FREQUENTLY ASKED QUESTIONS (FAQS)
FOR PROVIDER INDUSTRY

1. What are the changes to the Medicaid program in State Fiscal Year 2012?

Effective **July 1, 2011**, the following individuals who were previously exempt from managed care enrollment in the Medicaid/NJ FamilyCare program must be enrolled in managed care in one of New Jersey's four (4) Medicaid Health Maintenance Organizations (HMOs). This includes:

- individuals in the Community Care Waiver (CCW) program who are **not** dually eligible for Medicare and Medicaid;
- individuals in the Aged, Blind and Disabled (ABD) category who have Medicaid only;
- all DYFS children, except out-of-state placements;
- individuals who have been allowed exemptions from managed care enrollment;
- individuals on Medicaid who are also enrolled in or covered by a private health plan;
- Medicaid individuals who have been in the pharmacy lock-in program; and
- Breast and Cervical Program Medicaid individuals.

Dually eligible individuals or those participating in a waiver program (other than the Community Care Waiver – CCW) will be enrolled in a managed care plan on October 1, 2011.

For most clients, Medicaid is changing from Medicaid fee-for-service (FFS) to Medicaid managed care. Clients currently in a program operated under Medicaid FFS must enroll in an HMO unless they are in an excluded group.

Care will now be coordinated by the member's HMO and for the most part, individuals will need to use providers that are in the health plan's network. The State's HMO contract requires continuity of care with existing services and providers until the HMO can assess the member and put any alternate plans of care in place.

Individuals with private health insurance or Medicare should continue using providers in these networks for services covered by them. However, dental and other non-covered services must be obtained from the Medicaid HMO providers.

2. Why is enrollment in managed care necessary?

A significant percentage of New Jersey's Medicaid clients are successfully enrolled in managed care. The 2012 budget initiative to enroll additional populations and "carve-in" additional services to managed care will make it possible to better manage and coordinate

client care and avoid the reductions in services that other states are experiencing this year.

3. Does the managed care enrollment affect clients with both Medicare and Medicaid?

Yes, the initiative requires the enrollment in managed care of those with dual eligibility in Medicare and Medicaid. If clients have both Medicare and Medicaid, they can continue to use the Medicare network except for dental services, which Medicare doesn't cover, as well as their HMO's Medicaid network for Medicaid services. Clients who are dually eligible for Medicaid and Medicare services, and clients participating in a waiver program (except Medicaid-only CCW clients) will need to enroll in a managed care plan effective October 1, 2011.

4. What excluded groups will remain Medicaid fee-for-service?

- Medically Needy - Long Term Care and not Long Term Care
- Individuals in ICF/IDs
- Individuals in inpatient psychiatric hospitals
- Individuals in the PACE program
- Individuals in Nursing Facilities - Long Term Care
- Individuals in Out of State Placements
- Individuals enrolled in the Cystic Fibrosis Program with the Department of Health and Senior Services - Note: The Department of Health and Senior Services' Cystic Fibrosis Program is not a Medicaid program.
- Fee-for-service Newborns
- Note: For Individuals in acute hospitals at the time of enrollment, managed care enrollment begins after discharge.
- Presumptively Eligible Pregnant Women
- Presumptively Eligible Children

5. What are the 4 New Jersey HMOs?

The four (4) health plans are:

1. Amerigroup New Jersey, Inc. (Serving all counties except Salem)

2. Healthfirst Health Plan of New Jersey (in 10 counties: Bergen, Essex, Hudson, Mercer, Middlesex, Morris, Passaic, Somerset, Sussex and Union)

3. Horizon NJ Health (Serving all counties)

4. UnitedHealthcare Community Plan (Serving all counties)

You can also learn more about New Jersey's Medicaid health plans at www.njfamilycare.org.

6. What is the deadline for selecting and joining an HMO?

July 1, 2011 Group
Enrollees in the group with a July 1, 2011 effective date should have received a letter informing them to select an HMO by June 10, 2011 with a July 1, 2011 HMO enrollment date. However, due to a data match error, the "Ready to Enroll" letter contained a July 18, 2011 deadline for enrollment.

This information systems glitch created understandable confusion, and Medicaid encouraged clients to expedite their HMO enrollment as close to the June 10 deadline, as possible. Enrollments received after June 10 or before July 18 were honored beginning August 1. Non-selection of an HMO by July 18, 2011 triggered an auto-selected HMO, with coverage beginning August 1, 2011.

October 1, 2011 Group
Enrollees who are dually eligible or participating in a waiver program (other than the Community Care Waiver – CCW), will receive by mail information regarding the scheduled October 1, 2011 enrollment. These enrollees have until September 15, 2011 to select a Medicaid health plan. Non-selection of an HMO by September 15, 2011 will trigger an auto-selected HMO, with coverage beginning October 1, 2011.

Obtaining Services

7. What services will now be carved into managed care?

On July 1, 2011, the following services will be covered by the NJ FamilyCare/Medicaid HMOs for all HMO members:

1. Home Health for all members, including members who have been receiving this benefit with Medicaid fee-for-service;
2. Pharmacy for all members, including those members who have been receiving this benefit with Medicaid fee-for-service;
3. Personal Care Assistant (PCA) (Personal Preference, a self directed service, will remain under Medicaid fee-for-service);
4. Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST); and
5. Adult and Pediatric Medical Day Care Services.

Dually eligible and waiver program clients will continue to receive these services under Medicaid fee-for-service until they enroll in a managed care plan on October 1, 2011.

8. Will my clients continue to receive the same services they are receiving now?

Your HMO will assure that the members' care continues after enrollment without interruption. Once enrolled, the HMO will do an assessment of the members' needs and new care plans may be put in place at that time.

9. What will happen to existing prior authorizations? Will they be honored?

Prior authorizations will be honored until a reassessment can be done by the HMO. Prior authorizations may be changed at that time.

10. Will individuals served continue to receive their home and community based waiver services separate from the HMO?

As a rule, the HMOs will provide medical services and the Waiver programs will provide all other services available under the respective waiver. A set of summary charts that explains this further is attached to the FAQs.

11. Will existing DHSS and DDS waiver case managers be informed of these changes?

Yes. A series of meetings have been held to provide waiver care and case managers with information about the transition beginning in June 2011 and in September 2011.

12. Will Mental Health/Behavioral Health services be carved into managed care?

No. Except for DDD, mental health/behavioral health services remain in Medicaid fee-for-service.

13. How will Durable Medical Equipment (DME) rental to purchase agreements be handled?

The HMO will make arrangements with non-participating DME providers for the remaining months of the rental at the non-participating reimbursement rate, and with participating DME providers at the contracted rate. Since each HMO has its own policies on which items are on their DME rental-to-purchase list, you should contact the HMOs' provider relations departments to find out which items are on their list.

The following are phone numbers for the provider relations departments at each of the four HMOs:

Amerigroup New Jersey, Inc.	1-800-454-3730
Healthfirst NJ	1-866-889-2523
Horizon NJ Health	1-800-682-9091
UnitedHealthcare Community Plan	1-973-297-5635

14. Will Family Planning Services be carved into managed care?

HMO enrollees in Plans A, B , C, and certain Plan D enrollees (those who are in a particular program status code group) may use providers in the HMO network or Medicaid providers outside of the HMO network for family planning services and supplies. Plan D enrollees should call their HMOs to ask if they are eligible to access these services out-of-network.

Prescription Services

15. What will happen to Pharmacy benefits?

All clients enrolled in a NJ FamilyCare/Medicaid managed care HMO beginning July 1, 2011, will receive pharmacy benefits from their health plan. They will no longer receive these benefits through the Medicaid fee-for-service program.

Clients who are not currently enrolled in a NJ FamilyCare/Medicaid managed care HMO, but who will be enrolled over the next few months will also receive pharmacy benefits from their NJ FamilyCare/Medicaid managed health care plan upon enrollment.

Clients may use their HMO Member ID card at the pharmacy counter to obtain prescriptions. Clients with Medicare Part D will continue to be covered for their prescriptions by Medicare Part D.

16. How will prescriptions and renewals be handled during this transition?

The client's HMO will assure that care including pharmacy continues after enrollment without interruption until an assessment is done of the individual's needs and services. Notices will be sent to affected members and prescribers about changes, which will include information about the medical exception process to assure continuity of care.

HMOs can authorize a drug which is not on their approved formulary (list of approved drugs) when requested by the individual's primary care physician or other referring provider if they certify medical necessity for the drug to the HMO. If the HMO's formulary includes generic drug equivalents in their formulary, the Plan will provide for a brand name exception process when medically necessary.

Provider Networks and Reimbursement

17. If I am a Medicaid provider, am I automatically an HMO provider?

You can continue to be a provider for continuity of care purposes until the member is assessed by the HMO and a new care plan put in place. The HMO may require that the member choose a provider from within their own network. To be a managed care provider, you will need to contact the HMO and apply to be considered as a participating provider in their network. Each HMO has its own process for recruiting and maintaining its provider network.

Provider relations at each HMO are:

- Amerigroup New Jersey, Inc. 1-800-454-3730
- Healthfirst NJ 1-866-889-2523
- Horizon NJ Health 1-800-682-9091
- UnitedHealthcare Community Plan 1-973-297-5635

18. Will my clients have to change providers when they join an HMO if I am not an HMO provider?

No. The HMOs must maintain continuity of care for new enrollees until an assessment of the member's needs is done. A new care plan may be developed at that time. The continuity of care period is provided to make the transition as seamless as possible to members and to avoid disruptions in their care.

19. How will claims be processed after July 1, 2011 and after the dually eligible and waiver program clients' HMO enrollment goes into effect on October 1, 2011? How will claims incurred before the HMO enrollments take effect be paid?

Effective July 1, 2011, and again on October 1, 2011, claims must be submitted to the HMO for newly enrolled HMO members.

Claims incurred prior to these effective dates, will be handled by the State's fiscal agent.

20. Will rates remain the same as in Medicaid fee-for-service? Can the HMO pay different rates and when will this take effect?

Each HMO sets their own fee structure for the providers with whom they have a contract or agreement.

21. Will the HMOs accept new provider enrollments?

This is a decision that each HMO will make. Continuity of care provisions will be in place during this transition to avoid disruption of care. This includes maintaining current client/provider relationships until a new assessment of the member can be done and a new care plan put in place. Most HMOs have requirements for selection of providers and the member is assisted to make these choices.

22. How will Medicare services be impacted if Medicare is primary?

These changes should not have any impact on Medicare services. Clients with Medicare can continue to use their Medicare network providers, and will have access to their HMO's Medicaid network as well.

23. How will crossover claims be handled?

New Jersey's fiscal agent will provide each HMO with electronic crossover claim submissions to facilitate timely claims payment.

24. I am a PCA provider; will I be required to be Medicare Certified?

In New Jersey, PCA providers are not required to be Medicare Certified since PCA is not a Medicare covered service. Hospice providers must be Medicare certified and only

Medicare certified and DHS licensed home health agencies (specialty 380) can provide skilled nursing visits. All other home care agencies are required to have a Consumer Affairs license and also be accredited by one of the accrediting bodies for PCA services. These are:

- Community Health Accreditation Program, Inc. (CHAP)
- Commission on Accreditation for Home Care, Inc. (CAHC)
- The Joint Commission (TJC)
- National Association for Home Care/HomeCare University (NAHC).

25. I am currently a provider under Medicaid fee-for-services (for example, Adult or Pediatric Medical Day Care, Pharmacy, Home Health, Therapy). If I contract with an HMO, what will I be paid? If I want to contract with an HMO, who do I call?

Each HMO sets its own fee structure and rates in its contracts and agreements with vendors/providers. You can contact the HMOs' provider relations departments to find out how to apply to become a participating provider:

Provider relations at each HMO are:

Amerigroup New Jersey, Inc.	1-800-454-3730
Healthfirst NJ	1-866-889-2523
Horizon NJ Health	1-800-682-9091
UnitedHealthcare Community Plan	1-973-297-5635

AIDS Community Care Alternatives Program (ACCAP)

HMO Responsible For Authorization and Payment of:	Waiver Services paid for by Division of Disability Services (DDS):	Other Services paid fee for service by Division of Medical Assistance and Health Services (DMAHS):
• Care management when indicated by an Individual Health Assessment and/or Complex Needs Assessment; • Primary & specialty care; • Preventive health care, counseling and health promotion; • Early and periodic screening and diagnostic treatment (EPSDT) benefit;[1] • Emergency medical care; • Inpatient hospital services; • Outpatient hospital services; • Laboratory services; • Radiology services – diagnostic & therapeutic; • Prescription drugs; • Family planning services & supplies; • Audiology; • Inpatient rehabilitation services; • Podiatrist services; • Chiropractor services; • Optometrist services; • Optical appliances; • Hearing aid services; • Home health agency services; • Hospice services; • Durable medical equipment/assistive technology devices; • Medical supplies; • Prosthetics & orthotics; • Dental services; • Organ transplants – donor and recipient costs; • Emergency Transportation;[2] • Nursing facility for first 30 days of admission;[3] • Mental health/substance abuse for clients of the Division of Developmental Disabilities; • Personal care assistant services, except for Personal Preference Program;[4] • Medical day care; and • Physical therapy, occupational therapy and speech pathology services.	• Case management;[5] • Private-duty nursing;[6] • Personal care assistant services (beyond the 40 hour limit available through the HMO or Personal Preference Program);[7]	• Personal Preference Program; • Abortions and related services; • Non-emergent Transportation to medical services through Logisticare contract; • Sex abuse examinations; • Services provided by New Jersey MH/SA and DYFS Residential Treatment Facilities or Group Homes; • Family Planning Services & Supplies when furnished by a nonparticipating provider; • Mental Health Services for enrollees other than clients of the Division of Developmental Disabilities; • Costs for Methadone and its administration; • Up to twelve (12) inpatient hospital days when required for social necessity, in accordance with Medicaid regulations; • Nursing facility care beyond 30 consecutive days;[8] • Inpatient psychiatric services (except for Residential Treatment Centers - RTCs) for individual under age 21 and ages 65 and over; and • Intermediate care facilities for intellectual disabilities

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AIDS Community Care Alternatives Program (ACCAP)

Footnotes:

An ACCAP Waiver participant must have a diagnosis of Acquired Immune Deficiency Syndrome (AIDS); must meet the nursing home level of care (LOC); and need and use at least one ACCAP Waiver Service to be eligible for the ACCAP Waiver.

[1] For individuals under the age of 21, private-duty nursing would typically be an EPSDT service; however, for individuals enrolled in ACCAP, the private-duty nursing service is covered as a waiver service instead of through the HMO covered benefit.
[2] Non-emergent transportation is covered by the Logisticare Contract.
[3] Coordination is required between HMO care manager and Waiver case manager because waiver eligibility is affected by stay in nursing facility. Loss of waiver eligibility may result in loss of Medicaid eligibility.
[4] HMO assesses for need for personal care assistant services and refers to the Division of Disability Services if individual wishes to participate in Personal Preference Program.
[5] An ACCAP waiver participant must receive case management as one of his/her waiver services. ACCAP Waiver participants must need and use a minimum of one waiver service on an ongoing monthly basis in order to be eligible for initial and continued enrollment on the ACCAP waiver.
[6] See footnote 1, above.
[7] The waiver only pays for additional hours if the person has an assessed need for more than 40 hours. This requires coordination between the HMO care manager and the waiver case manager.
[8] Continued nursing facility stay will result in loss of waiver eligibility and possible loss of Medicaid eligibility. If Medicaid eligibility is maintained, disenrollment from managed care will result because of institutional placement.

Community Care Waiver (CCW)

HMO Responsible For Authorization and Payment of:	Waiver Services Paid for by Division of Developmental Disabilities (DDD):	Other Services paid fee for service by Division of Medical Assistance and Health Services (DMAHS):
• Care management when indicated by an Individual Health Assessment and/or Complex Needs Assessment; • Primary & specialty care; • Preventive health care, counseling and health promotion; • Early and periodic screening and diagnostic and treatment (EPSDT) benefit;[1] • Emergency medical care; • Inpatient hospital services; • Outpatient hospital services; • Laboratory services; • Radiology services – diagnostic & therapeutic; • Prescription drugs; • Family planning services & supplies; • Audiology; • Inpatient rehabilitation services; • Podiatrist services; • Chiropractor services; • Optometrist services; • Optical appliances; • Hearing aid services; • Home health agency services; • Hospice services; • Durable medical equipment/assistive technology devices; • Medical supplies; • Prosthetics & orthotics; • Dental services; • Organ transplants – donor and recipient costs; • Transportation (other than Logisticare covered transportation);[2] • Nursing facility for first 30 days of admission;[3] • Mental health/substance abuse for clients of the Division of Developmental Disabilities; • Personal care assistant services, except for Personal Preference Program;[4] • Medical day care;[5] and • Physical therapy, occupational therapy and speech pathology services.	• Case management; • Support coordination for people who self-direct; • Assistive Technology devices;[6] • Day habilitation; • Environmental and vehicle adaptations; • Individual supports for activities of daily living; • Personal emergency response systems; • Respite care; • Supported employment services; • Transition services; • Transportation services to waiver services	• Personal Preference Program; • Abortions and related services; • Non-emergent Transportation to medical services through Logisticare contract; • Sex abuse examinations; • Services provided by New Jersey MH/SA and DYFS Residential Treatment Facilities or Group Homes; • Family Planning Services & Supplies when furnished by a nonparticipating provider; • Costs for Methadone and its administration; • Up to twelve (12) inpatient hospital days when required for social necessity, in accordance with Medicaid regulations; • Nursing facility care beyond 30 consecutive days;[7] • Inpatient psychiatric services (except for Residential Treatment Centers - RTCs) for individual under age 21 and ages 65 and over; and • Intermediate care facilities for intellectual disabilities

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Community Care Waiver (CCW)

Footnotes:

A CCW Waiver participant must be eligible for services through the Division of Developmental Disabilities; need ICF/ID-DD level of care; and need and use one waiver service in addition to case management.

[1] For individuals under the age of 21, private-duty nursing is an EPSDT service; individuals under the age of 21 and enrolled on CCW may receive private duty nursing as an HMO covered benefit, if medically necessary.
[2] Non-emergent transportation is contained in the Logisticare Contract.
[3] Coordination is required between HMO care manager and Waiver case manager because waiver eligibility is affected by stay in nursing facility other than for use of nursing facility as a respite service covered as a waiver service. Loss of waiver eligibility as the result of a non-respite nursing facility stay may result in loss of Medicaid eligibility.
[4] HMO assesses for need for personal care assistant services and refers to the Division of Disability Services if individual wishes to participate in Personal Preference Program. Personal care assistant services cannot be provided to an individual who lives in a DDD group home, skilled development home or supervised apartment or other congregate living program where personal assistance is provided as part of a service package included in the living arrangement.
[5] Coordination is required between HMO care manager and Waiver case manager because waiver eligibility may be affected by the enrollment into Medical Day Care program if individual is not receiving other CCW services in addition to Case Management.
[6] The waiver pays for medically necessary assistive technology services that have been denied by the Medicaid program.
[7] Continued nursing facility stay will result in loss of waiver eligibility and possible loss of Medicaid eligibility. If Medicaid eligibility is maintained, disenrollment from managed care will result because of institutional placement.

Community Resources for People with Disabilities (CRPD)

HMO Responsible For Authorization and Payment of:	Waiver Services paid for by Division of Disability Services (DDS):	Other Services paid fee for service by Division of Medical Assistance and Health Services (DMAHS):
• Care management when indicated by an Individual Health Assessment and/or Complex Needs Assessment; • Primary & specialty care; • Preventive health care & counseling and health promotion; • Early and periodic screening and diagnostic treatment (EPSDT) benefit;[1] • Emergency medical care; • Inpatient hospital services; • Outpatient hospital services; • Laboratory services; • Radiology services – diagnostic & therapeutic; • Prescription drugs; • Family planning services & supplies; • Audiology; • Inpatient rehabilitation services; • Podiatrist services; • Chiropractor services; • Optometrist services; • Optical appliances; • Hearing aid services; • Home health agency services; • Hospice services; • Durable medical equipment/assistive technology devices; • Medical supplies; • Prosthetics & orthotics; • Dental services; • Organ transplants – donor and recipient costs; • Emergency Transportation;[2] • Nursing facility for first 30 days of admission;[3] • Mental health/substance abuse for clients of the Division of Developmental Disabilities; • Personal care assistant services, except for Personal Preference Program;[4] • Medical day care; and • Physical therapy, occupational therapy and speech pathology services.	• Case management;[5] • Private-duty nursing;[6] • Environmental/residential modification; • Vehicular modification; • Personal emergency response systems; • Community transitional services	• Personal Preference Program; • Abortions and related services; • Non-emergent Transportation to medical services through Logisticare contract; • Sex abuse examinations; • Services provided by New Jersey MH/SA and DYFS Residential Treatment Facilities or Group Homes; • Family Planning Services & Supplies when furnished by a nonparticipating provider; • Mental Health Services for enrollees other than clients of the Division of Developmental Disabilities; • Costs for Methadone and its administration; • Up to twelve (12) inpatient hospital days when required for social necessity, in accordance with Medicaid regulations; • Nursing facility care beyond 30 consecutive days;[7] • Inpatient psychiatric services (except for Residential Treatment Centers - RTCs) for individual under age 21 and ages 65 and over; and • Intermediate care facilities for intellectual disabilities

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Community Resources for People with Disabilities (CRPD)

Footnotes:

A CRPD Waiver participant must be in need of institutional care and meet, at a minimum, the nursing facility (NF) level of care (LOC) criteria and be determined disabled by the Social Security Administration (SSA) or by the Disability Review Section of DMAHS, using SSA disability criteria. Eligible individuals must need and receive a minimum of two CRPD Waiver services.

- Any individual referred for CRPD Waiver who requires private duty nursing (PDN) services must have a live-in primary caregiver (adult relative or significant other adult) who accepts 24-hour responsibility for that applicant's health and welfare and provide a minimum of 8-hours hands on nursing care.
- If the individual only requires State Plan services through the HMO benefit package or other services paid for by DMAHS, CRPD Waiver enrollment is not appropriate.

[1] For individuals under the age of 21, private-duty nursing is an EPSDT service; individuals under the age of 21 and enrolled on CRPD receive private-duty nursing service as an HMO covered benefit, if medically necessary.
[2] Non-emergent transportation is contained in the Logisticare Contract.
[3] Coordination is required between HMO care manager and Waiver case manager because waiver eligibility is affected by stay in nursing facility. Loss of waiver eligibility may result in loss of Medicaid eligibility.
[4] HMO assesses for need for personal care assistant services and refers to the Division of Disability Services if individual wishes to participate in Personal Preference Program.
[5] A CRPD Waiver participant must receive Case Management as a CRPD Waiver service and at least one additional monthly CRPD waiver service in order to be eligible for initial and continued enrollment on the CRPD Waiver.
[6] See footnote 1, above.
[7] Continued nursing facility stay will result in loss of waiver eligibility and possible loss of Medicaid eligibility. If Medicaid eligibility is maintained, disenrollment from managed care will result because of institutional placement.

Global Options for Long-Term Care (GO)

HMO Responsible For Authorization and Payment of:	Waiver Services Paid for by Department of Health and Senior Services:	Other Services paid fee for service by Division of Medical Assistance and Health Services (DMAHS):
• Care management when indicated by an Individual Health Assessment and/or Complex Needs Assessment; • Primary & specialty care; • Preventive health care & counseling and health promotion; • Early and periodic screening and diagnostic treatment (EPSDT) benefit;[1] • Emergency medical care; • Inpatient hospital services; • Outpatient hospital services; • Laboratory services; • Radiology services – diagnostic & therapeutic; • Prescription drugs; • Family planning services & supplies; • Audiology; • Inpatient rehabilitation services; • Podiatrist services; • Chiropractor services; • Optometrist services; • Optical appliances; • Hearing aid services; • Home health agency services; • Hospice services; • Durable medical equipment/assistive technology devices; • Medical supplies; • Prosthetics & orthotics; • Dental services; • Organ transplants – donor and recipient costs; • Emergency Transportation;[2] • Nursing facility for first 30 days of admission;[3] • Mental health/substance abuse for clients of the Division of Developmental Disabilities; • Personal care assistant services, except for Personal Preference Program;[4] • Medical day care;[5] and • Physical therapy, occupational therapy and speech pathology services.	• Care management;[6] • Assisted living (ALR/CPCH); • Assisted Living Program in subsidized housing; • Attendant care; • Caregiver/participant training; • Chore services; • Community transition services; • Environmental accessibility adaptations; • Home based supportive care;[7] • Home-delivered meal service; • Personal emergency response systems; • Respite care; • Special medical equipment and supplies;[8] • Social adult day care; • Transitional care management • Transportation to waiver and non-state plan services	• Personal Preference Program; • Abortions and related services; • Non-emergent Transportation to medical services through Logisticare contract; • Sex abuse examinations; • Services provided by New Jersey MH/SA and DYFS Residential Treatment Facilities or Group Homes; • Family Planning Services & Supplies when furnished by a nonparticipating provider; • Mental Health Services for enrollees other than clients of the Division of Developmental Disabilities; • Costs for Methadone and its administration; • Up to twelve (12) inpatient hospital days when required for social necessity, in accordance with Medicaid regulations; • Nursing facility care beyond 30 consecutive days;[9] • Inpatient psychiatric services (except for Residential Treatment Centers - RTCs) for individual under age 21 and ages 65 and over; and • Intermediate care facilities for intellectual disabilities

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Footnotes:

A GO Waiver participant must be: Aged (age 65 and older), or Disabled (Physical) (between the ages of 21-64) as determined by the Social Security Administration (SSA) or by the NJ Division of Medical Assistance and Health Services, Disability Review Section. Individuals between the ages of 21 and 64 who are chronically mentally ill, intellectually disabled or developmental disabled are ineligible for Global Options for Long-Term Care enrollment.

[1] Because enrollment on GO is limited to individuals aged 21 and above, no one enrolled on GO is eligible for EPSDT services.
[2] Non-emergent transportation is contained in the Logisticare Contract.
[3] Coordination is required between HMO care manager and GO Waiver care manager because waiver eligibility may be affected by nursing facility placement. If a person enters a nursing facility for long-term care or hospice care, GO enrollment ceases; if a person enters a nursing facility for temporary respite services, GO eligibility continues. Loss of waiver eligibility may result in loss of Medicaid eligibility.
[4] A GO participant can choose Personal Care Assistant services through the HMO benefit package or choose Home-Based Supportive Care through the GO Waiver, but he or she cannot receive both; PCA and HBSC are mutually exclusive of one another and both are based on assessed need for service. If the participant wishes to participate in the Personal Preference Program, a referral is made to the Division of Disability Services. A GO enrollee who receives Assisted Living or Assisted Living in Subsidized Housing cannot also receive Personal Care Assistant Services. A GO enrollee who receives Adult Family Care as a GO Waiver service cannot also receive Personal Care Assistant Services. Each GO waiver service may be limited in duration or amount or unauthorized if duplicative of another waiver service or State Plan Service.
[5] A GO participant who receives Assisted Living (in an ALR or CPCH) or Assisted Living in Subsidized Housing (ALP) as a GO waiver service cannot also receive medical day care (commonly called adult day health services) or Personal Care Assistant services through the State Plan/HMO benefit package as they would duplicate services integral to and inherent in the provision of assisted living. A person who receives Adult Family Care as a GO waiver service cannot also receive Personal Care Assistant services through the State Plan/HMO benefit package.
[6] A GO participant must receive Care Management as a GO Waiver service and at least one additional GO Waiver service monthly in order to be eligible for initial and continued enrollment on GO (if the person only requires State Plan Services through the HMO benefit package, GO enrollment is not appropriate.) Enrollment on the GO Waiver is contingent on a person's requiring GO Waiver services in order to avoid institutionalization in a nursing facility.
[7] See endnote 4, above.
[8] The GO Waiver covers medically necessary specialized medical equipment and supplies that are assessed as needed, and otherwise not covered and/or have been denied by the Medicaid program.
[9] If a GO participant is admitted to a nursing facility for reasons other than temporary Respite services, the GO Care Manager may provide Transitional Care Management services – billable for up to three months (90 days) only if the Care Manager makes the required contacts each month and the participant is discharged back to the community. At any time within the 90 day period, upon notification that a participant will remain in the NF for long-term care or when electing Hospice services in the nursing facility, the GO Care Manager will disenroll the participant from the GO program. If the GO participant resides in the nursing facility for over 30 days, he or she will be disenrolled from managed care.

Traumatic Brain Injury (TBI)

HMO Responsible For Authorization and Payment of:	Waiver Services Paid for by Division of Disability Services (DDS):	Other Services paid fee for service by Division of Medical Assistance and Health Services (DMAHS):
• Care management when indicated by an Individual Health Assessment and/or Complex Needs Assessment; • Primary & specialty care; • Preventive health care & counseling and health promotion; • Early and periodic screening and diagnostic treatment (EPSDT) benefit;[1] • Emergency medical care; • Inpatient hospital services; • Outpatient hospital services; • Laboratory services; • Radiology services – diagnostic & therapeutic; • Prescription drugs; • Family planning services & supplies; • Audiology; • Inpatient rehabilitation services; • Podiatrist services; • Chiropractor services; • Optometrist services; • Optical appliances; • Hearing aid services; • Home health agency services; • Hospice services; • Durable medical equipment/assistive technology devices; • Medical supplies; • Prosthetics & orthotics; • Dental services; • Organ transplants – donor and recipient costs; • Emergency Transportation;[2] • Nursing facility for first 30 days of admission;[3] • Mental health/substance abuse for clients of the Division of Developmental Disabilities; • Personal care assistant services, except for Personal Preference Program;[4] • Medical day care; and • Physical therapy, occupational therapy and speech pathology services.	• Case management;[5] • Adult companion (being eliminated when waiver is renewed – expected 7/1/11); • Behavioral program; • Environmental/vehicular modifications; • Community residential services; • Counseling; • Cognitive rehabilitative therapy; • Structured day program; • Supported day program; • Physical therapy;[6] • Occupational therapy;[7] • Speech, language and hearing therapy;[8] • Respite care	• Personal Preference Program; • Abortions and related services; • Non-emergent Transportation to medical services through Logisticare contract; • Sex abuse examinations; • Services provided by New Jersey MH/SA and DYFS Residential Treatment Facilities or Group Homes; • Family Planning Services & Supplies when furnished by a nonparticipating provider; • Mental Health Services for enrollees other than clients of the Division of Developmental Disabilities; • Costs for Methadone and its administration; • Up to twelve (12) inpatient hospital days when required for social necessity, in accordance with Medicaid regulations; • Nursing facility care beyond 30 consecutive days;[9] • Inpatient psychiatric services (except for Residential Treatment Centers - RTCs) for individual under age 21 and ages 65 and over; and • Intermediate care facilities for intellectual disabilities

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Traumatic Brain Injury (TBI)

Footnotes:

Waiver participants must be in need of institutional care and meet, at a minimum, the nursing facility (NF) level of care (LOC) criteria. Individuals must have a diagnosis of acquired, non-degenerative, or traumatic brain injury after their 21st birthday but prior to turning 65 years of age (those who turn 65 while enrolled in the waiver may remain on the waiver) and have a rating of at least 4 on the Rancho Los Amigos Level of Cognitive Functioning Scale. Individuals must be determined disabled by the Social Security Administration or by the Disability Review Section of the DMAHS, using the SSA disability criteria.

- Eligible individuals must need and receive a minimum of two CRPD Waiver Services.
- In the individual only requires State Plan Services through the HMO benefit package or other services paid for by DMAHS, TBI Waiver enrollment is not appropriate.

[1] Because enrollment on TBI is limited to individuals aged 21 and above, no one enrolled on TBI should be eligible for EPSDT services.
[2] Non-emergent transportation is contained in the Logisticare Contract.
[3] Coordination is required between HMO care manager and Waiver case manager because waiver eligibility is affected by stay in nursing facility. Loss of waiver eligibility may result in loss of Medicaid eligibility.
[4] HMO assesses for need for personal care assistant services and refers to the Division of Disability Services if individual wishes to participate in Personal Preference Program. Individuals who reside in a CRS are not eligible to receive PCA as this in included as part of the CRS package of services.
[5] A TBI Waiver participant must receive Case Management as a TBI Waiver service and at least one additional TBI monthly waiver service in order to be eligible for initial and continued enrollment on TBI Waiver.
[6] Physical therapy is provided as a TBI waiver service when the required therapy is no longer intensive rehabilitation; will require coordination between the care manager for the HMO and the case manager for the TBI waiver.
[7] Occupational therapy is provided as a TBI waiver service when the required therapy is no longer intensive rehabilitation; will require coordination between the care manager for the HMO and the case manager for the TBI waiver.
[8] Speech, language and hearing therapy is provided as a TBI waiver service when the required therapy is no longer intensive rehabilitation; will require coordination between the care manager for the HMO and the case manager for the TBI waiver.
[9] Continued nursing facility stay will result in loss of waiver eligibility, possible loss of Medicaid eligibility, and if Medicaid eligibility is maintained disenrollment from managed care because of institutional placement.