MLTSS SERVICES DICTIONARY

A program that applies solely to individuals who meet MLTSS eligibility requirements and encompasses the NJ FamilyCare A benefit package, NJ FamilyCare ABP as specified in Article 4.1.1.C, HCBS and institutionalization for long term care in a nursing facility or special care nursing facility.

Adult Family Care (Eligible for MFP 25%)

Adult Family Care (AFC) enables up to three unrelated individuals to live in the community in the primary residence of a trained caregiver who provides support and health services for the resident. Adult Family Care may provide personal care, meal preparation, transportation, laundry, errands, housekeeping, socialization and recreational activities, monitoring of participant's funds when requested by the participant, up to 24 hours a day of supervision, and medication administration.

Service Limitations:

Individuals that opt for Adult Family Care do not receive Personal Care Assistant services, Chore Service, Home-Delivered Meals, Home-Based Supportive Care, Caregiver/Participant Training, Assisted Living, or Assisted Living Program. Those services would duplicate services integral to and inherent in the provision of Adult Family Care services. A person may not receive long term care nursing home care at the same time they are in Adult Family Care. The individual service recipient or their authorized representative is responsible to pay the cost of room and board.

Adult Family Care Members may attend Social Adult Day Care two (2) days per week.

Provider Specifications:

- Licensed Adult Family Care (AFC) Sponsor Agency (Agency):
- Licensed by HFEL

MLTSS HIPAA COMPLIANT CODE:
S5140

Unit of Service: 1 day (Per Diem)

Licensing Entity: HFEL

Accredited by:

Regulation Cites:

Taxonomy Code:

Assisted Living Services (ALR, CPCH)

Assisted Living Services means a coordinated array of supportive personal and health services, , medication administration, available 24 hours per day, to residents who have been assessed to need these services including persons who require a nursing home level of care. Assisted Living Services include personal care, and medication oversight and administration throughout the day. A planned, diversified program of resident activities shall be offered daily for residents, including individual and/or group activities, on-site or off-site, to meet the individual needs of residents. Assisted Living facilities also either arrange or provide for transportation that is specified in the Plan of Care and periodic nursing evaluations. Assisted Living promotes resident self-direction and participation in decisions that emphasize independence, individuality, privacy, dignity, and homelike surroundings.

1. Assisted Living Residence (ALR) means a facility which is licensed by the Department of Health to provide apartment-style housing and congregate dining and to ensure that assisted living services are available when needed, for four or more adult persons unrelated to the proprietor. Apartment units within the assisted living residence offer, at a minimum, one unfurnished room, a private bathroom, a kitchenette, and a lockable door on the unit entrance. Residents in ALRs have access to both their own living unit's kitchen 24/7 and to a facility food and beverages 24/7.

Comprehensive Personal Care Home (CPCH) means a facility which is licensed by the Department of Health to provide room and board and to ensure that assisted living services are available when needed, to four or more adults unrelated to the proprietor. Residential units in comprehensive personal care homes house no more than two residents and have a lockable door on the unit entrance. Residents in CPCHs have access to facility food and beverages 24/7 and, if equipped, access to their own unit's food preparation area.

Service Limitations:

Individuals that opt for Assisted Living Services in an ALR/CPCH do NOT receive: Personal Care Assistant (PCA) services, Adult Day Health Services (ADHS), Adult Family Care, Assisted Living Program, Environmental Accessibility Adaptations, Chore Services, Personal Emergency Response Services, Home-Delivered Meals, Caregiver/Participant Training, Adult Day Health Services, Social Adult Day Care, Attendant Care, Home-Based Supportive Care, or Respite as they would duplicate services integral to and inherent in the provision of Assisted Living Services.

Individuals in an ALR/CPCH are responsible to pay their room and board costs.

Provider Specifications:

Assisted Living Facility licensed by the Department of Health pursuant to N.J.A.C. 8:36 as an Assisted Living Facility. Appropriateness for this type of housing is subject to screening through the housing screening process. Must meet licensing requirements, as applicable per:

- N.J.A.C. 8:34 - Rules for Licensing Nursing Home Administrators and Rules Regulating the Nursing Home Administrators Licensing Board
- N.J.A.C. 8:36 - Standards For Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs
- N.J.A.C. 8:43E - Standards For Licensure of Residential Health Care Facilities, General Licensure Procedures and Enforcement of Licensure Regulations
- N.J.A.C. 8:43I - Criminal Background Investigations: Nurse Aides, Personal Care Assistants and Assisted Living Administrators

MLTSS HIPAA COMPLIANT CODE:
T2031 (ALR 1 DAY); T2031_U1 (CPCH 1 DAY)

Unit of Service: 1 day (per diem)

Licensing Entity: Health Facilities Evaluation and Licensing (HFEL)

Accredited by:

Regulation Cites: N.J.A.C. 8:34, 8:36, 8:43E, 8:43I

Taxonomy Code:

Assisted Living Program (ALP) (Eligible for MFP 25%)

Assisted Living Program means the provision of assisted living services to the tenants/residents of certain publicly subsidized housing buildings. Assisted Living Programs (ALPs) are available in some subsidized senior housing buildings. Each ALP provider shall be capable of providing or arranging for the provision of assistance with personal care, and of nursing, pharmaceutical, dietary and social work services to meet the individual needs of each resident.

Assisted Living Services include personal care, homemaker, chore, and medication oversight and administration throughout the day.

Individuals receiving services from an ALP reside in their own independent apartments. The individual is responsible for his or her own rent and utility payments as defined in a lease with the landlord. Individuals are also responsible for the cost of meals and other household expenses.

Having an ALP provider offers the subsidized housing tenants the opportunity to remain in their own apartments with the support of others, while maintaining their independence and dignity.

Participation in the services of an Assisted Living Program (ALP) is voluntary on the part of any tenant of any ALP contracted publicly subsidized housing building.

The ALP is to make available dining services and/or meal preparation assistance to meet the daily nutritional needs of residents.

ALP providers work with participants to ensure a strong sense of connectedness in each apartment community as well as with the larger communities in which they are located. Individuals may participate in tenant/resident meetings, attend community-based civic association meetings and plan recreational activities. Sometimes, ALP providers host community health screening events to encourage wellness for the tenant population at large.

By State regulation, ALP providers shall have written policies and procedures for arranging resident transportation to and from health care services provided outside of the program site, and shall provide reasonable plans for security and accountability for the resident and his or her personal possessions. ALP Providers shall develop a mechanism for the transfer of appropriate resident information to and from the providers of service, as required by individual residents and as specified in their service plans. ALP participants, not ALR or CPCH participants may attend Social Adult Day Care 2 (two) days a week; (3) three days with prior authorization.

Service Limitations:

Individuals that opt for Assisted Living Program (ALP) do NOT receive: Personal Care Assistant (PCA) services, Chore Service, Home-Based Supportive Care, Caregiver/Participant Training, Assisted Living, or Adult Family Care as they would duplicate services integral to and inherent in the provision of Assisted Living Program services. The subsidized housing provider is responsible for Environmental Accessibility Adaptations.

A person enrolled in the ALP is NOT permitted to attend Adult Day Health Services (also called medical day care) as it would duplicate an ALP service as required by N.J.A.C. 8:36-23.14(a).

The ALP provider must agree to accept the individual in the facility as a Medicaid MLTSS participant.

Provider Specifications:

Assisted Living Facility licensed by the Department of Health pursuant to N.J.A.C. 8:36 as an Assisted Living Facility. Appropriateness for this type of housing is subject to screening through the housing screening process. Must meet licensing requirements, as applicable per:

- N.J.A.C. 8:34 - Rules for Licensing Nursing Home Administrators and Rules Regulating the Nursing Home Administrators Licensing Board
- N.J.A.C. 8:36 - Standards For Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs
- N.J.A.C. 8:43E - Standards For Licensure of Residential Health Care Facilities, General Licensure Procedures and Enforcement of Licensure Regulations
- N.J.A.C. 8:43I - Criminal Background Investigations: Nurse Aides, Personal Care Assistants and Assisted Living Administrators

MLTSS HIPAA COMPLIANT CODE:
T2031_U2 (ALP 1 DAY)

Unit of Service: 1 day (per diem)

Licensing Entity: Health Facilities Evaluation and Licensing (HFEL)

Accredited by:

Regulation Cites: N.J.A.C 8:34, 8:36, 8:43E, 8:43I

Taxonomy Code:

Behavioral Management - TBI (Group and Individual) (Eligible for MFP 25%)

A daily program provided by, and under the supervision of, a licensed psychologist or board-certified/board-eligible psychiatrist and by trained behavioral aides designed to service recipients who display severe maladaptive or aggressive behavior which is potentially destructive to self or others. The program, provided in the home or out of the home, is time-limited and designed to treat the individual and caregivers, if appropriate, on a short-term basis. Behavioral programming includes a complete assessment of the maladaptive behavior(s); development of a structured behavioral modification plan, implementation of the plan, ongoing training and supervision of caregivers and behavioral aides, and periodic reassessment of the plan. The goal of the program is to return the individual to the prior level of functioning which is safe for him/her and others.

Service Limitations:

Entry to this service is based on medical necessity criteria as defined in the contract. The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who transitions into MLTSS. Program enrollment requires prior evaluation and recommendation of a board-certified and eligible psychiatrist, a licensed neuro-psychologist or neuro-psychiatrist with subsequent consultation by same on an as-needed basis.

Provider Specifications:

- A board-certified and board-eligible psychiatrist
- Clinical psychologist
- Mental Health Agency
- A rehabilitation hospital
- Community Residential Services (CRS) provider
- Post-acute non-residential rehabilitative services provider agency

MLTSS HIPAA COMPLIANT CODE:
H0004_HQ = GROUP;
H0004 = INDIVIDUAL

Unit of Service: 15 minutes = ONE unit of service

Licensing Entity:

Accredited by:

Regulation Cite:

Taxonomy Code:

Caregiver/ Participant Training (Eligible for MFP 25%)

Instruction provided to a client and/or caregiver in either a one-to-one or group situation to teach a variety of skills necessary for independent living, including but not limited to: coping skills to assist the individual in dealing with disability; coping skills for the caretaker to deal with supporting someone with long term care needs; skills to deal with care providers and attendants. Examples include seminars on supporting someone with dementia, seminars to support someone with mobility difficulties. Training needs must be identified through the comprehensive evaluation, re-evaluation, or in a professional evaluation and must be identified in the approved Plan of Care as a required service.

Service Limitations:

Caregiver/Participant Training is not available to participants who have chosen Assisted Living Services, Assisted Living Program or Adult Family Care. This training will not duplicate the training that would be inherent in a therapist's scope of practice on instruction on use of adaptive equipment.

One visit per day

Provider Specifications:

- Individual with appropriate expertise (i.e. RN, OT) to train the recipient/caregiver as required by the Plan of Care (Individual Provider)
- Centers for Independent Living (CIL)
- Health Care Service Firm
- Licensed Medicare Certified Home Health Agency
- Adult Family Care Sponsor Agency
- Proprietary or Not-for-Profit Business entity

MLTSS HIPAA COMPLIANT CODE:
S5111

Unit of service: One visit per day

Licensing Entity:

Accredited by:

Regulation Cite:

Taxonomy Code:

Chore Services (Eligible for MFP 25%)

Services needed to maintain the home in a clean, sanitary and safe environment. The chores are non-continuous, non-routine heavy household maintenance tasks intended to increase the safety of the individual. Chore services include cleaning appliances, cleaning and securing rugs and carpets, washing walls, windows, and scrubbing floors, cleaning attics and basements to remove fire and health hazards, clearing walkways of ice, snow, leaves, trimming overhanging tree branches, replacing fuses, light bulbs, electric plugs, frayed cords, replacing door locks, window catches, replacing faucet washers, installing safety equipment, seasonal changes of screens and storm windows, weather stripping around doors, and caulking windows.

Service Limitations:

Chore services are not available to those who opt for Assisted Living Services, Assisted Living Program or Adult Family Care. Chore services are appropriate only when neither the participant, nor anyone else in the household, is capable of performing the chore; there is no one else in the household capable of financially paying for the chore service; and there is no relative, caregiver, landlord, community agency, volunteer, or 3rd party payer capable or responsible to complete this chore.

Chore Services do not include normal everyday housekeeping tasks such as dusting, vacuuming, changing bed linens, washing dishes, cleaning the bathroom, etc. Utility providers who offer free services shall be used first for home weatherization/energy efficiency products. In the case of rental property, the responsibility of the landlord pursuant to the lease is to be examined prior to any authorization for service. In the case of an individual residing in a community governed by a homeowner association or community trust, the obligations of the association or trust to make repairs and renovations also should be examined prior to any authorization for service

Provider Specifications:

- Private Contractor (Individual Provider)
- Subsidized Independent Housing for Seniors
- Is a business entity with evidence of authority to conduct such business in New Jersey, (i.e. New Jersey Tax Certificate or Trade Name Registration)
- Has any license required by law to engage in the service, provide furnishings, appliances, equipment
- Has Product/business Insurance, including Worker's Compensation, provides required evidence of qualifications and signs an agreement with the MCO to provide services prior to providing initial service.
- Participant Directed Provider

MLTSS HIPAA COMPLIANT CODE:
S5120 (15 minutes); S5121 (PER DIEM)
S5120 SE (15 minutes)

Unit of service = 15 Minutes; PER DIEM. No current limit on the maximum number of hours

Licensing Entity:

Accredited by:

Regulation Cite:

Taxonomy Code:

Cognitive Rehabilitation Therapy (Group and Individual) (Eligible for MFP 25%)

Therapeutic interventions for maintenance and prevention of deterioration which include direct retraining, use of compensatory strategies, use of cognitive orthotics and prostheses, etc. Activity type and frequency are determined by assessment of the participant, the development of a treatment plan based on recognized deficits, and periodic reassessments. Cognitive Rehabilitation therapy can be provided in various settings, including but not limited to the individual's own home and community, outpatient rehabilitation facilities, or residential programs. This service may be provided by professionals with the credentials, training, experience, and supervision noted in Provider Specifications.

MLTSS Cognitive Rehabilitation Therapy Services may be considered medically necessary when the following conditions are met:

1. The therapy is for a condition that requires a provider with the unique knowledge and skills in the provision of Cognitive Rehabilitation Therapy as delineated in the Provider Specifications noted below, and is a part of the beneficiary's skilled treatment plan; and
2. There is an expectation that the therapy will incrementally (minimal unpredictable changes over longer lengths of time) improve and/or prevent the loss of previously achieved/attained progress ; and
3. An individual would either not be expected to develop the function or would be expected to permanently lose the function without the MLTSS Cognitive Rehabilitation Therapy service (not merely fluctuate); and
4. The MLTSS Cognitive Rehabilitation Therapy on-going clinical documentation objectively continues to verify that, at a minimum, functional status is preserved while continued pursuit of incremental progress toward further development; and
5. The services are delivered by a qualified provider of Cognitive Rehabilitation Therapy services who has experience in delivery of therapy services to individuals with TBI.

Clinical assessment by the provider shall be used to objectively determine and verify that, at a minimum, functional status is preserved while continued incremental (minimal unpredictable changes over longer lengths of time) progress towards further development is pursued. This will be utilized to establish member's need of MLTSS Cognitive Rehabilitation Therapy.

Service Limitations:

- The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who is assessed to be in need of Cognitive Rehabilitation Therapy and who transitions to MLTSS.
- MLTSS Cognitive Rehabilitation Therapy is provided for an individual with a TBI diagnosis. This therapy is not eligible under Medicare, Medicaid State Plan and/or Third Party coverage/benefits for this service.
- The ratio for group sessions may not be larger than ONE therapist to FIVE patients.
- The MCO will determine the number of authorized therapy units that will be included in a member's plan of care.

- A member may receive individual and group units of the same therapy; e.g. morning units of individual therapy and afternoon units of group therapy in the same day.
- A member may receive different therapies on the same day of service; e.g., morning units of individual ST, morning units of OT, and afternoon units of CRT.

Provider Specifications:

- Minimum of a master's degree or a degree in an allied health field from an accredited institution or holds licensure and/or certification; or
- Minimum of a bachelor's degree from an accredited institution in an allied health field where the degree is sufficient for licensure, certification or registration or in fields where licensure, certification or registration is not available (i.e., special education);
- Applicable degree programs including but not limited to communication disorders (speech), counseling, education, psychology, physical therapy, occupational therapy, recreation therapy, social work, and special education;
- Certified Occupational Therapy Assistants (COTAs) and Physical Therapy Assistants (PTAs) may provide this service only under the guidelines described in the New Jersey practice acts for occupational and physical therapists.
- Staff members who meet the above-mentioned degree requirements, but are not licensed or certified, may practice under the supervision of a practitioner who is licensed and/or meets the criteria for certification by the Society for Cognitive Rehabilitation (actual certification is not necessary so long as criteria is met).
    - Supervision
        - This service must be coordinated and overseen by a provider holding at least a master's degree. Provided by a professional that is licensed or certified. The master's level provider must ensure that bachelor's level providers receive the appropriate level of supervision, as delineated below.
        - Supervision for providers who are not licensed or certified is based on the number of years of experience
        - For staff with less than one year of experience: four hours of individual supervision per month.
        - For staff with one to five years' experience: two hours individual supervision per month
        - For staff with more than five years' experience: one hour per month.

All individuals who provide or supervise the service must complete 6 hours of relevant ongoing training in Cognitive Rehabilitation Therapy and/or brain injury rehabilitation. Training may include, but is not limited to, participation in seminars, workshops, conferences, and in-services.

MLTSS HIPAA COMPLIANT CODE:
INDIVIDUAL: G0515_96 (15 minutes) effective 1/1/2018
GROUP: 96153_96_59 (15 minutes)

When a member is receiving multiple therapy sessions on the same day of service, the provider must use the modifier "59" in addition to the modifier for MLTSS when submitting the claim for payment. This will permit the claim to be processed and not be subject to the NCCI conflict edits. If the member is only receiving one (a SINGLE) therapy session on a given date, the provider will NOT use the modifier "59".

Unit of Service: 15 minutes with a maximum allowable of no more than 8 units in a 24 hour period.

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Community Residential Services (CRS) (Eligible for MFP 25%)

A package of services provided to a participant living in the community, residence-owned, rented, or supervised by a CRS provider. The services include personal care, companion services, chore services, transportation, night supervision, and recreational activities. A CRS is a participant's home. The CRS provider is responsible for coordinating the service to ensure the participant's safety and access to services as determined by the participant and care manager. Participants are assigned one of three levels of supervision. These levels are determined by the dependency of the participant. The care manager, in conjunction with CRS staff, evaluate participant, using the "LEVEL OF CARE GUIDELINES FOR CRS" form as a guide.

Service Limitations:

The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who is transitioning to MLTSS. The level of assessment is assessed minimally on an annual basis, more frequently if there is a change in participants' care. Only one level of service can be billed per 24-hour period (12:00 a.m. to 11:59 p.m.)

- The participant must have a diagnosis of TBI and meet MLTSS Nursing Facility Level of Care
- The participant or their responsible party must pay room and board costs
- The participant must agree to receive the therapy services of the CRS provider

Provider Specifications:

- Current license per N.J.A.C 10:44C to operate as a group home for individuals with a diagnosis of TBI

MLTSS HIPAA COMPLIANT CODES:
SERVICE BASED ON LEVEL OF NEED:

- Low Level Supervision: T2033
- Moderate Level Supervision: T2033_TF
- High Level Supervision: T2033_TG

Unit of Service = per diem

Licensing Entity:
STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
OFFICE OF LICENSING
DEVELOPMENTAL DISABILITIES LICENSING

Accredited by:

Regulation Cites: N.J.A.C. 10:44C

Taxonomy Code:

Community Transition Services (Eligible for MFP 25%)

Those services provided to a participant that may aid in the transitioning from institutional settings to his/her own home in the community through coverage of non-recurring, one-time transitional expenses. This service is provided to support the health, safety and welfare of the participant. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

- security deposits and necessary application fees that are required to obtain a lease on an apartment or home;
- essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
- set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
- services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy;
- necessary accessibility adaptations to promote safety and independence; and
- activities to assess need, arrange for and procure needed resources.

Service Limitations:

- Limit of up to $5,000.
- Community Transition Services do not include residential or vehicle modifications. Community Transition Services do not include recreational items such as televisions, cable television access or video players.
- Community Transition Services do not include monthly rental or mortgage expenses. Payment for security deposit is not considered rent.
- Community Transition Services do not include recurring expenses such as food and regular utility charges.
- Community Transition Services do not include payment for room and board.
- Community Transition Services are one-time per the life of the individual.
- Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan, and the person is unable to meet such expense or when the services cannot be obtained from other sources.
- Service is based on identified need as indicated in the plan of care.

MLTSS HIPAA COMPLIANT CODE:
T2038; T2038_U6 for administration

Unit of Service: As negotiated per the MCO.

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Home Based Supportive Care (Eligible for MFP 25%)

Home-Based Supportive Care (HBSC) services are designed to assist MLTSS participants with their Instrumental Activities of Daily Living (IADL) needs. HBSC are available to individuals whose Activities of Daily Living (ADL) needs are provided by non-paid caregivers such as a family member or as a wrap-around service to non-Medicaid programs such as Veterans Health Care System that are assisting participants with their ADL health related tasks. HBSC services must address IADL deficits identified through the NJ Choice comprehensive assessment process and go beyond "health-related" services.

Home-Based Supportive Care is distinct from the State Plan service of Personal Care Assistant in that it does not include "hands on personal care." According to N.J.A.C. 10:60-1.2, Personal Care Assistant (PCA) services means "health related tasks performed by a qualified individual in a beneficiary's home, under the supervision of a Registered Nurse, as certified by a physician in accordance with a beneficiary's written plan of care.

Home-Based Supportive Care includes services such as, but not limited to the following: meal preparation, grocery shopping, money management, light housework, laundry.

Service Limitations:

Home-Based Supportive Care is not available for those who have chosen Assisted Living Services (ALR, CPCH, ALP). Since the PCA State Plan Service can assist with IADL, HBSC is offered only when Activities of Daily Living related tasks are provided by a caregiver or another non-Medicaid program.

Provider Specifications:

- Licensed Home Health Agency
- Licensed Health Care Service Firm
- Licensed Employment Agency or Temporary Help Agency
- Congregate Housing Services Program
- Licensed Hospice Provider
- Participant Directed Provider

MLTSS HIPAA COMPLIANT CODE:
S5130 (15 minutes)
S5130 HQ - Group Homemaker Service, NOS per 15 minutes; T1022_SE Self Directed

Unit of Service = 15 minutes

Licensing Entity:

Accredited by:

Regulation Cites: N.J.A.C. 10:60-1.2

Taxonomy Codes:

Home-Delivered Meals (Eligible for MFP 25%)

Nutritionally balanced meals delivered to the participant's home when this meal provision is more cost effective than having a personal care provider prepare the meal. These meals do not constitute a full nutritional regimen, but each meal must provide at least 1/3 of the current Dietary Reference Intakes (DRIs) established by the Food & Nutrition Board of the National Academy of Sciences, and National Research Council.

Criteria: Home-delivered meals are provided to an individual residing in an unlicensed residence, only when the participant is unable to prepare the meal, unable to leave the home independently, and there is no other caregiver, paid or unpaid, to prepare the meal. No more than one meal per day will be provided through the MLTSS benefit.

Persons eligible for home delivered meals are those individuals:

1. Who are home-bound;
2. Are 18 years of age and older;
3. Incapacitated due to accident, illness, or frailty;
4. Unable to prepare meals because of lack of facilities, inability to shop or cook for self, unable to prepare meals safely, or lack knowledge and skills to prepare meals;
5. Lacking support from family, friends, neighbors or other caregivers to help secure meals.
6. Receives home health aide services less than three hours a day.

Menus for Home Delivered Nutrition programs must be certified and documented as meeting DRI standards by a qualified nutritionist.

An in home assessment is required, to determine if a weekly or biweekly delivery of refrigerated or frozen meals is suitable for the participant. Specifically:

- The client indicates a preference for refrigerated /frozen meal;
- The client must have adequate storage to safely store the frozen meals;
- The client must have the needed appliance to safely prepare the frozen meals and must demonstrate their ability in using the appliance safely;

The individual delivering the meal must bring to the attention of appropriate officials, conditions or circumstances that place the older person or household in imminent danger.

Service Limitations:

When the participant's needs cannot be met due to: geographic inaccessibility, special dietary needs, the time of day or week the meal is needed, a meal may be provided by restaurants, cafeterias, or caterers who comply with current DRIs, the New Jersey State Department of Health and local Board of Health regulations for food service establishments.

Home-Delivered Meals are not provided in an Assisted Living Facility (ALR/CPCH ONLY) or Adult Family Care as meal provision is included in the Assisted Living Facility or Adult Family

Care service package. A Home-Delivered Meal is not to be used to replace the regular form of "board" associated with routine living in an Assisted Living Facility or Adult Family Care Home.

A Home Delivered Meal may be provided in Assisted Living Program (ALP)

Provider Specifications:

- Area Agency on Aging (AAA) Title III Nutrition Program
- Provider of Meal Service, who meets the criteria set forth in New Jersey Standards for the Nutrition Program for Older Americans, PM 2011-33, I-164, dated January 3, 2012.
- All Home Delivered Nutrition providers must ensure that the meals meet one-third (1/3) RDI requirements and all food handling must comply with NJAC 8:24-1, "Chapter 24 Sanitation in Retail Food Establishments and Food and Beverage Vending Machines." Additionally, the State Department of Health/Division of Epidemiology, Environmental and Occupational Health and/or local health department personnel will conduct routine unannounced operational inspections of all caterers, kitchens and sites involved in the program annually as often as deemed necessary. Follow-up inspections are conducted and/or initiate legal action when conditions warrant.
- Home Delivered Nutrition programs will provide at least one hot or other appropriate home delivered meal, daily for five or more days per week

MLTSS HIPAA COMPLIANT CODE:
S5170

Unit of Service: One Meal per day

Licensing Entity: Department of Health

Accredited by:

Regulation Cite: NJAC 8:24-1, "Chapter 24 Sanitation in Retail Food Establishments and Food and Beverage Vending Machines.", New Jersey Standards for the Nutrition Program for Older Americans, PM 2011-33, I-164, dated January 3, 2012

Taxonomy Code:

Medication Dispensing Device: SET UP (Eligible for MFP 25%)

This may include an electronic medication-dispensing device that allows for a set amount of medications to be dispensed as per the dosage instructions. If the medication is not removed from the unit in a timely manner the unit will "lock" that dosage, not allowing the participant access to the missed medication. Before locking, the unit will use a series of verbal and/or auditory reminders that the participant is to take his or her medication. If there is no response, a telephone call will be made to the participant, participant's contact person, and care management site in that order until a "live" person is reached. Installation, upkeep and maintenance of device/systems are provided.

Service Limitations:

Per Medical Necessity as defined in the contract. Medication Dispensing Device is for an individual who lives alone or who is alone for significant amounts of time per the plan of care. Individuals might not have a regular care giver for extended periods of time or would require extensive routine supervision.

Provider Specifications:

The provider must apply and become approved through the MCO.

MLTSS HIPAA COMPLIANT Code:
T1505

Unit of Service: Per Occurrence

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Medication Dispensing Device: Monthly Monitoring (Eligible for MFP 25%)

This may include an electronic medication-dispensing device that allows for a set amount of medications to be dispensed as per the dosage instructions. If the medication is not removed from the unit in a timely manner the unit will "lock" that dosage, not allowing the participant access to the missed medication. Before locking, the unit will use a series of verbal and/or auditory reminders that the participant is to take his or her medication. If there is no response, a telephone call will be made to the participant, participant's contact person, and care management site in that order until a "live" person is reached. Installation, upkeep and maintenance of device/systems are provided.

Service Limitations:

Per Medical Necessity as defined in the contract. Medication Dispensing Device is for an individual who lives alone or who is alone for significant amounts of time per the plan of care. Individuals might not have a regular care giver for extended periods of time or would require extensive routine supervision.

Provider Specifications:

The provider must apply and become approved through the MCO.

MLTSS HIPAA COMPLIANT CODE:
S5185

Unit of Service: Monthly Monitoring Fee

Licensing Entity:

Regulation Cites:

Accredited by:

Taxonomy Code:

Non-Medical Transportation (Eligible for MFP 25%)

Service offered to enable individuals to gain access to community services, activities and resources specified in the Plan of Care. This service is offered in addition to medical transportation required under 42 Code of Federal Regulations 431.53 and transportation services under the State plan, defined at 42 Code of Federal Regulations 440.170(a) (if applicable), and shall not replace them. Transportation services shall be offered in accordance with the individual's Plan of Care. Transportation is a service that enhances the individual's quality of life. An approved provider may transport the participant to locations including but not limited to: shopping; beauty salon; financial institution; or religious services of his or her choice.

Service Limitations:

Services are limited to those that are required for implementation of the Plan of Care.
Whenever possible, family, neighbors, friends, public transit, tickets, or community agencies, which can provide this service without charge, will be utilized.

Provider Specifications

- Vehicle must be maintained in proper operating condition and must meet the requirements of New Jersey regulations, as evidenced by a valid inspection sticker.
- Owner must have proof of liability insurance coverage for the vehicle
- Owners and drivers are required to undergo civil and criminal background checks
- Evidence of Insurance, i.e. Declaration Page from Insurance Company
- Provides Description of vehicles used in service and copies of any required licenses.
- Vehicle appropriately registered, inspected and insured. Driver licensed to operate the vehicle.
- Provides proof of New Jersey Business Authority, i.e. tax certificate or trade name registration.
- Provides Fee Schedule.
- Participant Directed Provider

MLTSS HIPAA COMPLIANT CODES:
T2002 (per diem)
T2003: Per service (Encounter/Trip)
T2003SE: (self-directed) – Encounter/Trip

Unit of Service: One Way Trip

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Nursing Facility and Special Care Nursing Facility Services (Custodial)

A facility that is licensed (per N.J.A.C 8:39 and 8:85) to provide health care under medical supervision and continuous nursing care for 24 or more consecutive hours to two or more patients who do not require the degree of care and treatment which a hospital provides and who, because of their physical or mental condition, require continuous nursing care and services above the level of room and board. NF/SCNF residents are those individuals who require services which address the medical, nursing, dietary and psychosocial needs that are essential to obtaining and maintaining the highest physical, mental, emotional and functional status of the individual. Care and treatment shall be directed toward development, restoration, maintenance, or the prevention of deterioration. Care shall be delivered in a therapeutic health care environment with the goal of improving or maintaining overall function and health status. The therapeutic environment shall ensure that the individual does not decline (within the confines of the individual's right to refuse treatment) unless the individual's clinical condition demonstrates that deterioration was unavoidable.

All Medicaid participating NFs and SCNFs shall provide or arrange for services in accordance with statutory and regulatory requirements under 42 CFR 483 and Department of Health licensing rules at N.J.A.C. 8:39.

Reimbursement of NF services is discussed in N.J.A.C. 8:85-3.

NF and SCNF services shall be delivered within an interdisciplinary team approach. The interdisciplinary team shall consist of a physician and a registered professional nurse and may also include other health professionals as determined by the individual's health care needs. The interdisciplinary team performs comprehensive assessments and develops the interdisciplinary care plan.

Service Limitations:

The individual must meet Nursing Facility Level of Care as determined and/or authorized by the NJ Department of Human Services, Office of Community Choice Options or their designee. Provider Specifications: Current license to operate as a Nursing Facility in NJ as per the Department of Health's N.J.A.C. 8:39 and 8:85.

Unit of Service: 1 day

MLTSS HIPAA COMPLIANT CODE:
Revenue Codes:
NFs: Rev codes 0100, 0119, 0120, 0129, 0139,0149, 0159,0169
SCNF: Rev codes 0100, 0119, 0120, 0129, 0139,0149, 0159,0169

Licensing Entity: NJ Department of Health, Health Facilities Evaluation and Licensing

Regulation Cite: 42 CFR 483 and N.J.A.C. 8:39 and 8:85.

Accredited by:

Taxonomy Code:

Occupational Therapy (Group and Individual) (Eligible for MFP 25%)

MLTSS Occupational Therapy Services are intended to incrementally (minimal unpredictable changes over longer lengths of time) develop or improve skills, or prevent the loss of previously achieved/attained progress which is at risk of being lost as a result of a traumatic or acquired non-degenerative brain injury (TBI/ABI). MLTSS Occupational Therapy is also intended to allow a member to acquire new skills that will allow them to function optimally in their current or future least restrictive environment.

MLTSS Occupational Therapy Services may be considered medically necessary when all of the following conditions are met:

1. The therapy is for a condition that requires the unique knowledge, skills, and judgment of an Occupational Therapist for education and training that is part of a clinician's (OT) skilled plan of treatment; and
2. There is an expectation that the therapy will incrementally (minimal unpredictable changes over longer lengths of time) improve and/or prevent the loss of previously achieved/attained progress; and
3. An individual would either not be expected to develop the function or would be expected to permanently lose the function without the MLTSS Occupational Therapy service (not merely fluctuate); and
4. The MLTSS Occupational Therapy on-going clinical documentation objectively continues to verify that, at a minimum, functional status is preserved while continued pursuit of incremental progress toward further development; and
5. The services are delivered by a qualified provider of occupational therapy services who has experience in delivery of therapy services to individuals with TBI.

Clinical assessment by the OT shall be used to objectively determine and verify that, at a minimum, functional status is preserved while continued incremental (minimal unpredictable changes over longer lengths of time) progress towards further development is pursued. This will be utilized to establish member's need of MLTSS Occupational Therapy.

Service Limitations:

- Third party liability shall, if available, be used first and to the fullest extent possible prior to accessing MLTSS occupational therapy services.
- Per Medical Necessity as defined in the contract.
- The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who is assessed to be in need of occupational therapy and who transitions to MLTSS.
- The ratio for group sessions may not be larger than ONE therapist to FIVE members.
- The MCO will determine the number of authorized therapy units that will be included in a member's plan of care.
- If a clinical evaluation of the member demonstrates that the member has the potential to achieve significant improvement in restoration of, or compensation

for loss of function in a reasonable and generally predictable period of time, or, the member would benefit from the establishment of a maintenance program, rehabilitation/maintenance programs are available through other payor sources (ie Medicare, Medicaid State Plan or other third party liability such as commercial health insurance) and not a covered MLTSS service.

- If skilled therapy services by a qualified therapist are needed to instruct the patient or appropriate caregiver regarding the **maintenance program**, such instruction is covered by other payor sources (i.e., Medicare, Medicaid State Plan or other third party liability such as commercial health insurance).
- Periodic evaluations of the member's condition and response to treatment may be covered via the Medicare, Medicaid State Plan or other third party liability benefit when medically necessary, as identified by a qualified professional.
- A member may receive individual and group sessions of the same therapy in the same day; e.g., a morning session of individual therapy and an afternoon session of group therapy.
- A member may receive different therapies on the same day of service; e.g., morning session of individual ST, morning session of OT, and an afternoon session of CRT.
- A member must be evaluated by a licensed therapist at least annually or upon change in condition to determine whether the beneficiary has the need for skilled therapy service delivery and/or qualifies for rehabilitation or habilitation services. Documentation supporting this evaluation shall be maintained in provider clinical records.
- Occupational therapy services require the clinical skills of a licensed occupational therapist or occupational therapy assistant (or their students, in accordance with State OT licensing guidelines), for the duration of service delivery.

Provider Specifications:

- A rehabilitation hospital per NJAC 8:43 – 1.1 et.seq. and NJAC 10:54-5
- Community Residential Services (CRS) provider per NJAC 10:44c
- Licensed, certified home health agency per NJAC 8:42 and certified by the center for Medicare and Medicaid Services
- Post-acute non-residential rehabilitative services provider agency
- Individuals rendering MLTSS Occupational Therapy services shall be registered as an occupational therapist (OTR) with the American Occupational Therapy Association (AOTA). A certified occupational therapy assistant (COTA) shall be registered with the AOTA and work under the supervision and direction of an OTR.
- Individuals rendering occupational therapy services shall also be licensed/certified in accordance with state practice law

Unit of Service: 15 Minutes with a maximum allowable of no more than 8 units in a 24 hour period.

MLTSS CPT CODES:

CPT Code: 97535_96_59 – Individual, 15 minutes unit of service
CPT Code 97150_96_59 – Group, per diem unit of service

NOTE: For Free Standing Clinic or ANY therapy service provided out of the home; EXISTING Codes should be used. The modifier of 96 must be used to signify the MLTSS benefit is being used.

When a member is receiving multiple therapy sessions on the same day of service, the provider must use the modifier "59" in addition to the modifier for MLTSS when submitting the claim for payment. This will permit the claim to be processed and not be subject to the NCCI conflict edits. If the member is only receiving one (a SINGLE) therapy session on a given date, the provider will NOT use the modifier "59".

Unit of Service: 15 minutes

Licensing Entity:

Regulation Cites:

- A rehabilitation hospital per NJAC 8:43 – 1.1 et.seq. and NJAC 10:54-5
- N.J.A.C. 13:44K
- Community Residential Services (CRS) provider per NJAC 10:44c
- Licensed, certified home health agency per NJAC 8:42 and certified by the center for Medicare and Medicaid Services
- Medicare Local Coverage Determination (LCD): Therapy and Rehabilitation Services (PT, OT) (L35036) – effective 4/1/2016
- Medicare Benefit Policy Manual, Chapter 15 - Section 220.2 - Reasonable and Necessary Outpatient Rehabilitation Therapy Services (Rev. 221 effective 3-11-2016)
- 42CFR410.59
- 42CFR410.60

Accredited by:

Taxonomy Code:

Personal Emergency Response System (PERS): SET UP (Eligible for MFP 25%)

PERS is an electronic device which enables participants at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and is programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. The service consists of two components both of which are managed by the PERS contractor; first is the initial installation of the equipment and the second is the monitoring of the service by staff at the response center. The addition of the fiscal intermediary is the modification to the provider specifications. Previously the provider of the specific service was required to execute a purchase agreement with the case management agency; now that agreement is between the fiscal intermediary and the service provider.

Service Limitations:

Per Medical Necessity as defined in the contract. PERS is for an individual, age 18 or over, who lives alone or who is alone for significant amounts of time per the plan of care. Individuals might not have a regular care giver for extended periods of time or would require extensive routine supervision.

Provider Specifications:

The provider must apply and become approved through the MCO.

MLTSS HIPAA COMPLIANT CODE:
S5160

Unit of Service: One time set-up fee. Cost per provider.

Licensing Entity:

Accredited by:

Regulation Cite:

Taxonomy Code:

Personal Emergency Response System (PERS): Monitoring (Eligible for MFP 25%)

PERS is an electronic device which enables participants at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and is programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. The service consists of two components both of which are managed by the PERS contractor; first is the initial installation of the equipment and the second is the monitoring of the service by staff at the response center. The addition of the fiscal intermediary is the modification to the provider specifications. Previously the provider of the specific service was required to execute a purchase agreement with the case management agency; now that agreement is between the fiscal intermediary and the service provider.

Service Limitations:

Per medical necessity criteria as defined in the MCO contract. PERS is for an individual who lives alone or who is alone for significant amounts of time per the plan of care. Individuals might not have a regular care giver for extended periods of time or would require extensive routine supervision.

Provider Specifications:

The provider must apply and become approved through the MCO.

MLTSS HIPAA COMPLIANT CODE:
S5161 – Standard Landline
S5161_U1 – Cellular Unit
S5161_U2 – Cellular Unit with fall detection
S5161_U3 – Mobile Unit
S5161_U4 – Standard Landline Unit with Fall Detection

Unit of Service: Monthly Monitoring Fee

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Physical Therapy (Group and Individual) (Eligible for MFP 25%)

MLTSS Physical Therapy Services are intended to incrementally (minimal unpredictable changes over longer lengths of time) develop or improve skills, or prevent the loss of previously achieved/attained progress which is at risk of being lost as a result of a traumatic or acquired, non degenerative brain injury (TBI/ABI). MLTSS Physical Therapy is also intended to allow a member to acquire new skills that will allow them to function optimally in their current or future least restrictive environment.

MLTSS Physical Therapy Services may be considered medically necessary when all of the following conditions are met:

1. The therapy is for a condition that requires the unique knowledge, skills, and judgment of s Physical Therapist for education and training that is part of a clinician's (PT) skilled plan of treatment; and
2. There is an expectation that the therapy will incrementally (minimal unpredictable changes over longer lengths of time) improve and/or prevent the loss of previously achieved/attained progress ; and
3. An individual would either not be expected to develop the function or would be expected to permanently lose the function without the MLTSS Physical Therapy service (not merely fluctuate); and
4. The MLTSS Physical Therapy on-going clinical documentation objectively continues to verify that, at a minimum, functional status is preserved while continued pursuit of incremental progress toward further development; and
5. The services are delivered by a qualified provider of physical therapy services who has experience in delivery of therapy services to individuals with TBI.

Clinical assessment by the PT shall be used to objectively determine and verify that, at a minimum, functional status is preserved while continued incremental (minimal unpredictable changes over longer lengths of time) progress towards further development is pursued. This will be utilized to establish member's need of MLTSS Physical Therapy.

Service Limitations:

- Third party liability shall, if available, be used first and to the fullest extent possible prior to accessing MLTSS physical therapy services.
- Per Medical Necessity as defined in the contract.
- The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who is assessed to be in need of physical therapy and who transitions to MLTSS.
- The ratio for group sessions may not be larger than ONE therapist to FIVE members.
- The MCO will determine the number of authorized therapy units that will be included in a member's plan of care.
- If a clinical evaluation of the member demonstrates that the member has the potential to achieve significant improvement in restoration of, or compensation

for loss of function in a reasonable and generally predictable period of time, or, the member would benefit from the establishment of a maintenance program, rehabilitation/maintenance programs are available through other payor sources (i.e. Medicare, Medicaid State Plan or other third party liability such as commercial health insurance) and not a covered MLTSS service.

- If skilled therapy services by a qualified therapist are needed to instruct the patient or appropriate caregiver regarding the **maintenance program**, such instruction is covered by other payor sources (i.e., Medicare, Medicaid State Plan or other third party liability such as commercial health insurance).
- Periodic evaluations of the member's condition and response to treatment may be covered via the Medicare, Medicaid State Plan or other third party liability benefit when medically necessary, as identified by a qualified professional.
- A member may receive individual and group sessions of the same therapy in the same day; e.g., a morning session of individual therapy and an afternoon session of group therapy.
- A member may receive different therapies on the same day of service; e.g., morning session of individual ST, morning session of OT, and an afternoon session of CRT.
- A member must be evaluated by a licensed therapist at least annually or upon change in condition to determine whether the beneficiary has the need for skilled therapy service delivery and/or qualifies for rehabilitation or habilitation services. Documentation supporting this evaluation shall be maintained in MCO and provider clinical records.
- Physical therapy services require the clinical skills of a licensed physical therapist or licensed physical therapy assistant (or their students, in accordance with State PT licensing guidelines), for the duration of service delivery.

Provider Specifications:

- A rehabilitation hospital per NJAC 8:43 – 1.1 et.seq. and NJAC 10:54-5
- Community Residential Services (CRS) provider per NJAC 10:44c
- Licensed, certified home health agency per NJAC 8:42 and certified by the center for Medicare and Medicaid Services
- Post-acute non-residential rehabilitative services provider agency
- Clinical assessment by the PT shall be used to objectively determine and verify that, at a minimum, functional status is preserved while continued incremental (minimal unpredictable changes over longer lengths of time) progress towards further development is pursued. This will be utilized to establish member's need of MLTSS Physical Therapy.

MLTSS CPT CODES:
Individual: 97110_96_59 (15 minutes);
Group: S8990_96_HQ (15 minutes);

NOTE: For Free Standing Clinic or ANY therapy service provided out of the home; EXISTING Codes should be used. The modifier of 96 must be used to signify the MLTSS benefit is being used.

When a member is receiving multiple therapy sessions on the same day of service, the provider must use the modifier "59" in addition to the modifier for MLTSS when submitting the claim for payment. This will permit the claim to be processed and not be subject to the NCCI conflict edits. If the member is only receiving one (a SINGLE) therapy session on a given date, the provider will NOT use the modifier "59".

Unit of Service:
Individual: 15 minutes with no more than six (6) units maximum allowable in a 24 hour period.

Group: 15 minutes with no more than eight (8) units maximum allowable in a 24 hour period.

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Private Duty Nursing (Eligible for MFP 25%)

Private Duty Nursing shall be a covered service only for those beneficiaries enrolled in MLTSS and the DDD Supports Plus PDN program operated by DDD. When payment for private duty nursing services is being provided or paid for by another source, the benefit of private duty nursing hours shall supplement the other source up to a maximum of 16 hours per day, including services provided or paid for by the other sources, if medically necessary, and if cost of service provided is less than institutional care.

The 16 hours per day limitation for PDN services noted above and below shall not apply to children under the age of twenty one years who are eligible for Medicaid/NJ FamilyCare EPSDT services.

Service Limitations:

Per Medical Necessity as defined in the contract. Private Duty Nursing services are provided in the community only (the home or other community setting of the individual), and not in hospital inpatient or nursing facility settings. Private Duty Nursing services are a State Plan benefit for children under the age of 21. EPSDT services must be exhausted before accessing MLTSS PDN. Children who meet the eligibility criteria for MLTSS services contained in this dictionary shall not have their access to Medicaid EPSDT services limited through the language contained in this document. For adults over the age of 21, private duty nursing is provided under the MLTSS benefit and through the DDD Supports Plus program.
Persons meeting NF level of Care are eligible to receive private duty nursing. Private Duty Nursing criteria is based on medical necessity, and is prior approved by the MCO in a plan of care. Private duty nursing is individual, continuous, ongoing nursing care in the home, and is a service available to a beneficiary only after enrollment in MLTSS or, in the case of DDD Supports Plus PDN, being determined as meeting nursing facility level of care.

(a) Private duty nursing services shall be provided in the community only and not in an inpatient hospital or nursing facility setting. Services shall be provided by a registered nurse (RN) or a licensed practical nurse (LPN).

1. Private Duty Nursing (PDN) services rendered during hours when the beneficiary's normal life activities take him or her outside the home will be reimbursed. If a beneficiary seeks to obtain PDN services to attend school or other activities outside the home, but does not need such services in the home, there is no basis for authorizing PDN services. Only those PDN beneficiaries who require, and are authorized to receive, private duty nursing services in the home may utilize the approved hours outside the home during those hours when normal life activities take the beneficiary out of the home.

2. Due to safety concerns, the nurse shall not be authorized to engage in non-medical activities while accompanying the client, including the operation of a motor vehicle.

(b) Private Duty Nursing shall be a covered service only for those beneficiaries enrolled MLTSS or the DDD Supports Plus program, when payment for Private Duty Nursing services is being provided or paid for by another source (that is, insurance), Private Duty Nursing hours shall supplement up to a maximum of 16 hours per day, including services provided or paid for by the other sources, if medically necessary, and if cost of service provided is less than institutional care.

(c) Private Duty Nursing services shall be limited to a maximum of 16 hours, including services provided or paid for by other sources, in a 24-hour period, per person. There shall be a live-in primary adult caregiver (as defined in N.J.A.C. 10:60-1.2) who accepts 24-hour per day responsibility for the health and welfare of the beneficiary unless the sole purpose of the private duty nursing is the administration of IV therapy. (See N.J.A.C. 10:60-6.3(b)2 and 7.4(a)2 for exceptions to 16-hour maximum in a 24-hour period.)

Approval for private duty nursing service is provided by the Managed Care Organization for MLTSS beneficiaries and DDD Supports Plus PDN enrollees. Approval is provided by the State for Fee For Service beneficiaries.

Provider Specifications:

Registered nurse or a licensed practical nurse under the direction of the enrollee's physician.

Private Duty Nursing services shall be provided by a licensed home health agency, voluntary non-profit homemaker agency, private employment agency and temporary-help service agency approved by DMAHS/the MCO. The voluntary nonprofit homemaker agency, private employment agency and temporary help-service agency shall be accredited, initially and on an ongoing basis.

“Accreditation organization” means an agency approved by the Department of Human Services to provide quality oversight of Medicaid/NJ FamilyCare home care agencies and certify that services are being performed in accordance with acceptable practices and established standards.

MLTSS HIPAA COMPLIANT CODE:
T 1000_UA = Combination of LPN and RN
T 1002_UA = RN
T 1003_UA = LPN

Unit of Service: 15 minutes

Licensing Entity:

Accredited by:

Regulation Cites: N.J.A.C 10:60-5, N.J.A.C. 10:60-1.2, See N.J.A.C. 10:60-6.3(b)2 and 7.4(a)2 for exceptions to 16-hour maximum in a 24-hour period.

Taxonomy Code:

Residential Modifications (Eligible for MFP 25%)

Those physical modifications/adaptations to a participant's private primary residence required by his/her plan of care which are necessary to ensure the health, welfare and safety of the individual, or which enable him/her to function with greater independence in the home or community and without which the individual would require institutionalization. Such adaptations may include the installation of ramps and grab bars, widening of doorways, modifications of bathrooms, or installation of specialized electrical or plumbing systems that are necessary to accommodate the medical equipment and supplies which are needed for the health, safety and welfare of the individual.

Service Limitations:

Residential Modifications are limited to $5,000 per calendar year, $10,000 lifetime.

Participants living in licensed residences (ALR, CPCH, ALP, and Class B & C Boarding Homes) are not eligible to receive Residential Modifications. Adaptations to rented housing units must have the prior written approval of the landlord. Continued tenancy of at least one year is to be assured prior to approval of the request. Modifications to public areas of apartment buildings, communities governed by a homeowner association or community trust and/or rental properties are the responsibility of the owner/landlord, association or trust and excluded from this benefit.

Residential Modifications may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services, except for approved Adult Family Care (AFC) Caregivers' homes. All residential modifications are limited based on the participant's assessed need. The adaptation will represent the most cost effective means to meet the needs of the participant.

Excluded from this service are those modifications to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

All services shall be provided in accordance with applicable State/local building codes.

If it is determined that one of the above limitations would prevent the MCO from implementing a more appropriate or cost effective method of support or ensuring the health, safety and well-being of an individual, the MCO may exceed these limitations in those specific circumstances. The need to exceed the limitation must be documented in the plan of care.

A letter from the owner of the property approving the modification to the property and acknowledging that the State/MCO is not responsible for the removal of the modification from the property is required.

Provider Specifications:

The provider must be licensed in NJ per the NJ Division of Consumer Affairs, NJSA 56:8-136 et seq. as a home repair contractor and exist in the NJ Division of Consumer Affairs database located at:
http://www.njconsumeraffairs.gov/LVinfo.htm

The provider must apply and become approved through the MCO.

- The Contractor must provide his/her license number.
- Each provider must meet applicable State and county requirements for licensure, certification, or other qualifications necessary to conduct the scope of business.
- Evidence of permits and approvals must be available as required.
- All improvements must meet applicable State and local building and safety codes. (N.J.A.C. 5:23-2)
- All services shall be provided in accordance with applicable State, local and Americans with Disabilities Act (ADA) and/or ADA Accessibility Guidelines (ADAAG) and specifications.

MLTSS HIPAA COMPLIANT CODE:
S5165, T1028 = Evaluation

Unit of Service: Per Occurrence

Licensing Entity: NJ Department of Law and Public Safety, Division of Consumer Affairs

Accredited by:

Regulation Cites: NJAC 5:23-2, NJSA 56:8-136 et seq.

Taxonomy Code:

Respite (Daily and Hourly) (Eligible for MFP 25%)

Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of an unpaid, informal caregiver (those persons who normally provide unpaid care) for the participant. In the case where a person is in the personal preference program or is self-directing services, respite may be used to provide relief for the temporary absence of the primary paid care giver. Federal financial participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Service Limitations:

Respite is limited to up to 30 days per participant per calendar year. If respite is provided in a nursing home, room and board charges are included in the Institutional Respite rate. Respite will not be reimbursed for individuals who reside permanently in a Community Residential Service setting (CRS), an Assisted Living Residence or Comprehensive Personal Care Home or for individuals that are admitted to the Nursing Facility. Respite care shall not be reimbursed as a separate service during the hours the participant is participating in either Adult Day Health Services or Social Adult Day Care. Services excluded from additional billing while simultaneously receiving Respite care include: Chore, Home-Based Supportive Care, Home-delivered Meals, and Personal Care Assistant services. Sitter, live-in, or companion services are not considered Respite Services and cannot be authorized as such. Respite services are not provided for formal, paid caregivers (i.e. Home Health or Certified Nurse Aides). Respite services are not to be authorized due to the absence of those persons who would normally provide paid care for the participant. Eight or more hours of respite in one 24-hour period, provided by the same provider is the DAILY respite service.

Provider Specifications:

Respite care may be provided in the following location(s):

- Individual's home or place of residence
- Medicaid certified Nursing Facility that has a separate Medicaid provider number to bill for Respite
- Another community care residence that is not a private residence including: an Assisted Living Residence (AL), a Comprehensive Personal Care Home (CPCH), or an Adult Family Care (AFC) Home
- Community Residential Services as licensed under N.J.A.C 10:44C for those individuals with a TBI diagnosis.

MLTSS HIPAA COMPLIANT CODE:
T1005 = In home respite per 15 minutes
S5151 = Institutional respite, per diem (Assisted Living)
REV 0663 is to be used for Daily Respite Care in a NF (per diem)

Unit of service: 15 minutes, per diem

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Social Adult Day Care (Eligible for MFP 25%)

Social Adult Day Care (SADC) is a community-based group program designed to meet the non-medical needs of adults with functional impairments through an individualized Plan of Care. Social Adult Day Care is a structured comprehensive program that provides a variety of health, social and related support services in a protective setting during any part of a day but less than 24-hour care. Individuals who participate in Social Adult Day Care attend on a planned basis during specified hours. Social Adult Day Care assists its participants to remain in the community, enabling families and other caregivers to continue caring at home for a family member with impairment. Social Adult Day Care services shall be provided for at least five consecutive hours daily, exclusive of any transportation time, up to five days a week.

Service Limitations:

Per the identified need as included in the individual's plan of care.

Social Adult Day Care services shall be provided for at least five consecutive hours daily, exclusive of any transportation time, up to five days a week.

Social Adult Day Care is not available to those residing in an Assisted Living Facility as it would duplicate services required by the Assisted Living Licensing Regulations.

Social Adult Day Care cannot be combined with Adult Day Health Services.

The individual has no specific medical diagnosis requiring the oversight of an RN while in attendance at the Social Adult Day Care.

Assisted Living Program (ALP) participants, not ALR or CPCH participants may attend Social Adult Day Care 2 (two) days a week; (3) three days with prior authorization.

Adult Family Care (AFC) participants may attend Social Adult Day Care two (2) days per week.

Provider Specifications:

- Facility that (a) has a license or occupancy permit available, (b) has police and fire department response agreements, and (c) has written safety and emergency management policies and procedures.
- Personnel: (a) Program director designated, (b) has adequate Staff to meet program needs of target population, and (c) and at a minimum, has identified a nurse consultant.
- Client population: Established criteria for target population based on resources and program capabilities of facility.
- Program activities: Planned and ongoing age appropriate activities based on social, physical, and cognitive needs of the target population.
- Individualized Plans of Care: Based on identified individual client needs, jointly developed with client and family.

- Social Services: Coordination with, and referrals to, available community agencies and services. Staff has periodic contact with families.
- Nutrition: Provides a minimum of one nutritionally balanced meal per day. Special diet needs are met. Snacks provided as necessary.
- Health Management: (a) An initial health profile is completed. (b) Monthly weights are taken and other health related observations are recorded as necessary.
- Personal Care: Personal assistance as needed with mobility and activities of daily living.
- Possesses business authority to conduct such business in New Jersey and is in compliance with all applicable laws, codes, and regulations, including physical plant requirements, fire safety and ADA compliance.

MLTSS HIPAA COMPLIANT Code:
S5102_U3 (per Diem)

Unit of service = Per Diem

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Speech, Language and Hearing Therapy (Group and Individual) (Eligible for MFP 25%)

MLTSS Speech, Language and Hearing Therapy Services are intended to incrementally (minimal unpredictable changes over longer lengths of time) develop or improve skills, or prevent the loss of previously achieved/attained progress which is at risk of being lost as a result of a traumatic or acquired, non-degenerative brain injury (TBI/ABI). MLTSS Speech, Language and Hearing Therapy is also intended to allow a member to acquire new skills that will allow them to function optimally in their current or future least restrictive environment.

MLTSS Speech, Language and Hearing Therapy Services may be considered medically necessary when all of the following conditions are met:

1. The therapy is for a condition that requires the unique knowledge, skills, and judgment of a Speech Therapist for education and training that is part of a clinician's (ST) skilled plan of treatment; and
2. There is an expectation that the therapy will incrementally (minimal unpredictable changes over longer lengths of time) improve and/or prevent the loss of previously achieved/attained progress ; and
3. An individual would either not be expected to develop the function or would be expected to permanently lose the function without the MLTSS Speech, Language and Hearing Therapy Service (not merely fluctuate); and
4. The MLTSS Speech, Language and Hearing Therapy Service on-going clinical documentation objectively continues to verify that, at a minimum, functional status is preserved while continued pursuit of incremental progress toward further development; and
5. The services are delivered by a qualified provider of speech therapy services who has experience in delivery of therapy services to individuals with TBI.

Clinical assessment by the ST shall be used to objectively determine and verify that, at a minimum, functional status is preserved while continued incremental (minimal unpredictable changes over longer lengths of time) progress towards further development is pursued. This will be utilized to establish member's need of MLTSS Speech, Language and Hearing Therapy Services.

Service Limitations:

- Third party liability shall, if available, be used first and to the fullest extent possible prior to accessing MLTSS Speech, Language and Hearing Therapy Services.
- Per Medical Necessity as defined in the contract.
- The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who is assessed to be in need of speech, language and hearing therapy and who transitions to MLTSS.
- The ratio for group sessions may not be larger than ONE therapist to FIVE members.
- The MCO will determine the number of authorized therapy units that will be included in a member's plan of care.

- If a clinical evaluation of the member demonstrates that the member has the potential to achieve significant improvement in restoration of, or compensation for loss of function in a reasonable and generally predictable period of time, or, the member would benefit from the establishment of a maintenance program, rehabilitation/maintenance programs are available through other payor sources (i.e. Medicare, Medicaid State Plan or other third party liability such as commercial health insurance) and not a covered MLTSS service.
- If skilled therapy services by a qualified therapist are needed to instruct the patient or appropriate caregiver regarding the **maintenance program**, such instruction is covered by other payor sources (i.e., Medicare, Medicaid State Plan or other third party liability such as commercial health insurance).
- Periodic evaluations of the member's condition and response to treatment may be covered via the Medicare, Medicaid State Plan or other third party liability benefit when medically necessary, as identified by a qualified professional.
- A member may receive individual and group sessions of the same therapy in the same day; e.g., a morning session of individual therapy and an afternoon session of group therapy.
- A member may receive different therapies on the same day of service; e.g., morning session of individual ST, morning session of OT, and an afternoon session of CRT.
- A member must be evaluated by a licensed therapist at least annually or upon change in condition to determine whether the beneficiary has the need for skilled therapy service delivery and/or qualifies for rehabilitation or habilitation services. Documentation supporting this evaluation shall be maintained in MCO and provider clinical records.
- MLTSS Speech, Language and Hearing Therapy services require the clinical skills of a licensed speech therapist or speech therapy assistant (or their students, in accordance with State ST licensing guidelines), for the duration of service delivery.

Provider Specifications:

- A rehabilitation hospital per NJAC 8:43 – 1.1 et.seq. and NJAC 10:54-5
- Community Residential Services (CRS) provider per NJAC 10:44c
- Licensed, certified home health agency per NJAC 8:42 and certified by the center for Medicare and Medicaid Services
- Post-acute non-residential rehabilitative services provider agency
- MLTSS Speech, Language and Hearing Therapy services require the clinical skills of a licensed speech therapist or speech therapy assistant (or their students, in accordance with State ST licensing guidelines), for the duration of service delivery.

MLTSS CPT CODE:
Individual = 92507_96_59 (per diem);
Group = 92508_96_59 (per diem)

NOTE: For Free Standing Clinic or ANY therapy service provided out of the home; EXISTING Codes should be used. The modifier of 96 must be used to signify the MLTSS benefit is being used.

When a member is receiving multiple therapy sessions on the same day of service, the provider must use the modifier "59" in addition to the modifier for MLTSS when submitting the claim for payment. This will permit the claim to be processed and not be subject to the NCCI conflict edits. If the member is only receiving one (a SINGLE) therapy session on a given date, the provider will NOT use the modifier "59".

Unit of Service: per diem

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Structured Day Program (Eligible for MFP 25%)

A program of productive supervised activities, directed at the development and maintenance of independent and community living skills. Services will be provided in a setting separate from the home in which the participant lives. Services may include group or individualized life skills training that will prepare the participant for community reintegration, including but not limited to attention skills, task completion, problem solving, money management, and safety. This service will include nutritional supervision, health monitoring, and recreation as appropriate to the individualized care plan.

Service Limitations:

The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who is transitioning to MLTSS. The program will not cover services paid for by other agencies. The program excludes medical day care.

Provider Specifications:

- Post-acute, non-residential rehabilitation services provider agency
- Comprehensive Outpatient Rehabilitation Facility; Post-acute Day Program
- Community Residential Services (CRS) provider
- Rehabilitation Hospital (outpatient)

MLTSS HIPAA COMPLIANT CODE:
S5100 (15 minutes)

Unit of Service = 15 minutes

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Supported Day Services (Eligible for MFP 25%)

A program of individual activities directed at the development of productive activity patterns, requiring initial and periodic oversight, at least monthly.

The supported day service is intended to be a home and community based service, not provided in an outpatient setting or within a Community Residential Service Day Program, although it may be provided by staff that work in either of these settings. The service supports a person's plan of care in a community setting, like volunteering, shopping, recreation, building social supports, etc. The activity is provided one to one, as opposed to a group home outing or group services provided in a structured program. Individuals tend to be either higher functioning and able to eventually do the activities they are being supported in independently, or lesser functioning, capable of such activities in the community with increased support.

Activities that support this service include but are not limited to therapeutic recreation, volunteer activities, household management, shopping for food, household goods, clothing, etc., negotiating various components of activities in the community, building social supports in the community etc.

Service Limitations:

The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who is transitioning to MLTSS.

Supported Day Services are provided as an alternative to Structure Day Program when the participant does not require continual supervision. Services are not to be provided in a setting where the setting itself is already paid to supervise the participant. Limits in service should be delineated by assessment of the person receiving the service, as directed by the Master's level Rehabilitation professional. The amount, frequency, and duration of this service are determined by the recommendation made by the qualified professional. The care manager develops the plan of care, taking the professional's recommendations into account when developing the total service package necessary to maintain the participant in the home/community environment.

Provider Specifications:

A professional holding at least a Master's degree in a rehabilitation related discipline (including but not limited to; Psychology, Social Work, PT, OT, SLP, Nursing, CRC, etc.) to sustain the program. This service may be provided by rehabilitation staff at the paraprofessional level (minimum of 48 college credits) or higher, and the program and service providers will receive ongoing supervision from a licensed or certified professional at a minimum, in addition to the clinical oversight provided by the aforementioned Master's level rehabilitation professional. Registered nurses (NJSA 45:11-26) and licensed clinical social workers (NJSA 45:1-15) may provide this service when employed by an approved provider agency such as a mental health agency or family service agency. Licensed, clinical social worker may provide this service if under the supervision of a psychologist.

MLTSS HIPAA COMPLIANT CODE:
T2021

Unit of Service = 15 minutes

Licensing Entity:

Accredited by:

Regulation Cites: NJSA 45:11-26, NJSA 45:1-15

Taxonomy Code:

Vehicle Modifications (Eligible for MFP 25%)

The service includes needed vehicle modification (such as electronic monitoring systems to enhance beneficiary safety, mechanical lifts to make access possible) to a participant or family vehicle as defined in an approved plan of care. Modifications must be needed to ensure the health, welfare and safety of a participant or which enable the individual to function more independently in the home or community. All services shall be provided in accordance with applicable State motor vehicle codes.

Service Limitations:

The vehicle must be owned by the participant or their authorized representative. The vehicle must be registered in NJ.

Excluded are those adaptations/modifications to the vehicle which are of general utility, and are not of direct medical or remedial benefit to the participant. Maintenance of the normal vehicle systems is not permitted as a part of this service; neither is the purchase of a vehicle.

Provider Specifications:

MLTSS HIPAA COMPLIANT CODE:
T2039; T2039_U7 (Eval)

Unit of Service: Per Occurrence

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

B.9.3 Cost Effectiveness Policy Guidance: Exceptions Process

Appendix B.9.3
Cost Effectiveness Policy Guidance: Exceptions Process

This Policy Guidance is intended to provide direction to the Managed Care Organizations for the Cost Effectiveness Exceptions Process which is referenced in full in Section 9.3.2 of the January 2015 contract between the State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services and the Managed Care Organization Contractor.

MLTSS Members who wish to receive HCBS have a plan of care whose annual long term services and support (LTSS) cost is aligned to the Annual Cost Threshold established by the State. This guidance is intended to be used for people whose plan of care will exceed the cost threshold and the circumstances in which an exception can be applied. The annualized long term services and support portion of the capitation rate for residency in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF) as appropriate to the member's needs as determined by the Office of Community Choice Options will herein be referred to as an MLTSS member's Annual Cost Threshold (ACT). A member's costs that reach 85% of the ACT is considered an Annual Cost Threshold Trigger used to identify those members whose LTSS cost are approaching the ACT LTSS cost cap.

A member's LTSS costs cannot exceed the Annual Cost Threshold Cap unless granted an exception due to the following: 1) temporary higher care needs; or 2) long term complex medical needs, as identified in the Interdisciplinary Team (IDT) process.

The provision of HCBS for members who exceed the annual cost threshold shall be considered for members who are identified through the assessment performed by the MCO, plan of care development, and IDT process as meeting the following criteria:

1. The member has been assessed as having higher care need costs that are required to adequately meet their care needs, are temporary in nature and expected to fall within the ACT parameters within the next six months. The temporary higher care needs includes but is not limited to:
    - Temporary loss of primary caregiver
    - Acute medical condition which should reasonably resolve in six months or less

2. The member has been clinically assessed as having long term complex medical needs which can only be met through Private Duty Nursing. The MCO Care Manager or designee is responsible for the assessment of Private Duty Nursing hour needs and forwarding to the MCO Medical Director for review. The assessed level of Private Duty Nursing service hours results in LTSS costs which exceed the Annual Cost Threshold for the member's assessed level of care need. Private Duty Nursing hours shall be limited in scope to 16 hours per day by all payer sources as outlined in the MLTSS Service Dictionary and in accordance with N.J.A.C. 10:60-1.2. N.J.AC. 10:60-6.3(b) 2 allows for temporary exceptions to this limit. The MCO shall ensure that the temporary exceptions are followed if necessary. The complex medical need includes but is not limited to:
    - Ventilator Management;

- Presence of active tracheostomy and need for deep suctioning and/or around the clock nebulizer treatments with chest physiotherapy requiring skilled Nursing services;
- Gastrostomy feeding when complicated by frequent regurgitation and/or aspiration requiring skilled Nursing services;
- A seizure disorder manifested by frequent prolonged seizures, requiring emergency administration of anticonvulsant medication as a skilled Nursing service

Interdisciplinary Team (IDT):

The member may invite any individual to participate in the IDT including their physician(s) who may provide medical input and recommendations. Any information provided during the IDT process shall be provided to MCO Medical Director and the DHS Medical Director for their review and consideration.

During the IDT meeting processes, it shall be determined if the member meets the criteria for temporary LTSS services or complex medical needs that result in costs in excess of the Annual Cost Threshold and that HCBS services are the preferred service delivery system which can safely meet the member's needs. If the criteria are met, the following process shall occur

1. The MCO Care Manager who participated in the IDT process shall complete the MLTSS Exception Determination request form and submit to the MCO Medical Director for review and approval. The MCO Medical Director will make a determination within three (3) business days.
2. Upon approval of the determination by the MCO Medical Director, the MCO shall submit the Request form to the DHS/DMAHS Medical Director. .
3. The DHS/DMAHS Medical Director shall review the documentation and make a final agency determination within five (5) business days.
    a. If the member meets the Exception criteria, s/he may receive services in excess of the ACT for a period of six months
    b. If the member does not meet the Exception criteria, s/he may receive services up to the ACT
    c. The DHS/DMAHS Medical Director shall notify the DHS Deputy Commissioner, DMAHS Director, Chief of Managed Health Care, DoAS Director, and OCCO Program Director.

Expedited timeframes for the IDT and review processes are to be considered for members who are residing in HCBS and have an acute change in condition such as loss of caregiver. **The expedited review shall occur within three (3) business days of a request.** The MCO shall notify the Office of Community Choice Options of the circumstances and need for expedited review.

The MCO is responsible for notification to its member of the DHS Medical Director's determination including their grievance and appeal rights. These appeal rights include if the determination is different from the treating physician's assessment. When informed of their appeal rights, the MCO shall ensure that the individual and family understand the continuity of

care provisions remaining in effect through the appeals process. The final Plan of Care shall be issued to the member within 3 business days of receipt of the agency's determination.

Members authorized to receive services in excess of the ACT either due to temporary higher needs or complex medical needs are required to be reassessed at the time their condition changes or 30 days in advance of the end of the six month or annual approval period.

MCO ACT Guidance Document

SECTION C
CAPITATION RATES

MANAGED CARE CAPITATION RATES July 1, 2018 – June 30, 2019					
					Capitation Rates
Category	**Benefit Plan**	**Age/Sex**	**Rating District**		**7/1/2018 – 6/30/2019 Rates**
Children (< 21 yrs of age) in AFDC, NJ Care, DCP&P or KidCare A-C	NJFC A, B, C	< 21 M&F	Statewide		$168.87
Children (< 21 yrs of age) in AFDC, NJ Care, DCP&P or KidCare A-C DDD	NJFC A, B, C	< 21 M&F	Statewide		$233.69
Parents in AFDC (greater than 21 years of age), or all ages in NJCPW	NJFC A	21+ M&F	21+ M&F		$368.24
Parents in AFDC (greater than 21 years of age), or all ages in NJCPW - DDD	NJFC A	21+ M&F	21+ M&F		$433.06
NJ Children (< 19 yrs of age) – No Copay	NJFC C	<19 M&F	Statewide		$169.74
KidCare D	NJFC D	< 21 M&F	Statewide		$179.49
NJ KidCare D – No Copay	NJFC D	<19 M&F	Statewide		$192.56
ABD with Medicare and Other Dual Eligibles	NJFC A	All	Statewide		$456.81
ABD with Medicare and Other Dual Eligibles - DDD	NJFC A	All	Statewide		$479.91
ABD with Medicare and D-SNP	NJFC A	All	Statewide		$484.80
ABD without Medicare	NJFC A	All	Statewide		$1,343.30
ABD without Medicare DDD, All, Add-on	NJFC A	All	Statewide		$1,408.12
Maternity, Northeastern		All	Northeastern		$18,419.96
Maternity, Northwestern		All	Northwestern		$19,108.46
Maternity, Central		All	Central		$21,930.29
Maternity, South Central		All	South Central		$19,075.88
Maternity, Southern		All	Southern		$20,788.83

MANAGED CARE CAPITATION RATES July 1, 2018 – June 30, 2019					
					Capitation Rates
Category	**Benefit Plan**	**Age/Sex**	**Rating District**		**7/1/2018 – 6/30/2019 Rates**
Expansion					
New Jersey Care Parents (29% - 133% FPL)	ABP	All	Statewide		$320.65
New Jersey Care Adults w/o Dependent Children(< 134% FPL)	ABP	All	Statewide		$501.19
MLTSS					
MLTSS- HCBS with Medicare	M	All	Statewide		$4,204.12
MLTSS –Custodial Nursing Facilities With Medicare	M	All	Statewide		$4,204.12
MLTSS in Special Care Nursing Facilities –Vents & Pediatrics. With Medicare	M	All	Statewide		$14,603.96
MLTSS in Special Care Nursing Facilities –All Other With Medicare	M	All	Statewide		$12,378.30
MLTSS- HCBS without Medicare	M	All	Statewide		$7,881.36
MLTSS –Custodial Nursing Facilities Without Medicare	M	All	Statewide		$7,881.36
MLTSS in Special Care Nursing Facilities –Vents & Pediatrics. Without Medicare	M	All	Statewide		$24,110.47
MLTSS in Special Care Nursing Facilities –All Other Without Medicare	M	All	Statewide		$15,545.53