWSLETTER

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TO: Assisted Living Programs - **For Action**
Health Maintenance Organizations - **For Information Only**

SUBJECT: **Fee-for-Service (FFS) Coverage of Assisted Living Programs and Managed Long Term Services and Supports (MLTSS)**

EFFECTIVE: Effective for claims with service dates on or after July 1, 2014

PURPOSE: To notify Assisted Living (AL) Programs of newly established billing procedures intended to provide FFS coverage for NJ FamilyCare (NJFC) beneficiaries pending enrollment with a managed care organization (MCO).

BACKGROUND: The NJ FamilyCare (NJFC) Managed Long Term Services and Supports (MLTSS) benefit refers to the delivery of long-term services and supports through NJFC. MLTSS uses NJFC MCOs, also known as health maintenance organizations (HMOs), to coordinate all long term services, along with primary health care and behavioral health care services. MLTSS provides comprehensive services and supports, whether a beneficiary lives at home, or in a Community Alternative Residential Setting (CARS) which includes Assisted Living Residence, Assisted Living Program, Adult Family Care, Community Residential Service and Comprehensive Personal Care Home, or in a nursing home. MLTSS services are only available to a client who meets nursing home level of care and are enrolled in a NJFC MCO.

AL programs are experiencing difficulties receiving reimbursement for established residents with pending MCO enrollments that have "spent down" their resources and have been determined eligible for AL services. The reason for this is that upon a determination of eligibility for MLTSS, enrollment into a MCO may require up to sixty (60) days. In response to this concern, the Division of Medical Assistance and Health Services (DMAHS) is implementing a new billing procedure intended to avoid a gap in service payment for Medicaid eligible beneficiaries residing in AL programs. AL programs will now be able to request fee-for-service (FFS) payments during this gap period.

ACTION: **For claims with service dates on or after July 1, 2014**, AL programs may submit claims to request FFS reimbursement for AL services provided to those 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.

The following example illustrates the new billing procedure:

1. An AL resident applied to the NJFC program in July and was determined eligible by the State on August 5, 2014. The beginning date for this resident's **NJFC eligibility is made retroactive to July 1, 2014.**
2. This resident's MLTSS "**clinical**" **eligibility** (i.e. a determination that the resident has a nursing home level of care) is **established on July 15, 2014.**
3. This resident's **enrollment in a MCO** becomes **effective on September 1, 2014.**

In this example, the AL resident is responsible for payment to the AL facility as a private pay resident for the period **July 1, 2014 through July 14, 2014** since only the "financial" eligibility and not the "clinical" eligibility for this resident has been determined.

The AL provider may submit FFS claims to Molina Medicaid Solutions with **service dates on or after July 15, 2014 and prior to September 1, 2014** since (1) both the "financial" and "clinical" eligibilities have been determined; and (2) the resident's enrollment in a MCO is still pending.

Effective September 1, 2014, the resident is enrolled in a MCO and, the AL provider submits claims with service dates **on or after September 1, 2014** to the responsible MCO. The MCO becomes responsible for AL payments less any determined cost share for the resident.

Any AL providers with NJFC-eligible residents "clinically" eligible for AL services, but 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 member became "clinically" eligible for AL services
 - Facility name
- Please allow ten business days after notifying DMAHS before submitting FFS claims. After ten business days, the AL provider may submit claims to Molina Medicaid Solutions.
- AL providers are to bill reporting the appropriate HCPCS procedure code, modifier and per diem rate listed below. The provider shall submit per diem claims only for those days for which the resident was in the facility less any established resident payment liability.
- Once the resident is enrolled in an MCO, the AL provider shall submit AL claims to the MCO. The AL provider may bill for the date of admission. The date of discharge, if applicable, is not billable.

**FEE-FOR-SERVICE RATES
EFFECTIVE JULY 1, 2014**

Facility Type	HCPCS Procedure Code/Modifier	Per Diem Rate
Assisted Living Residence (ALR)	T2031	\$72.50
Comprehensive Personal Care Home (CPCH)	T2031 U1	\$62.50
Assisted Living Program (ALP)	T2031 U2	\$52.50
Adult Family Care (AFC)	S5140	\$50.00

If you have any questions concerning this Newsletter, please contact the DMAHS Office of Customer Service at 609-631-4641.

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