# Your Plan of Care

The Plan of Care is based on your assessed care needs. It outlines what services and supports are needed to help you. Your Plan of Care is personalized for you.

The Plan of Care form and the tools and methods used to support and develop it help make sure you are getting comprehensive and cost-effective delivery of services. The Plan of Care is reviewed often and updated at least every year to ensure you get the services you need.

The Plan of Care will be developed with you and/or your authorized representative, based on your needs. The plan will include unmet needs, personal goals, risk factors, and backup plans.

The Plan of Care will be signed and dated by you and/or your authorized representative and you will get a copy within 45 days. You will be told about any changes to the Plan of Care and you must state if you agree or disagree with the following statements:

- I agree with the Plan of Care.
- I had the freedom to choose the services in the Plan of Care.
- I had the freedom to choose the providers of my services based on available providers.
- I helped develop this Plan of Care.
- I am aware of my rights and responsibilities as a member of this program.
- I am aware that the services outlined in this Plan of Care are not guaranteed.
- I have been told about potential risk factors outlined in this Plan of Care.
- I understand and accept these potential risk factors.
- I understand and accept that a backup plan will be initiated as stated in my Plan of Care.
- I understand that I may appeal or request a Medicaid Fair Hearing for the reduction or denial of services after I receive the Horizon NJ Health decision letter from the Internal Appeal.

If you disagree with any of these statements, your concerns will be noted on the plan before you sign it. You must review and sign off on any changes to your Plan of Care.

Your Care Manager will also explain and sometimes remind you that specific clinical and financial criteria are required to participate in this program. They will tell you who is responsible for making sure you continue to be eligible for both.

## Participant Direction and Personal Preference Program

The Personal Preference Program (PPP) was designed to give you the most independence possible so you have more control over making decisions, planning and managing your care. You are the employer and are able to hire your own paid caregivers. You can choose who provides your care, what type of care you want and need, when you want care, and where the care will be provided.

Caregivers or service providers become accountable to you. For those members who are capable of and choose to direct their own care, you may do so under the PPP.

Members who participate in the Participant Direction of Home and Community-Based Services choose either to serve as the employer of record of their workers or to name a representative to serve as employer of record on his/her behalf.

As the employer of record, you and/or your representative are responsible for:

1. Recruiting, hiring and firing workers
2. Determining workers' duties and creating job descriptions
3. Scheduling workers
4. Supervising workers
5. Evaluating worker performance and addressing any faults or concerns
6. Setting the wage to be paid to each worker within the boundaries of the Plan of Care funds
7. Training workers to provide personalized care based on your needs and preferences
8. Ensuring that workers deliver only those services authorized, and reviewing and approving hours of workers
9. Reviewing and ensuring documentation for services provided
10. Developing and implementing as needed a backup plan to address instances when a scheduled worker is not available or does not show up as scheduled

You or your guardian may designate a representative to take over the participant direction responsibilities on your behalf. The representative must:

1. Be at least 18 years of age
2. Understand your support needs
3. Know your daily schedule and routine, medical and functional status, medication regimen, likes and dislikes, and strengths and weaknesses
4. Be physically present in your residence on a regular basis or at least often enough to supervise and evaluate each worker

Your representative may not be paid for serving in this role and may not serve as your worker for any participant-directed service.

You may change your representative at any time. Contact your assigned Care Manager and the Participant Directed Program agency right away if you would like to change representatives.

If Participation Direction is something you are interested in, your Care Manager can tell you more about the program.

## Health care appointments

Tell your care management team about your medical appointments. You should tell your Care Manager about what happened at your appointment. Include information about any changes to your medications or services. If you are unsure about what happened, tell your care management team. Your Care Manager will help you understand what happened. Your Care Manager will also help you include any new information in your care plan.

## Bills

You should not get a bill from Horizon NJ Health network providers for covered services. You do not have to pay a network provider for covered services even if Horizon NJ Health denies payment to them. If we do not pay for all or part of a covered service, the provider is NOT allowed to bill you for what we did not pay.

The only time you should get a bill from a doctor is when you have:

- Been treated for a service not covered by Horizon NJ Health
- Sought care from a non-participating doctor without an authorization from Horizon NJ Health
- Received a service not covered by the NJ FamilyCare program

***If you get a bill***

Do not ignore it; call Member Services for instructions and we will help you.

In these cases, you will be responsible to pay the entire cost of the service (except in cases where only a copay is due) and must make payment arrangements directly with the doctor or provider.

If you receive a bill for any covered medical service, call your Care Manager or Member Services about the bill. Member Services may ask you to send the bill to:

**Horizon NJ Health**
**Member/Provider Correspondence**
**PO Box 24077**
**Newark NJ, 07101-0406**

Medicaid benefits received after the age of 55 may be reimbursable to the State of New Jersey from the member's estate. The recovery may include premium payments made on behalf of the beneficiary.

## MLTSS services

Covered services are services Horizon NJ Health will pay for because you are a member. These services should be provided by a network provider. The exact service(s) you receive and how often and how long you get them is based on your medical condition(s), health and social needs and your Plan of Care. You can get covered services as long as they are medically necessary. A service is medically necessary if it is needed to prevent, diagnose, correct or cure conditions that may cause acute suffering, endanger life, result in illness, interfere with your capacity for normal activity, or threaten some serious handicap.

The Plan of Care you develop with your Care Manager will help make sure you get what you need. Sometimes Horizon NJ Health may need to review your request before you get a service. We may ask your PCP for an order or authorization. This is to make sure you get the right care at the right place when you need it.

You will be able to get the care and services you need by calling your care management team. The services you need will be put on your Plan of Care. Most of the time, your Care Manager will know what you need by just talking to you. You may always ask for a service you think may help you take better care of yourself.

Members must need and receive MLTSS services to remain in the program, as well as meet all other requirements listed in the Eligibility section, *Who Qualifies for MLTSS,* on page 42.

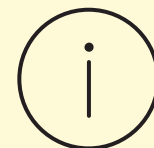
Your assigned Care Manager can give you a detailed description of each MLTSS service. Your Care Manager will also explain that there are limits on the amount, frequency and length of time of some services. Before services can begin, your Care Manager must approve and arrange the services.

MLTSS services are subject to limitations; your Care Manager can give you more information on these restrictions. Here is a list of limitations that apply to all MLTSS services:

- Services must be cost-effective, while supporting your care needs.
- Services are designed to supplement, not replace, assistance already being provided by family, friends and neighbors.
- Services are for the MLTSS member, NOT other household members.
- Services are requested according to the plan of care but cannot be guaranteed.
- MLTSS cannot be used to pay for what is already being paid for privately, through another program, or through another insurance plan.

If any changes are made to your benefits, Horizon NJ Health or the State of New Jersey will notify you of the change within 30 days.

### *Words to know*



**Personal Care Assistant:** Staff that assist members with hands-on activities of daily living (e.g., bathing, dressing)

## How do I get these services?

To obtain any covered services listed above, talk to your Care Manager. Your Care Manager will be able to review and approve most services you need. When you are approved to receive services, we will pay for you to receive the services for a period of time. If we think that you need more or fewer services, your Care Manager will talk to you about your needs. After that discussion and with your agreement, we may change the amount or type of services you are receiving to keep you independent in the community. Your care plan – with your input – will be updated to reflect these changes.

## Who provides these services?

Services, as authorized and arranged by your assigned Care Manager, may only be given by approved, contracted providers with Horizon NJ Health.

All service providers must meet qualification requirements determined by the State of New Jersey, approved by the federal government (if applicable), and credentialed by Horizon NJ Health.

## Reporting abuse, neglect or exploitation

You have the right to be free from exploitation (when someone else benefits from your misfortune), fraud and abuse. Professionals, including care takers, are required to report suspected abuse, neglect or exploitation of any:

- Child or adult who resides in a community setting
- Elderly living in nursing homes or other long term care facilities

If you believe you are the subject of abuse, neglect or exploitation, report it immediately to your Care Manager and the appropriate source outlined below:

### Adult Protective Services

The New Jersey Adult Protective Services (APS) program has offices in each of the 21 counties. Reports may be made to those County APS offices or to:

The Public Awareness, Information,
Assistance & Outreach Unit
24-Hour Toll-Free Hotline:
**1-800-792-8820** (TTY **711**)

### Child Protective Services

The New Jersey Division of Child Protection and Permanency (DCPP) handles all reports of child abuse and neglect, including those occurring in institutional settings such as child care centers, schools, foster homes and residential treatment centers. These must be reported to the State Central Registry (SCR).

Child Abuse Hotline (SCR)
24-Hour Toll-Free Hotline:
**1-877-NJ-ABUSE** (**1-877-652-2873**)
(TTY **1-800-835-5510**)

### Facility-Based Complaints and Investigation

The New Jersey Office of the State Long-Term Care Ombudsman claims of abuse and neglect of people age 60 and older living in nursing homes and other long-term health care facilities, such as assisted living facilities.

24-Hour Toll-Free Hotline: **1-877-582-6995**

Email: **ombudsman@ltco.nj.gov**

Write: **The Office of the State Long-Term Care Ombudsman**
**PO Box 852**
**Trenton, NJ 08625-0852**

Fax: **1-609-943-3479**

NJ Division of Health Facilities Evaluation and Licensing investigates all complaints against health care facilities, nursing homes, assisted living residences, comprehensive personal care homes, adult medical day care, and other licensed acute and long term care facilities.

24-Hour Toll-Free Hotline: **1-800-792-9770**

Write: **New Jersey Department of Human Services**
**Division of Health Facilities Evaluation and Licensing**
**PO Box 367**
**Trenton, NJ 08625-0367**

## Advance Directive

It is a good idea to make an advance directive. An advance directive is a legal document in which you state instructions about how you want to be cared for during the end stages of your life. It is sometimes called a living will. This document can help your family and doctors know how to treat you if you become too sick to tell them.

There are three kinds of advance directives in New Jersey:

- A proxy directive means you can name a person (18 years old or older) to make health care decisions when you no longer can.
- An instruction directive states your desires/ instructions for care.
- A combined directive names a person and gives instructions for care.

Your advance directive only goes into effect if your physician has evaluated you and determined that you are unable to understand your diagnosis, treatment options or the possible benefits and harms of the treatment options.

You can find more information about advance directives and forms at **state.nj.us/health/ advancedirective**.

### Proxy Directive (Durable Power of Attorney for Health Care)

A proxy directive is a document you use to appoint a person to make health care decisions for you in the event you become unable to make them yourself. This document goes into effect whether your inability to make health care decisions is temporary because of an accident or permanent because of a disease. The person you appoint is known as your "health care representative" and they are responsible for making the same decisions you would have made under the circumstances. If they are unable to determine what you would want in a specific situation, they are to base their decision on what they think is in your best interest.

### Instruction Directive (Living Will)

An instruction directive is a document you use to tell your physician and family about the kinds of situations in which you would want or not want life-sustaining treatment in the event you are unable to make your own health care decisions. You can also include a description of your beliefs, values and general care and treatment preferences. This will guide your physician and family when they have to make health care decisions for you in situations not specifically covered by your advance directive.

## Plan ahead for emergencies

The first line of defense against the effects of a disaster is to make sure you are prepared. During a State or National emergency, the government and other agencies may not be able to meet your needs. It is important for you to create your own emergency plan and prepare for your own care and safety in an emergency.

### NJ Register Ready

The NJ Office of Emergency Management (OEM) has a website for residents of New Jersey with special needs and their families to register. The information will allow emergency responders to better serve them in a disaster or other emergency. To register, visit **https://www13.state.nj.us/SpecialNeeds/signin.aspx**. Your Care Manager can assist you if you need help registering.

### NJ 2-1-1

NJ 2-1-1 connects people in need with services that can help. If there is a community emergency, 2-1-1 links emergency management professionals with the public. For more information visit **nj211.org** or call **2-1-1** (TTY **711**).

### Federal Emergency Management Agency (FEMA)

FEMA works with local governments to prepare for and recover from disasters. This includes working with emergency responders during disasters and helping rebuild after. New Jersey is part of FEMA's Region II. For more information, **visit fema.gov**.

## Privacy and confidentiality

It is the policy of Horizon NJ Health to protect your confidentiality and that of your family. To protect this confidentiality:

- All information in your member record is confidential. Horizon NJ Health's staff protects against accidental release of information by safeguarding records and reports from unauthorized use.
- All requests for information will be reviewed by the Horizon NJ Health Compliance Officer to protect your right to privacy. Only necessary information will be shared with community agencies, hospitals, long-term care facilities, and other providers to ensure the continuity and coordination of your care.
- Horizon NJ Health will permit only legally authorized representatives of Horizon NJ Health to inspect and request copies of your medical record and other records of the covered services provided to you according to the written consent you will have been asked to execute authorizing Horizon NJ Health to release such information.
- Horizon NJ Health will follow all federal and New Jersey state laws regarding confidentiality, including those that relate to HIV testing results.
- Horizon NJ Health will maintain all records relating to you for a period of not less than seven years after your disenrollment. Horizon NJ Health medical and financial records are, and will remain, the property of Horizon NJ Health except in accordance with applicable state and federal law, regulations, and Horizon NJ Health policy and procedures.
- Any requests for information received from law enforcement agencies regarding your care, such as from the police or district attorney's office, will be brought to the attention of Horizon NJ Health legal counsel prior to providing any information to ensure that the proper authorization is obtained when the law requires it.

## Fraud, waste and abuse

It is very important that you take personal responsibility for your health care and the costs of your care. Make sure you know as much as possible about the doctors you use and the treatments they provide.

Billions of dollars are lost to health care fraud, waste and abuse each year. That means money is paid for services that may never have been given. It could also mean that the service that was billed was not the one performed. Fraud, waste and abuse by doctors and members threaten our health care system and can victimize consumers.

**What is fraud, waste and abuse?**

Fraud and abuse happen when someone knowingly gives false information that lets someone get a benefit they are not entitled to.

**Examples of doctor fraud, waste and abuse**

- Forging or altering bills or receipts
- Billing for services that were not performed
- Giving a patient a false diagnosis to justify tests, surgeries or other procedures that are not medically necessary
- Billing more than once for the same service

**Examples of member fraud, waste and abuse**

- Telling a lie on purpose that results in you or another person receiving benefits that you or they are not entitled to
- Loaning or selling your Horizon NJ Health member ID card or the information on the card to someone else
- Forging or altering prescriptions

Misuse of your Horizon NJ Health ID card could result in you losing eligibility for health care services. Fraud and abuse are also crimes punishable by legal action with possible time in jail.

If you or someone you know is aware of health care fraud, waste and abuse, you should immediately report it to Horizon NJ Health's Fraud Hotline at **1-855-FRAUD20** (**1-855-372-8320**, TTY **711**), or the New Jersey Medicaid Fraud Division at **1-888-937-2835** (TTY **1-877-294-4356**).

When making a report, please be clear about who you believe is committing the fraud, tell us dates of service or items in question, and describe in as much detail as possible why you believe fraud may have been committed. If possible, please include your name, telephone number and address so we can contact you if we have questions during the investigation.

Any information you give us will be treated with strict confidentiality and no medical information will be released without lawful authorization. When reporting suspected insurance fraud, you do not have to give your contact information. If you decide to give your contact information, we will try to keep it confidential as much as legally possible.

## Estate recovery

This is to remind you that the Division of Medical Assistance and Health Services (DMAHS) has the authority to file a claim and lien against the estate of a deceased Medicaid client or former client to recover all Medicaid payments for services received by that client on or after age 55. Your estate may be required to pay back DMAHS for those benefits.

The amount that DMAHS may recover includes, but is not limited to, all capitation payments to any managed care organization or transportation broker, regardless of whether any services were received from an individual or entity that was reimbursed by the managed care organization or transportation broker. DMAHS may recover these amounts when there is no surviving spouse, no surviving children under the age of 21, no surviving children of any age who are blind, and no surviving children of any age who are permanently and totally disabled as determined by the Social Security Administration. This information was previously provided to you when you applied for NJ FamilyCare.

To learn more, visit **state.nj.us/humanservices/dmahs/clients/The_NJ_Medicaid_Program_and_Estate_Recovery_What_You_Should_Know.pdf**.

### Change of information

It is very important that we have your correct information. If not, your Horizon NJ Health Care Manager or clinical care coordinator may not be able to contact you. If you change your address or phone number, you must call Member Services at **1-844-444-4410** (TTY **711**), your Care Manager or the clinical care coordinator.

You also must contact your County Welfare Agency (CWA) to let them know about the change. If not, you may not get important notices regarding your NJ FamilyCare coverage and annual renewal.

## Ending your membership

The following are reasons you can be disenrolled from Horizon NJ Health's MLTSS program:

- You are no longer enrolled with Horizon NJ Health
- You no longer meet financial or clinical eligibility criteria for long term level of care
- You will not allow the Department of Human Services staff or its designee complete the clinical eligibility assessment
- You relocate to an unapproved licensed residence/setting
- You move out of New Jersey
- You are incarcerated
- You were transferred/enrolled into another waiver program or the State's Program of All Inclusive Care for the Elderly (PACE)
- You refuse to pay your room and board and/or patient payment liability
- You no longer need the services offered in the MLTSS program
- You have not received services and/or cannot be contacted or located at the last known address
- You refuse services that are outlined in your plan of care and you refuse to voluntarily withdraw
- You fail to act in accordance with the rules governing involvement in the program

If you are disenrolled from the program, you will be told the reason and about any rights you may have to appeal the disenrollment. If you are not satisfied with a State agency determination that there is not good cause for disenrollment, you may request a State Fair Hearing.

# Your Plan of Care *(continued)*

**You can choose to end your membership**

Being a Horizon NJ Health member is your choice.

NJ FamilyCare members may end their membership without cause during the first 90 days after the date of enrollment or notice of enrollment (whichever happened later), and then every 12 months during the Open Enrollment Period. The State's Open Enrollment Period occurs between **October 1** and **November 15** each year.

Members may leave Horizon NJ Health for good cause at any time.

As an NJ FamilyCare MLTSS member, you must choose another health plan before your membership ends. Once you ask to be disenrolled, it will take about 30 to 45 days from the date you ask until the time you are enrolled in the new health plan you select. During this time, Horizon NJ Health will continue to provide your health care services. This includes transferring to another Managed Care Organization (MCO).

If you choose to voluntarily withdraw from the MTLSS program, your Care Manager will hold a face-to-face meeting with you to discuss your options for care. You will be given a Voluntary Withdrawal Form to sign. This decision to leave the MTLSS program does not necessarily mean that you will no longer have NJ FamilyCare benefits. OCCO will work with you if your decision to leave the program results in the loss of NJ FamilyCare due to your financial standings.

If you lose eligibility, you will be disenrolled from Horizon NJ Health. If you get your eligibility back within 60 days, you will be re-enrolled in Horizon NJ Health. If you become eligible again after 60 days, you may be enrolled in a different MCO if you do not select Horizon NJ Health or if Horizon NJ Health cannot accept any more members in your county.

**When you leave Horizon NJ Health:**

- You will need to sign your enrollment application for your new health plan to allow us to send your medical records.
- Once your enrollment ends, destroy your Horizon NJ Health member ID card. It is very important that you protect your privacy by destroying the old cards so no one can steal your identity or your benefits.
- It will take 30 to 45 days between when you ask to leave and the date your enrollment with Horizon NJ Health ends. Horizon NJ Health or the State will continue to provide services until the disenrollment date.
- If you decide to disenroll voluntarily from Horizon NJ Health, you can list your reasons for leaving in writing.
- Enrollment and disenrollment are always subject to verification and approval by New Jersey DMAHS.
- If your enrollment with Horizon NJ Health ends before an approved dental service has been completed, Horizon NJ Health will cover the service until completion, unless there is a change in the treatment plan by the treating dentist. This prior authorization will be honored for as long as it is active, or for a period of six months, whichever is longer. If the prior authorization has expired, a new request for prior authorization will be required.

## MLTSS Member Advocate

Horizon NJ Health cares about making sure that members in the MLTSS program have the information they need to make informed decisions and have someone they can speak to if they have any issues or questions. Every MLTSS member will be assigned a Care Manager and there is also a MLTSS Member Advocate available to you.

The MLTSS Member Advocate is responsible for:

- Participating in Interdisciplinary Team (IDT) meetings and reviewing with the member, as needed, the IDT process.
- Interacting with members to provide additional support, education and clarification regarding the MLTSS program and what services are available.
- Encouraging members to be fully informed of their Rights and Responsibilities.
- Assisting members with information needed in filing grievances and appeals as warranted.
- Supporting members in navigating Horizon NJ Health's MLTSS program.

You can reach the Member Advocate Monday through Friday from 8:30 a.m. to 5 p.m. by calling **1-844-444-4410** (TTY **711**).

## Residence options

The MLTSS program helps qualified members get care in the most cost-effective, integrated and least restrictive environment that allows your needs to be met while feeling safe and secure with life, including your health and well-being. You may get services in various settings based on your desires, the cost of the services and the safest environment.

For members who meet program requirements, you have a right to choose between living in a nursing facility or in a home and community-based setting. You cannot be moved out of a nursing facility and into the community unless you agree to be moved. If you choose to live in a home and community-based setting, your needs must be met safely and cost effectively in the community. Your assigned Care Manager will evaluate the cost effectiveness of the Plan of Care if you receive home and community-based services in your community home. The cost of your plan of care is limited and must not be more than the rate set by the state.

## Patient Payment Liability

Members living in or placed in a nursing facility may have to pay Patient Payment Liability. The Patient Payment Liability for Cost of Care is that portion of the cost of care that nursing facility and assisted living residents must pay based on their income as determined by the County Welfare Agency.

Members pay this amount directly to the facility every month. You must pay your Patient Payment Liability to remain eligible for the MLTSS program. Your Care Manager can tell you about any Patient Payment Liability you will owe to the facility.

Members living in a Community Residential Setting (CRS), also known as a Traumatic Brain Injury (TBI) group home, will be advised by the provider about the amount they will need to pay. This amount is usually equal to 75 percent of the member's income.

Individuals who are living or placed in an assisted living residence must pay room and board payments and may have to pay Patient Payment Liability as well. These payments are paid directly to the facility every month.

You must pay your Patient Payment Liability to remain eligible for the MLTSS program. Your Care Manager can tell you about any Patient Payment Liability you will owe to the facility.

## Nursing facility to community transition

If you live in a nursing facility, you may want to move out of the facility and into the community. Your assigned Care Manager will work with you to assess the ability to move you out of the nursing facility and back into a community setting. Your Care Manager will create a plan of care needed for your expected services to live in the community. The cost of your plan of care in the community is limited and must not be more than the rate set by the state.

If it is determined that you can safely and cost-effectively move from the nursing facility back to the community, you may be able to use the Community Transition Services benefit. This service aids in the transition from an institutional setting to your own home in the community by covering transitional expenses. This benefit can only be used one time and has a limit of $5,000.

Allowable expenses are those needed for a person to establish a basic household that do not constitute room and board and may include, but are not limited to:

- Security deposits required to get a lease on an apartment or home
- Necessary household furnishings including furniture,  kitchen items, food preparation items and bed/bath linens

Community Transition Services does NOT include items such as:

- Payment for room and board
- Monthly rental or mortgage expenses
- Recurring expenses such as food and regular utility charges

Services must be reasonable and necessary as determined through the plan of care process developed by you and your Care Manager. Services must also be based on need. You must have no other way to obtain these services yourself or from any other sources, including community resources.

Your Care Manager can give you more information about this benefit and help coordinate these services during the transition.

## I Choose Home NJ

I Choose Home NJ is part of the federal program, “Money Follows the Person.” The goal of the program is to move people out of nursing homes and developmental centers and back into the community. New Jersey residents may be eligible if they:

- Have lived in a nursing home or developmental center for at least 90 days
- Are interested in moving back into the community
- Are eligible for Medicaid at least one day prior to leaving the facility

Eligible residents may be able to move to an independent community setting with supports and services. To learn more about I Choose Home NJ, visit **ichoosehome.nj.gov**, or talk to your Care Manager.