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

NEWSLETTER

Volume 25 No. 11 **November 2015**

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

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

EFFECTIVE: Effective immediately (replaces Volume 24 No. 14)

PURPOSE: To update NJ FamilyCare (NJFC)/Medicaid-participating managed care and fee-for-service providers on the revised Frequently Asked Questions (FAQs) for Managed Long Term Services and Supports (MLTSS) by the New Jersey Division of Medical Assistance and Health Services. The FAQs are for informational purposes regarding the implementation of MLTSS. They are posted on the Department's website at http://www.state.nj.us/humanservices/dmahs/home/MLTSS_Provider_FAQs.pdf

BACKGROUND:

The NJ FamilyCare Managed Long Term Services and Supports (MLTSS) benefit refers to the long-term care a person is determined to need, coordinated through a NJ FamilyCare managed care organization (MCO). MLTSS uses NJ FamilyCare MCOs (also known as HMOs) to coordinate ALL services.

MLTSS enables a beneficiary to live in the community with long-term supports for as long as possible. MLTSS provides comprehensive services and supports, whether you live at home, in an assisted living facility, in community residential services or in a nursing home.

If you have any policy questions regarding MLTSS, please contact 1-800-356-1561.

RETAIN THIS NEWSLETTER FOR FUTURE REFERENCE

New Jersey Department of Human Services

FREQUENTLY ASKED QUESTIONS (FAQs) FOR PROVIDERS
NJ FamilyCare MANAGED LONG TERM SERVICES AND SUPPORTS (MLTSS)

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(Revised April 2018)

AUTHORIZATION AND CLAIMS CONTRACT PARAMETERS FOR MLTSS PROVIDERS

1. **What federal/state regulations govern the payment of claims and the issuance of prior authorizations under the NJ FamilyCare managed care contract?**

   Existing law was amended and supplemented by L. 2005, c. 352 (Chapter 352) – the Health Claims Authorization, Processing and Payment Act (HCAPPA). As of July 11, 2006, health plans must have processes and procedures for providers regarding the handling of claims; claims payment appeals; prior authorization processes; utilization management; appeal rights and obligations; and information about clinical guidelines and claim submissions.

2. **What are the prior authorization parameters in the Health Claims Authorization Processing and Payment Act (HCAPPA)?**

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

3. **What is the timeframe for MLTSS claims' submission?**

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

4. **What claims submission requirements must MCOs follow to meet the NJ FamilyCare Contract parameters?**

   The MCOs must capture and adjudicate all the claims submitted by providers and comply with NJ FamilyCare's data reporting requirements. The MCOs must ensure the coordination of benefits by exhausting all other payment sources before NJ FamilyCare pays. The provider must follow the process established by each plan to submit claims.

5. **What is the universal billing format for MLTSS?**

   For paper submissions:
   Providers need to use the "1500" form for AL facilities, HCBS service providers, and non-traditional providers such as home improvement contractors, emergency response system providers, meal delivery providers and more.

   Providers need to use the "UB-04" form for NFs and SCNFs.

For electronic submissions:
Providers need to use the "837 P" form for AL facilities, HCBS service providers, and non-traditional providers such as home improvement contractors, emergency response system providers, meal delivery providers and more.
Providers need to use the "837 I" form for NFs and SCNFs.

6. What are the claims submission requirements of providers if there is an explanation of benefits?

The MCO contract specifies consistent claim submission timelines across all plans. Timeframes are consistent with the New Jersey Division of Banking and Insurance (DOBI) for all medical services.

Providers are to submit coordination of benefits (COB) claims within 60 days from the date of the primary insurer's explanation of benefits (EOB) or 180 days from the dates of service, whichever is later.

7. What are the claims processing requirements of the MCOs?

The MCO contract language specifies that MLTSS service claims should be processed by the MCO to the provider within 15 days of a clean submission. For non-MLTSS services, the MCO contract language specifies that claims should be processed by the MCO to the provider within 30 days of a clean submission.

8. What are the claims submission categories?

- Initial
- Claim resubmission
- Claim denial
- Claims appeal

9. What is a claim re-submission?

A claim may get denied for a variety of reasons, so it is important for a provider to supply the MCO with as much information as possible when re-submitting a claim. Some common reasons for a claim re-submission include: a corrected claim, the addition of prior notification/prior authorization information and the verification of a bundled claim.

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

If a member has another health or casualty insurer, the MCO is responsible for coordinating benefits to maximize the utilization of third party coverage and ensure that NJ FamilyCare is the payer of last resort. The provider must follow each MCO's process for submitting claims. (Refer to the section entitled **MCO Contract Parameters on Benefits Coordination with other Insurers.**)

11. What are the policies on "balance billing" with MLTSS for providers?

A provider shall not seek payment from, and shall not institute or cause the initiation of collection proceedings or litigation against, a beneficiary, a beneficiary's family member, any legal representative of the beneficiary, or anyone else acting on the beneficiary's behalf unless the service does not meet criteria referenced in NJAC 10:74-8.7(a).

For more information on the issue of balance billing and the limitations regarding the billing of NJ FamilyCare beneficiaries, refer to the Division of Medical Assistance and Health Services' *Medicaid/NJ FamilyCare Newsletter:* Volume 23 No. 15 dated September 2013. All NJ FamilyCare newsletters are posted on http://www.njmmis.com/

12. Is it the responsibility of the NF or the MCO case manager to ensure the approval of the member's authorization in MLTSS when it expires?

The NF needs to work directly with the member's case manager at the MCO to insure that the member has authorization for MLTSS at the NF.

13. If the NF does not receive weekly check runs for MLTSS custodial claims from the MCO, what should the provider do?

Clean[1] MLTSS claims are to be processed in 15 days. However, specific claim information and summary of any follow-up information may be sent to the Provider Inquiries mailbox at MAHS.Provider-Inquiries@dhs.state.nj.us

14. What is the MCO's authorization process for the NFs, ALs, CRS and SCNFs services?

The individual MCOs outline the MLTSS Authorization process and contact numbers on their websites and in their provider manual and provider education materials.
Link for MCO websites: http://www.state.nj.us/humanservices/dmahs/info/resources/hmo/.

15. What is the MCO's authorization process for home and community based services (HCBS)?

The individual MCOs outline the MLTSS Authorization process and contact numbers on their websites and in their provider manual and Provider Education materials.
Link for MCO websites: http://www.state.nj.us/humanservices/dmahs/info/resources/hmo/.

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[1] A clean claim is defined as a claim which has no defect, impropriety or special circumstance, including incomplete documentation that delays timely payment.

16. Are providers required to use clearinghouses to submit claims to the NJ FamilyCare MCOs?

The individual MCOs will outline their processes for claim submissions; however, there is no requirement to use a clearinghouse.

17. How are claim adjustments handled for NJ FamilyCare residents? Are claim adjustment forms specific to each MCO? Are they available online? Does the provider use claim adjustment forms to communicate the changes in resident income and leaves of absence?

The individual MCOs outline their processes for claims submissions and adjustments in the provider contract.

CLINICAL ELIGIBILITY DETERMINATION

1. Who and what will determine where a MLTSS member is going to be placed in the continuum of care?

The NJ FamilyCare MCOs coordinate the acute and primary health care services and home and community-based services for their members by a MLTSS care manager. The choice of services and setting is based on consumer preference and care needs.

2. What criterion does a member enrolled in NJ FamilyCare MCO need to meet in order to receive MLTSS?

MLTSS is a voluntary program. An individual must meet clinical and financial eligibility requirements, consent to required care manager visits, and be reassessed annually for eligibility requirements.

a. Clinical: an adult meets the qualifications for nursing home level of care, which means that the person requires assistance with a minimum of three activities of daily living (ADL) such as bathing, toileting, dressing, transfers and locomotion. The MCO will complete the NJ Choice assessment and forward it to the Division of Aging Services (DoAS)/Office of Community Choice Options (OCCO) for review and approval.
b. Institutional Medicaid Eligibility: Financial Eligibility for MLTSS includes a higher income and five–year "look back" of assets. The County Welfare Agency (CWA) completes the financial determination.

3. What entity conducts the clinical eligibility assessment process for new members to NJ FamilyCare MLTSS?

DoAS/OCCO conducts the clinical eligibility assessment process for individuals, who are new to NJ FamilyCare, and seeking clinical eligibility for MLTSS. The MCO conducts the assessment for its members seeking MLTSS, which are authorized by OCCO. All MLTSS members, regardless of their living arrangements, will receive annual clinical assessments by their MCO. The re-evaluations are authorized by OCCO.

4. How do the NJ FamilyCare MCO cover community services like cognitive rehabilitation and residential long-term care for patients discharged from post-acute facilities?

The MCO care manager will evaluate service needs of all members and provide care coordination needs on an annual basis and as the care needs change. It is the provider's responsibility to obtain authorization from the NJ FamilyCare MCO for services

5. When an Assisted Living resident is determined to be clinically eligible for LTC and pending MCO enrollment can the Assisted Living Provider bill for the Assisted Living Services?

If financial and clinically eligibility parameters have been met the Provider may be eligible for FFS payment.

Refer to the Medicaid Newsletter listed below for details:

- Volume 26: Number 17: Fee for Service (FFS) Coverage of Assisted Living Programs and Managed Long Term Services and Supports(MLTSS)
- Subject**:** Payment for assisted living services for clients pending MLTSS and MCO enrollment
  - Replaces Medicaid Newsletter Volume 24 Number 14–(November 2014)

ELIGIBILITY FOR MLTSS

What criteria must an individual meet to be eligible for MLTSS?
To be eligible for MLTSS, an individual must meet the following eligibility criteria:

1. Categorical Eligibility
   - Aged – 65 years old or older, or
   - Blind ***or*** Disabled – Under 65 years of age and determined blind or disabled by the Social Security Administration or the State of New Jersey.

2. Clinical Eligibility
   - An adult meets the qualifications for nursing home level of care, which means that s/he requires hands on assistance with a minimum of 3 activities of daily living (ADL) such as bathing, toileting and locomotion. Adults with cognitive deficits and supervision with 3 ADL areas may also qualify
   - A child under the age of 21 meets the qualifications for MLTSS when they require complex skilled nursing interventions 24 hours per day, seven days per week.

3. Financial Eligibility – Medicaid Only Program
   - Income
     - Individual income can be equal to or less than $2,250* per month (2018) or the individual may establish and fund a Qualified Income Trust.
     - All income is based on the gross amount.
     - Resources: Resources must be at or below $2,000 for an individual

*Income criteria changes annually and Financial eligibility component includes a 60 month "look back" at resources to insure that there were no assets transferred for less than fair market value in order to meet the requirements for the Medicaid Only program.

ENHANCED AT RISK CRITERIA PRE-ADMISSION SCREENING (EARC PAS) AUTHORIZATION (INCLUDING NURSING FACILITY AUTHORIZATIONS)

1. What is the EARC PAS?

- The EARC PAS (LTC-34) is a screening tool which provides a 90-day authorization for acute care hospital patients being discharged to a Medicaid certified nursing facility (NF) in the NJ FamilyCare program without enrollment in a Managed Care Organization (MCO). The authorization becomes valid once the individual becomes financial and clinically eligible for Medicaid. The Division of Aging Services, Office of Community Choice Options (DoAS/OCCO) is responsible for the authorization process. Hospital staff trained and certified through the DoAS-established curriculum can complete this tool.

The authorized EARC PAS and all PASRR documents can be found at www.state.nj.us/humanservices/doas/home/forms.html and must accompany the patient to the NF to be permanently filed in his/her active NF chart. The NF will not be eligible for NJ FamilyCare reimbursement unless all required paperwork and processes have been completed and Medicaid financial eligibility has been approved.

2. Who should request the EARC PAS?

- The EARC is only completed in an acute care hospital setting. The hospital is responsible for completing the EARC and submitting it to DoAS/OCCO for review and authorization to the admitting NF.

3. What is the EARC target population?

- The target population is for individuals who are currently in an acute non-psychiatric hospital setting and are seeking admission to a NJ FamilyCare-certified NF or Special Care Nursing Facility (SCNF) ventilator unit. The facility expects to bill NJ FamilyCare for all or part of the stay because the individual is eligible for NJ FamilyCare but not yet enrolled in a MCO or potentially eligible for NJ FamilyCare within 180 days of NF admission.

4. Is the Enhanced At-Risk Criteria Screening (EARC-PAS) applicable for hospitalized patients going to the nursing facility (NF) on NJ FamilyCare?

- The NF authorization process is the responsibility of the NJ FamilyCare MCOs under MLTSS. The EARC tool is only used for non-Medicaid participants and serves as a 90-day temporary authorization if the individual has financial Medicaid eligibility and a full clinical assessment.
- For individuals without MCO enrollment, the EARC PAS (LTC-34) may be used to provide a 90-day authorization for acute care hospital patients being discharged to a Medicaid certified nursing facility (NF) with expectation of billing the NJ FamilyCare program during the length of stay.

5. **Do members in NJ FamilyCare need an EARC PAS?**

- Individuals enrolled in NJ FamilyCare are enrolled into an MCO. There may be a temporary period of Medicaid fee-for-service (FFS) coverage until the MCO enrollment occurs. Individuals who are enrolled in an MCO are required to obtain authorization from their MCO to enter a sub-acute rehabilitation facility, NF or SCNF.

6. **Is an EARC necessary if the resident is pending for NJ FamilyCare or is not enrolled in an MCO?**

- Yes. The EARC is for those individuals who are pending NJ FamilyCare eligibility or those with no enrollment yet in an MCO. Those individuals enrolled in an MCO need to follow the processes required under their MCO.

7. **What is the difference between an authorization and PAS (Pre-Admission Screening)?**

- An authorization is an MCO process to approve services for a period of time (including in a NF).
- Pre-Admission Screening (PAS) is an assessment conducted by DoAS/OCCO to determine NF level of care clinical eligibility for individuals not enrolled in an MCO.
- Assessments to determine eligibility for MLTSS are conducted by both DoAS/OCCO and the MCO using the NJ Choice assessment tool. If the MCO conducts a NJ Choice assessment for MLTSS, it is submitted to DoAS/OCCO to determine MLTSS eligibility.
- An individual enrolled in an MCO is eligible for short-term NF/SCNF benefits with MCO authorization without being assessed for MLTSS. It is the provider's responsibility to contact the MCO to determine the authorization process.

8. **If a resident is being admitted to a NF from the hospital and already on MLTSS, does the hospital need to get authorization and a PAS?**

- An individual enrolled in MLTSS requires an authorization from the MCO.

9. **Is a new EARC required for readmission to a NF after a hospital stay?**

- EARCs conducted after January 1, 2015 is valid for one NF stay only. Upon admission to a hospital, a new EARC is required.

- Medicaid eligible individuals with a valid EARC or PAS in a NF before July 1, 2014 are considered NF EXEMPT and not eligible for MCO enrollment unless they change placement setting or payer source. These individuals do not require an EARC or PAS if they are hospitalized and returning to the same NF after the hospital stay.

10. **What happenes if the patient is admitted to the NF on Medicare A and is enrolled in an NJ FamilyCare MOC? Is a new EARC required for readmission to a NF after a hospital stay?**

- The hospital and NF are responsible for communicating with the specific MCO to determine the MCO's authorization process and what is required based on clinical need and the length of stay.

11. **Is an EARC required for a pediatric patient going from an acute rehabilitation facility (LTACH) to a SCNF?**

- Patients who are not enrolled in an MCO and seeking admission to a SCNF require a clinical assessment and determination by DoAS/OCCO. The EARC is only permitted for SCNF Ventilator and Nursing Facility admissions.

12. **If a patient is admitted to a NF/SCNF/SAR with an authorization from an MCO but then the resident's NJ FamilyCare eligibility terminates, will the facility get paid if there is no EARC or PAS? Can the facility request a PAS from DoAS/OCCO?**

- If the individual is terminated and is no longer eligible for NJ FamilyCare, then NJ FamilyCare would not be the payer source regardless of any authorization by the State or MCO. The facility is responsible for checking resident eligibility monthly. In the event of NJ FamilyCare termination, there is no payer source. If NJ FamilyCare enrollment is renewed without a gap within 2 months, the MCO enrollment will resume. If the renewal is greater than two months from the termination date, FFS billing will be required until MCO enrollment occurs.

13. **If a resident is a positive level 1 in PASSAR and is only going to need short term rehabilitation services but will be in the NF for longer than 30 days, can the individual be admitted to the NF?**

- Regardless of the length of stay when an individual is admitted to a NF, a PASRR Level I is required prior to admission. All positive Level 1 PASRR screens require a Level II determination prior to admission. If the 30 day exempted hospital discharge is used, then it is the responsibility of the NF to follow through and complete the level II prior to the 40th day from admission as per the federal regulations.

14. **Can a patient be admitted into a Medicaid certified NF without an EARC?**
    Individuals who do not expect to become Medicaid eligible during their stay in the nursing facility do not require an EARC or PAS. They may require authorization dependent on their insurance coverage.

    Yes, if Medicaid is not anticipated within 180 days of admission and not anticipated to be billed for any portion of the stay. For those Medicaid eligible or anticipated eligible within 180 days, one of the following is required:
    a) EARC
    b) Pre-Admission Screening (PAS) by DoAS/OCCO
    c) NJ FamilyCare MCO Authorization

15. **What happens when the hospital says it will complete the EARC, but fails to do so and discharges the patient?**

- The admitting provider is responsible for obtaining the proper EARC, PAS or MCO Authorization as well as the PASRR Level I and Level II, if applicable prior to admission. Providers should not be accepting individuals without these requirements. If a provider accepts an individual without the required documentation, it may jeopardize reimbursement.

FINANCIAL ELIGIBILITY DETERMINATION

1. Where do residents apply for New Jersey's Medicaid program, NJ FamilyCare – Aged, Blind, Disabled Programs?

- Individuals may apply for NJ FamilyCare – Aged, Blind, Disabled Programs either online at NJFamilyCare.org/abd.htm or at their County Welfare Agency (CWA). The submission of an application with its supporting documents is required to determine financial eligibility.

2. Who do residential providers contact to insure that the member meets financial eligibility for MLTSS if member is currently eligible and receiving benefits for a NJ FamilyCare – Aged, Blind, Disabled Program in the community (non-MLTSS)?

- Medicaid Only eligibility is required for MLTSS. Providers and the MCO should contact the CWA regarding a member's eligibility for Medicaid Only. Medicaid Only requires a PAS and a five-year "look back" of the individual's financial resources for transfer of assets for less than fair-market value.

3. **Who do residential providers contact if an individual is admitted to a facility pending NJ FamilyCare – Aged, Blind, Disabled eligibility?**

- The CWA determines financial eligibility for NJ FamilyCar – Aged, Blind, Disabled Programs.. A residential provider who is currently providing services to the individual can contact the CWA regarding a member's financial eligibility. The CWA may provide updates on the status of an application to providers that have a pending bill only. They may not discuss the application with billing companies or to "future" providers. This policy should be followed as per Medicaid Communication 17-04.

4. If the provider has a question regarding member's eligibility who do they contact?

- Providers can review a member's eligibility information in E-mevs. If they have specific questions regarding cost share and/or financial determination, they should contact the CWA where the member resides.
  The link below provides listing of local CWAs.
  http://www.nj.gov/humanservices/dfd/programs/njsnap/cwa/index.html

5. What is the best way for a provider to contact a CWA on behalf of an MLTSS member?

- The CWAs can only be contacted by phone as they don't have email addresses available to providers.
  Providers may forward information regarding eligibility questions to the Medicaid Provider Relations designated email if the member or provider has not received communication from the CWA. (Confidential information must be sent through a secure process) Some CWAs have designated staff that cover specific facilities, please ask the CWA if there is a designee already assigned to your company.

6. What financial documentation must be provided to the CWA for a NJ FamilyCare – Aged, Blind, Disabled member to get on MLTSS?

- When a member is admitted to a facility for long term services and supports, the facility must send an LTC-2 form to the appropriate CWA and the individual's MCO Care Manager must be informed so that they may assess for an institutional level of care. Individuals in need of an institutional level of care on MLTSS must be both clinically and financially eligible. These two processes are done concurrentlyThe MCO care manager will also provide a self-attestation form to their member in order to expedite the financial eligibility process. The MCO Care Manager is required to send the self-attestation information to DMAHS to begin the financial eligibility process. The self-attestation form states that the individual did not transfer resources for less than fair market value during the previous five years. The State of New Jersey is authorized to waive the five-year look back process for those individuals qualified to sign this form (individuals whose income is less than 100% of the federal poverty level). The CWA will also be required to renew the member's case because there is a change of circumstance and a cost share calculation must be completed on the Personal Responsibility form. The Personal Responsibility form outlines the amount of money that the facility must collect each month from the member. This amount is also provided in the EMevs system through the NJMMIS website. Once the form is completed the CWA sends a copy to the facility and to the member.

7. Do MCO members with NJ FamilyCare in the community have to submit a new application to the local CWA to become eligible for MLTSS?

- A new application is not necessary for NJ FamilyCare-Aged, Blind, Disabledrecipients in need of MLTSS. The CWA will use the information from the original application to complete the five-year look back process or request additional documentation as necessary.

MCO CONTRACT PARAMETERS REGARDING COORDINATION OF BENEFITS

MCO Contract Parameters regarding Coordination of Benefits

1. Does an MLTSS provider serving a member with a Medicare Part A and Part B and/or a Medicare Supplemental Plan need EOB information or a claim denial before the NJ FamilyCare MCO can pay?

- Providers serving MLTSS members who have a Medicare Fee-for-Service (FFS) and/or a Medicare Supplemental plan and are receiving services that are not eligible to be covered by Medicare do not have to obtain an EOB or claim denial from Medicare prior to submitting a claim to the NJ FamilyCare MCO.
  .
- However, if a member is receiving other services that are eligible to be covered by Medicare, the provider must submit an EOB for the individual services denying service from Medicare to be considered for payment from the NJ FamilyCare MCOs. This includes sub-acute rehab stay in a NF.
- Refer to MCO contract Coordination of Benefits- Contract Guidance –March 2018 for additional information the document can be found at http://www.state.nj.us/humanservices/dmahs/home/mltss_resources.html

2. **Does an MLTSS member in the Personal Preference Program, without Medicare Advantage coverage or commercial insurance, need an EOB or a claim denial before the NJ FamilyCare MCO can pay for PCA services?**

- An EOB statement does not apply to the PPP cash grant "service" because the state's Fiscal Intermediary (FI), is billing for funds that are part of the monthly spending plan approved for an MLTSS member.
- An EOB is not required if the member does not have Medicare Advantage or commercial insurance because PCA is for help with Instrumental Activities of Daily Living (IADLs) and Activities of Daily Living (ADLs) and is neither considered a medical service nor a service covered by any other medical payer.

3. **If a member has Medicare Advantage coverage or other TPL that includes benefits covered under Medicare Parts A and B, and/or another commercial coverage, does a NJ FamilyCare provider have to submit an explanation of benefits or denial of claim before the NJ FamilyCare MCO will process the claim?**

- The NJ FamilyCare MCO should require an EOB annually for an MLTSS member with a Medicare Advantage Plan and/or another commercial insurance. When an EOB is received indicating that the service is not covered by the primary insurer, the MCO will pay for MLTSS as the primary payer. A new EOB should not be required for subsequent claims during the calendar year for the same payer, provider, MLTSS member and service code.
- Services paid by a TPL carrier may become a non-paid service if the MLTSS member's benefits are exhausted. If this is the case, the provider should submit an EOB stating the benefit is exhausted before the MCO pays for the service.

4. **If Medicare is the primary payer and the MCO is the secondary payer for an individual entering a sub-acute rehabilitation (SAR) facility, is authorization by the MCO still required (assuming the patient has the full 100 Medicare SAR days remaining)?**

- It is the provider's responsibility to outreach the MCO to determine the process for coordination of benefits to ensure coverage during the NF stay.

MCO CONTRACT PARAMETERS FOR RESIDENTIAL PROVIDERS

1. **What are the covered services included in the per diem rates for NFs, SCNFs and AL facilities?**

- MLTSS service descriptions are included in the Managed Care Contract. The contract is posted on the DHS website.

2. **Are there exclusions for specialty items, such as special beds and wound vacuums, in the provider contracts with the MCOs?**

   Provider contracts with the individual MCOs are based on service descriptions in the MCO contract. Specialty Items that are not included in state FFS per diem rates may be priced separately with the individual MCOs.

Note the state has established a minimum rate for NF AL and SCNF through the Any Willing Provider (AWP) provision. In Calendar Year 2018 a process to implement Any Willing Qualified Provider (AWQP) wasinitiated and is setting the stage for value based purchasing..

3. **Does the provider bill for "bed hold" on the UB-04 when a resident is hospitalized or does the resident need to be discharged when going to a hospital under MLTSS?**

- Bed hold information will be reported in the parameters of the MCO contract with providers; in the MLTSS Service Dictionary and on the UB-04 lite and 8:37I. Bed hold days do not have a reimbursement value but they will be reported on a claim.

4. How will "bed hold" be handled under MLTSS?

- The reporting requirements for bed hold are outlined in individual MCO contracts with the residential providers. In the MLTSS Service Dictionary and on the UB-04 and 8:37I, bed hold days do not have a reimbursement value, but they will be reported in a claim.

5. **How are remittance advices for long term care handled under MLTSS?**

- The long-term care facilities need to follow MCO's guidelines. MCOs are required to follow Federal and State billing guidelines.

6. **How is the number of monthly Medicaid days reported? Does it differ for residents on MLTSS versus those residents on fee-for-service Medicaid?**

- The long-term care facilities need to report their census through the NJ Medicaid Management Information System (NJMMIS.)

7. **How are pharmacy services handled for the NFs and SCNFs?**

- Pharmacy service procedures depend on the contracts which the NJ FamilyCare MCOs have with each long-term care facility.

8. **How does the provider bill for room and board in the long-term care facilities under MLTSS?**

   Cost share is billed by and collected by the long-term care facilities. The MCO payment to facilities is reduced by the cost share amount and is outlined in the MCO contract with providers.

MCO PROVIDER NETWORK AND MLTSS

1. What is the health plan's responsibility with regard to establishing a provider network?

Each health plan has specific responsibilities when contracting with providers, including:
a) offering an application when considering enrolling providers in network;
b) credentialing/re-credentialing providers;
c) establishing a contract with providers selected to be network providers and subcontractors;
d) creating an annual provider manual and preparing updates as necessary;
e) offering provider education and outreach;
f) providing access to call center staff to resolve payment issues, and
g) providing a process for claim and utilization appeals.

2. How do health plan's contract with providers?

- The health plan will establish written agreements and/or contracts with providers selected to service enrolled members. Templates for provider contracts are reviewed and approved by the NJ Division of Medical Assistance and Health Services (DMAHS) and the NJ Department of Banking and Insurance (DOBI) before they are distributed to providers to ensure regulatory and contract compliance

3. What is Any Willing Qualified Provider (AWQP) for Nursing Facilities?

Any Willing Qualified Provider (AWQP) is a Nursing Home Quality Improvement Initiative under Managed Long Term Services and Supports (MLTSS). Details regarding the initiative can be found at:

The webpage (http://www.state.nj.us/humanservices/dmahs/home/mltss_nhq.html)

4. What do the Any Willing Provider (AWP) and Any Willing Plan (AWP) provisions mean for Assisted residential providers?

- The NJ FamilyCare MLTSS MCO contract has an Any *Willing Provider* and *Any Willing Plan* (AWP) provisions for providers in these categories: Assisted Living (AL), Community Residential Services (CRS), Nursing Facility (NF) and Special Care Nursing Facilities (SCNF).

- The AWP provisions include any New Jersey-based AL, CRS or SCNF provider. It also includes any long-term care pharmacy that applies to become a network provider. The pharmacy must comply with the pharmacy benefit plan (PBM) provider network requirements; and accept the terms and conditions of the health plan provider contract, or terms for network participation.

- If the health plan wishes to have any New Jersey-based SCNF, AL or CRS join its network, the providers will be instructed to complete an application form and conform to the MCO contract provisions.

5. What steps does a non-residential provider need to complete to be a provider for an MCO that administers the MLTSS benefit?

a) Inquire if the MCO is accepting applications for service;
b) Submit an application;
c) Complete the credentialing requirements, and,
d) Secure a contract if the MCO and provider reach a contract agreement.

The member and provider service contact information for each NJ FamilyCare MCO is also available on the DHS web-site at http://www.state.nj.us/humanservices/dmahs/info/resources/hmo/

MLTSS MEMBER ELIGIBILITY CONFIRMATION REQUIREMENT

1. Why must a provider confirm a member's eligibility status in NJ FamilyCare and/or the individual's enrollment in a NJ FamilyCare MCO for MLTSS?
Providers must have the information on an individual's NJ FamilyCare status to be sure that the prior authorization is obtained from the correct entity so that the billing is submitted to the correct payer. If a provider has inaccurate information and, as a result, bills incorrectly, the provider may not be able to file in a timely manner and will lose reimbursement.

2. What is a provider's requirement in terms of confirming a member's eligibility in NJFamilyCare?
Providers must confirm a member's NJ FamilyCare eligibility on a monthly basis to ensure that the member remains enrolled in the program. If a member has changed MCOs, providers must contact the existing health plan for an updated authorization. Providers also must confirm that the member is enrolled in an MCO with an active authorization to receive MLTSS.

3. **How can a provider check a member's eligibility status in NJ FamilyCare and/or the member's enrollment in a NJ FamilyCare MCO for MLTSS?**
There are two methods available for providers to verify a beneficiary's eligibility status:

a) The first option is to access REVS or the Recipient Eligibility Verification System if the provider is a NJ FamilyCare fee-for-service (FFS) provider. The provider may call 1-800-676-6562 to verify an individual's NJ FamilyCare eligibility and, at the same time, confirm if the individual has Medicare Parts A and B coverage. REVS may also be used to access health plan membership information.

b) The State has a second option to verify eligibility using the internet, which is referred to as eMEVS or the Electronic Medicaid Eligibility Verification System. This System is supported on a secure area of the www.njmmis.com website. A provider may visit www.njmmis.com and select the link on the left side of the page called "Contact Webmaster." The provider will complete a screen to request a username and password in order to access eMEVS. When using eMEVS, a provider has the option of entering a card control number from the health benefits identification (HBID) card; the beneficiary's social security number or name. EMEVS displays a formatted eligibility response on the computer, which a provider can view quickly and print for their records.

Any provider with an active login ID and password may access the web portal. However, a provider may only verify a member's NJ FamilyCare eligibility for service dates that fall within that provider's NJ FamilyCare provider eligibility period. For example, if a provider is eligible to participate in NJ FamilyCare as a valid provider between 01/01/13 and 12/31/13 and the service date for a member is 01/01/14; the provider would not have access to that member's eligibility information since the service date to be verified is outside of that provider's NJ FamilyCare provider eligibility period.

4. **Where will the indication on eMEVS be a member switches MCOs?**
The MCO history is in e-MEVS.

5. **If the individual changes his/her MCO, when is the change reflected in eMEVS?***E-mevs will only show the member's MCO for the current month. The MCO history will also be displayed in e-mevs.*

MLTSS MEMBER ENROLLMENT AND ELIGIBILITY INFORMATION

1. **Can an Assisted Living (AL) resident who already is enrolled in one NJ FamilyCare MCO change to a different MCO due to the transition of AL services to MLTSS? Is this a good cause situation? What happens if, for some reason, the AL is not part of the network of the MCO the resident is enrolled in?**

- All NJ FamilyCare MCO beneficiaries can change their MCO to another MCO during the open enrollment period, which runs annually from October 1 – November 15.
- In addition, if a member has good cause, he/she can call NJ FamilyCare at 1-866-472-5338 (TTY 800-701-0720) at any time to ask about changing his/her MCO to another MCO.
- The NJ FamilyCare MLTSS MCO contract has two-year *Any Willing Provider* and *Any Willing Plan* (AWP) provisions for AL, CRS, NF and SCNF providers.

2. **Who is doing the annual determination of clinical eligibility?**

- Level of care assessments will be conducted annually by the MCO for MLTSS participants and submitted for determination by DoAS/OCCO.

3. **Is there a waiting period for MLTSS services?**

- An individual must be enrolled in an MCO and determined to be clinically and financially eligible to receive MLTSS services. The enrollment into an MCO may take up to 60 days. NF and AL services may be paid on a fee-for-service (FFS) basis when enrollment in the MCO is pending.

4. **Are there still a Medicaid Track 1 and Track 2 in NFs and what is the impact on enrollment in MLTSS?**

   The Track 1 and Track 2 designation definitions have changed. The track designation is an internal mechanism and has no impact on the provider community.

5. **If a NJ FamilyCare member needs to stay in a SCNF beyond the 30th day, will the MCO automatically dis-enroll the patient?**

- No. The NJFamilyCare members are covered for all acute and non-acute services through their MCO. .

6. **Will the NJ FamilyCare MCO be assigned while the patient is still in the acute care hospital?**

- While the individual is in an acute care hospital, the individual will remain FFS until they are discharged from the acute care hospital. Enrollment in an MCO will take place when the member is discharged from the acute care hospital.

7. **Will the NJ FamilyCare MCO be assigned while the patient is in the long-term care facility?**

- Yes, the member will be enrolled in a NJ FamilyCare MCO as long as they are not in an acute hospital setting. .

8. **An individual is admitted to a sub-acute rehabilitation facility for a traumatic brain injury. The individual's application for NJ FamilyCare is pending and not yet approved. What entity provides the pre-authorization for admission to a SCNF if there is no NJ FamilyCare MCO yet involved?**

- The Division of Aging Services (DoAS)/Office of Community Choice Options (OCCO) is responsible for determining if an individual meets the clinical requirements for NJ FamilyCare MLTSS by using the NJ Choice assessment tool when the member's Medicaid eligibility is pending.

9. **An individual already is on NJ FamilyCare before a traumatic event. The individual is admitted to a sub-acute rehabilitation facility. Before the transition to MLTSS, this individual would have been disenrolled from NJ FamilyCare on day 31. Has this policy changed with the transition to MLTSS on July 1, 2014?**

- The 30-day limitation on NJ FamilyCare coverage ended after July 1, 2014 with the move to MLTSS. As a result the NJ FamilyCare member's long term care is managed by the member's MCO.

MCO UTILIZATION APPEALS FOR MLTSS MEMBER AND/OR PROVIDER

1. What is the Utilization Management Appeal process?

- An appeal of an adverse benefit decision is included as part of the MCO contract for any member and/or provider acting on behalf of the member who disagrees with the MCO as to whether a service, supply, or procedure is medically necessary.

2. What is the MCO function with regard to grievances and appeals?

- An MLTSS member has the right to appeal an adverse benefit determination by filing an Internal Appeal with the MCO. If the Internal Appeal is not resolved in their favor, members may also request an External Appeal through the Independent Utilization Review Organization (IURO), as well as a Medicaid Fair Hearing.
- Appeals based on certain services may not be eligible for the External (IURO) Appeal; these services are listed in Article 4.6.4.C.4.c of the MCO Contract.
- A member, or an authorized representative, such as a family member or a provider with the member's written consent, can file a grievance

3. Will the member continue to received services during his/her appeal?

A member's services will continue automatically while his/her appeal is being reviewed if the following conditions are met:

- The appeal is filed on time;
- The appeal involves a previously authorized course of treatment;
- The services were ordered by an authorized provider; and
- The appeal request is made on or before the final day of the previously approved authorization, or within 10 calendar days of the date of the MCO's notification of adverse benefit determination, whichever is later.
- For members requesting a Medicaid Fair Hearing, continuation of benefits must be requested in writing 10 calendar days of the date of the notice of action letter following the outcome of an Internal or External (IURO) appeal, or on or before the final day of the previously approved authorization, whichever is later.

4. What is the process to request a Medicaid Fair Hearing?

- A beneficiary or a provider acting on the beneficiary's behalf (with his/her written consent) can request a Medicaid Fair Hearing within 120 calendar days of the date of the notice of action letter following the outcome of an Internal Appeal.
- The Medicaid Fair Hearing Unit is available at 609-588-2655. The completed Fair Hearing request, along with a full copy of the adverse decision letter, must be mailed to the address below:

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

NURSING FACILITY RESIDENT DISCHARGE

1. **A nursing facility resident (NF) resident, who is Medicaid fee-for-service (FFS) was living in the NF before July 1, 2014, but is now transitioning into the community or another NF. How does the resident become enrolled in a NJ FamilyCare MCO to obtain MLTSS to either move into the community or another NF?**

- The Office of Community Choice Options (OCCO), Division of Aging Services (DoAS), Department of Human Services (DHS) is responsible for the transition process of NF residents, who are FFS Medicaid, and are moving into the community or another NF. The NF must make a referral to OCCO to reassess to determine the nursing home level of care and conduct Options Counseling to learn about his/her long term care options—MLTSS or the PACE program, and how to select a NJ FamilyCare MCO if MLTSS is chosen. OCCO works directly with the NJ FamilyCare enrollment unit, which inputs the resident's MCO selection into the system.

2. **How is a service plan developed for the NF resident's transition into a home and community-based setting if the individual does not have an MCO? Does OCCO take the lead on this process since the person is Medicaid FFS?**

- For FFS Medicaid NF residents, OCCO serves as the lead entity in the process. Once initial planning has taken place and specific benchmarks are met, the member would need to be enrolled into an MCO once enrollment occurs; the MCO becomes responsible for the individual, participates in the discharge planning and develops his/her plan of care. The MCO's care manager participates in the Interdisciplinary Team (IDT) meeting. Once the NF transition IDT is convened, the MCO care manager assumes the lead for developing a plan of care and the transition/discharge planning. OCCO serves as the subject matter expert.

3. **A FFS Medicaid NF resident wishes to sign himself out of the facility against medical advice. The individual is capable of making this decision from a cognitive standpoint. What is the process?**

- The Office of Community Choice Options (OCCO), Division of Aging Services (DoAS is responsible for the transition process of NF residents, who are FFS Medicaid, and are moving into the community or another NF. If the resident wants to move into a home and community based setting with MLTSS and the resident is unwilling to remain in the NF until OCCO is able to facilitate the process, then the individual will need to contact the Aging and Disability Resource Connection/County Welfare Agency and apply for MLTSS from the community. The individual will still need to enroll into an MCO to enroll in MLTSS.

4. **Does the LTC-2 form need to be generated and sent to OCCO when a NF resident in a NJ FamilyCare MCO has requested a transfer to another NF?**

- If the resident is already enrolled in an MCO, the MCO is always the primary point of contact for the provider. The MCO should be contacted regarding the member's request to transfer. Upon admission to the new NF, the receiving facility would submit a LTC-2 form to OCCO in accordance with N.J.A.C. 8:85. However, if the resident is FFS Medicaid, then the sending NF would have the resident/responsible party forward a letter to OCCO requesting a transfer to another NF.

5. **Who should the residential provider notify if they have a new Medicaid resident move into its facility?**

- The provider should notify the CWA associated with the case. For example if an Ocean county member moves to a facility in Burlington County, the facility should contact Ocean County CWA to insure continued eligibility for the *member. If the CWA is not notified, the member could lose benefits.*

OFFICE OF COMMUNITY CHOICE OPTIONS (OCCO)

1. **OCCO is supposed to assess individuals admitted with an E-ARC for MLTSS after 60 days if a member is not enrolled in an MCO. Does this mean that one can be enrolled into MLTSS without being enrolled in a MCO?**

- *MLTSS enrollment often occurs one month before MCO enrollment. FFS covers expenses as appropriate until the MCO enrollment occurs. Not all MLTSS services are available through FFS.*

2. **I'm experiencing delays in getting clinical assessments completed by OCCO. Who can I contact?**

- Any issues pertaining to OCCO Field Office operations should be directed to the OCCO Regional Manager. The Northern Regional Office and can be reached at 732-777-4650. The Southern Regional Office and can be reached at 609-704-6050

3. **The NFs have been advised that MLTSS assessments by MCOs are restricted in the first 20 days of admission. Why is it 20 days?**

- MLTSS eligibility should not be determined during a rehabilitation period. Rehabilitation services are a state plan benefit and do not require MLTSS enrollment to be covered by an MCO. Exceptions can be made to conduct the clinical assessment sooner than the completion of rehab benefits, for example, if the individual is seeking discharge to the community and requires services that can only be obtained through the MLTSS benefit package.

4. **When a patient is approved by NJ FamilyCare, but not yet enrolled in a MCO, how can we start the process to get them home with MLTSS?**

- OCCO facilitates discharge to home prior to enrollment in an MCO. Contact the Regional OCCO office for assistance.

5. **Providers were informed that the Northern Regional Office merged with the Central Regional Office. Is this the case?**

- There are two field offices, but due to volume, three email addresses are utilized for submission of the LTC-2s.

6. **Are Notification of Admission (LTC-2) forms required for all NF admissions?**

- Yes, the Notification of Admission Form (LTC-2) is used to notify OCCO of admission for current or potentially eligible NJ FamilyCare beneficiaries regardless of MCO enrollment.

7. **The 30-day gap in NJ FamilyCare MCO enrollment delayed a resident from going home in a timely fashion. They were fee-for-service (FFS) Medicaid during May but did not get enrolled in an MCO until June. Is there any way to prevent such a delay?**

- Residents do not require NJ FamilyCare MCO enrollment for discharge, although access to certain community services are limited in a FFS system. OCCO continues to facilitate transitions with the NF social worker and request the NJ FamilyCare MCO enrollment prior to discharge.

OPERATIONS

1. **How often do the long-term care facilities need to provide documentation under MLTSS to the MCOs?**

   The MCOs are required to conduct a face to face visit twice annually and participate on one NF IDT annually. Additionally, there may be documentation requirements related to the prior authorization process. . The MLTSS contract parameters between the MCOs and the Division of Medical Assistance and Health Services outline the standards to be followed for all MCOs.

2. **Please explain how the MCOs coordinate behavioral health services for MLTSS residents of ALs, NFs, and SCNFs under MLTSS?**

- The NJ FamilyCare MCOs will cover behavioral health services for MLTSS like they handle other specialty care for their members in long-term care facilities who need to visit specialists, i.e. podiatrists, pulmonologists and oncologists.

3. How is pharmacy processed for AL?

- The prescriptions will be filled according to the NJ FamilyCare MCO program's formulary (list of medications). For specific information regarding prescription coverage, the resident will need to contact the Member Services department phone number on the back of his/her MCO Member ID card.
- Medicare Part D benefits are not affected if the resident remains in traditional Medicare and a Medicare Part D Drug Plan, and is enrolled in a NJ FamilyCare MCO.

4. Is supplementation in AL allowed?

The Division of Aging Services (DoAS) updated the Operational Procedures for AL Supplementation on November 1, 2015. The program instruction and procedures are posted as a single document at http://www.state.nj.us/humanservices/doas/home/policy.html. Any supplementation paid to an Assisted Living facility for room and board must be considered as in-kind income to the member and may impact the member's financial eligibility for NJ FamilyCare. Since in-kind income is included in the member's cost share that is paid to the facility, the facility may receive less than the amount due on the Personal Responsibility (PR-2) form. The PR-2 form will be amended with a new row for in-kind support to be added to the total gross income.

5. **What is the NF responsible for when admitting a patient from an acute hospital?**

The NF is responsible for determining if the patient is enrolled in an MCO. If the individual is enrolled in an MCO, the NF is responsible for obtain authorization from the MCO. If the individual is NJ FamilyCare (fee for service) or pending NJ FamilyCare eligibility, the NF is responsible for obtaining an EARC authorization. Upon admission, the NF must submit an LTC-2 referral from to DoAS/OCCO.

6. How often do the care managers from the MCOs meet with NF and SCNF residents enrolled in MLTSS?

- The timing of care management meetings with long-term care facility residents depends on a variety of factors, including the individual resident's clinical needs, the MCO's care model and the MLTSS contract parameters between the MCOs and DHS.
- The contract stipulates a minimum of every 180 days for NF and Non-pediatric SCNF and every 90 days for Pediatric SCNF.

7. For pediatric patients, is a positive Level I PASRR screen required to be sent to the Division of Developmental Disabilities (DDD)?

- Yes, any individual who has a positive Level I is required to have the PASRR Level II completed by the applicable agency. DDD is the Level II authority for positive Level I DDD screens regardless of the individual's age.

8. How does the care management take place for MLTSS enrollees?

- All MLTSS beneficiaries have a care manager assigned to them by the MCO. The care manager visits with NJ FamilyCare residents in the long-term care facilities and evaluates the resident's service and care coordination needs every 180 days and as the individual's care needs change;
- Help the resident to develop a plan of Care (POC);
- Help the resident to select and arrange his/her services;
- Work with the resident and his/her doctors to ensure that all needed medical and dental visits and screenings take place;
- Assist with service problems or concerns, and
- Assist with the managed care plan's participant rights.
- MCO Care Managers are required to participate in one NF interdisciplinary team (IDT) conference per year

9. **Will DoAS/OCCO assess Special Care Nursing Facility (SCNF) eligibility on site in acute hospitals?**

- Yes, if the individual meets the Pre-Admission Screening criteria and eligibility for the SCNF and the individual is not enrolled in an MCO, then DoAS/OCCO will conduct an on-site assessment. The exception is for ventilator SCNFs as they can be authorized through the EARC process.
- Note**:** If the individual is enrolled in an MCO, the MCO is responsible for conducting the authorization for Behavioral SCNF. These individuals are not to be referred to OCCO.]

TRANSITION FROM FEE FOR SERVICE APPROVAL TO MANAGED CARE

1. **What is the process for providers to submit claims if the member is eligible for Medicaid and approved for Medicaid services but not enrolled in a MCO?**

- Molina will process fee for service (FFS) claims and issue payment for members who are approved for Medicaid and approved for Fee for Service Medicaid services but not enrolled in an MCO. Refer to the NJMMIS website for instructions regarding claim submission.

2. **If an individual is determined to be eligible for MLTSS, what services are they eligible to receive?**

- Members enrolled in MLTSS are eligible to receive state plan medical services included in the Plan A Benefit Package as well as services included in the MLTSS Service package.

http://www.state.nj.us/humanservices/dmahs/home/MLTSS_Service_Dictionary.pdf

- **If an NJ FamilyCare member does not meet clinical eligibility for MLTSS, are they eligible to receive home and community based services, if needed?**
- A member enrolled in a Medicaid Plan A as part of their State Plan benefit is eligible for Home Health Care-Non-Rehab, Home Health Care-Rehab, Personal Care Assistant and Medical Day Care- Adult.

- Refer to https://www.njmmis.com/downloadDocuments/23-20.pdf for full description of State Plan services for NJ FamilyCare members.

3. If a members changes his/her MCO what guarantees the authorization from the new MCO? How much time does the provider have to get a new authorization?

- Continuity of Care guidelines apply if an existing plan of care has been established for the member, however the provider is required to check eligibility on a monthly basis and contact the MCO for prior authorization.
- Approved services for the existing plan of care will be reimbursed until a new plan of care is established.

FEE-FOR-SERVICE (FFS) MEMBER TRANSITION TO MLTSS FOR CUSTODIAL FFS MEMBERS

1. Explain the triggers, which would cause a Medicaid eligible individual with a valid EARC or PAS in a NF or a SCNF before July 1, 2014 (who is considered NF EXEMPT and not eligible for MCO enrollment) to move into MLTSS?

- The triggers are as follows:

a) A change in a resident's level of care, meaning the resident is transitioning from a NF to a SCNF; transitioning from a SCNF to a NF, or transitioning from a SCNF to a different kind of SCNF (i.e. behavioral to vent);
b) A change in a NF/SCNF provider, meaning a resident was admitted to the hospital from the NF and subsequently discharged and admitted to a different NF; or the resident was transitioned from one NF to a different NF;
c) New admission to MLTSS, meaning the individual is transitioning from the NF to the community and eligible for MLTSS; or is a new NF admission for NJ FamilyCare;
d) New individual to NJ FamilyCare and eligible for MLTSS, meaning the individual is newly eligible for NJ FamilyCare and needs custodial care in a nursing home. (Note: A change from the Medically Needy program to NJ FamilyCare will trigger enrollment into MLTSS if individual meets clinical eligibility criteria.)
e) A change from rehabilitation to custodial care (regardless of when admission to the NF occurred), meaning that an individual's Medicare benefits are exhausted after July 1 and the individual is determined to need custodial care.
Note: If a member is custodial FFS prior to July 1, 2014 and uses the Medicare benefit for an acute or skilled service this is not a trigger for change in a members Medicaid enrollment.

2. Why are there residents who are now getting enrolled in an MCO yet was custodial care on Medicaid in the NF prior to July 1, 2014?

- A member's eligibility may change if there is an update to the PAS record. If member does not meet the triggers identified for change to MLTSS, the provider should contact DMAHS account coordinators office at MAHS.ManagedCare@dhs.state.nj.us to request disenrollment. The request must be submitted to the DMAHS Account Coordinators office within 60 days of enrollment. If claims are paid for the recipient by the MCO the member cannot be diserolled from the MCO.

RESOURCES FOR NJ FAMILYCARE MLTSS PROVIDERS

1. **Are MLTSS resources available on the NJ Department of Human Services' website?**

- Yes. The MCO contract is posted on line at http://www.state.nj.us/humanservices/dmahs/info/resources/care/
- The following link will connect you to the individual NJ FamilyCare MCO websites. Also included are phone numbers for the Member and Provider Relations units at the MCOs. It is http://www.state.nj.us/humanservices/dmahs/info/resources/hmo/.
- The following link includes MLTSS Information for Consumers and Stakeholders: http://www.state.nj.us/humanservices/dmahs/home/mltss_resources.html

2. **Who are the MLTSS contacts at DHS?**

DHS	***MLTSS Contacts***
Division of Disability Services Care Management Hotline	1-888-285-3036
NJ FamilyCare Member/Provider Hotline	1-800-356-1561
NJ FamilyCare Health Benefits Coordinator (HBC)	1-800-701-0710
NJ FamilyCare Office of Managed Health Care, Managed Provider Relations	MAHS.Provider-inquiries@dhs.state.nj.us