Managed Long Term Services and Supports (MLTSS): A Focus on Nursing Facility

NJ Department of Human Services

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NJ Department of Human Services Representatives

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Goals of Training

Provide an Overview of the following key areas:

- Identification of clinical needs and eligibility
  - NJ's Clinical Assessment
  - Nursing Facility Level of Care
  - PASRR
- Care Planning Process
  - Role of the MCO Care Manager
  - Discharge Planning & Transitions
- Financial Eligibility
  - Determining eligibility
  - Redeterminations
  - PR-1
  - QIT Resources
- Provider Responsibility
  - Check Member Eligibility
  - Claims Submission

NJ FamilyCare – MLTSS Program

- Managed Long Term Services and Supports (MLTSS) refers to the delivery of long-term services and supports through New Jersey Medicaid's NJ FamilyCare managed care program. MLTSS uses NJ FamilyCare Managed Care Organizations (MCOs) to coordinate all services.
- MLTSS can be provided in the following settings:
  - Private Home/Apartment
  - Subsidized Housing
  - Assisted Living Type Facilities
    - ALR
    - CPCH
    - ALP
    - AFC
  - Nursing Facility
  - Special Care Nursing Facility

interRAI Home Care Assessment Tool

- The Home Care is one of the interRAI assessment suite of tools designed by an international group of clinicians & researchers.
- The NJ Choice is a modified version of the interRAI Home Care, version 9.1. It is often referenced as the NJ Choice HC.
- The Home Care is one of a series of integrated assessment tools used to identify an individual's needs, strengths and preferences.
- It includes clinical assessment protocols(CAPS) which guide individualized care plans and services.
  - The POC is a person-centered process

NJ Choice HC Assessment Tool

All individuals seeking MLTSS must meet NJ's Nursing Facility Level of Care (NF LOC). The NJ Choice Home Care (HC) assessment tool is utilized to determine eligibility for NF LOC. The NJ Choice HC is a comprehensive assessment tool that captures information in the following areas:

- Demographics
- Cognition
- Communication and Vision
- Mood, Behavior, and Psychosocial well-being
- Functional Status and Continence
- Disease and Health Conditions
- Oral, Nutrition, and Skin Status
- Medications
- Treatments and Procedures
- Social Supports
- Environmental

NJ Choice HC Assessment Tool

- NJ Choice HC Assessment Tool – 8 page comprehensive assessment
- Narrative – documents overall picture of individual
- Service Authorization (OCCO, ADRC, PACE) – identifies level of care
- Clinical Assessment Protocols (CAPS)
- Interim Plan of Care (IPOC)/Consumer Planning Worksheet with Narrative – outlines Options Counseling and Service Options discussed

NJ Choice HC Assessment Tool

Who conducts the NJ Choice Assessment?

- Office of Community Choice Options (OCCO)
- Program of All-Inclusive Care of the Elderly (PACE) Organizations
- Aging & Disability Resource Connections (ADRC)
  - 3 designated counties- Warren, Gloucester & Atlantic
- NJ Family Care Managed Care Organizations (MCO)

Assessments conducted by entities other than OCCO are reviewed and Authorized by OCCO.

NJ Nursing Facility Level of Care (NF LOC)

Clinical eligibility criteria for an individual to meet NJ NF LOC in accordance with N.J.A.C. 8:85-2.1 requires that individuals are "dependent in several activities of daily living. Dependency in ADLs may have a high degree of variability."

- Several is defined as three or more
- What is considered?
  - Deficits in **Cognition**
- The NJ Choice HC is a comprehensive assessment which assesses more factors than ADLs and Cognition which are all considered in the care planning process

Activities of Daily Living (ADL) Assistance Criteria

The NJ Choice assesses self care performance in each ADL within the last three days of the assessment period

- ADL Self performance- measures what the individual actually did, or was not able to do, within each ADL. Measures an individual's performance <u>NOT</u> capacity.

- The individual must require at least limited assistance or greater assist in three eligible ADLs with no cognitive deficits.

- The individual must require at least supervision or greater assist in three eligible ADLs with cognitive deficits

ADLs Eligible for NJ NF LOC:

- Eating
- Bathing
- Dressing upper and/or lower body
- Transfer toilet and/or toilet use
- Bed mobility
- Transfers
- Locomotion
  - includes both indoor and outdoor mobility

Cognitive Deficits

- Areas assessed for NJ NF Level of Care:
  - Cognitive Skills for Daily Decision Making
    - Making decisions regarding tasks of daily life
  - Short-Term Memory
    - Ability to remember recent events
  - Making Self Understood
    - Ability to express or communicate requests/needs and engage in social conversation

What type of authorization is needed?

Individuals entering a Medicaid certified nursing facility **with the expectation** of billing part or all of their stay to Medicaid require one of the following dependent upon their insurance coverage:

Authorization	Entity Responsible	Who is Eligible
Enhanced At Risk Criteria (EARC)	Acute Care Hospital Discharge Planner (with Authorization by OCCO)	• Medicaid Eligible without MCO • Potentially Medicaid Eligible
Pre-Admission Screening (PAS)	OCCO (on-site assessment)	• Medicaid Eligible without MCO • Potentially Medicaid Eligible
NJ Family Care MCO Authorization	MCO	• NJ Family Care MCO Enrollees • MLTSS MCO Enrollees

Individuals who do not expect to become Medicaid eligible during their stay in the nursing facility **do not require** any of the above. They may require authorization dependent upon their non-Medicaid insurance coverage.

Enhanced At Risk Criteria (EARC)

EARC is a screening tool utilized to establish clinical eligibility for Nursing Facility placement or Ventilator SCNF placement for non-MCO individuals identified as needing Medicaid coverage during the NF stay.

- Individuals in NF/SCNF as a FFS Medicaid Recipient with valid PAS/EARC as of 7/1/14 **are not** required to reestablish clinical eligibility for hospitalizations with a return to the **same NF.**
  - **Hospital Discharge planners should be alerted not to request an EARC on these individuals**.

EARC allows the NF or Ventilator SCNF to bill NJ Family Care Fee for Service (FFS) for up to 90 days.

EARC is completed by a Certified NJ Acute Care Hospital employee (Discharge Planner, Care Manager, etc)

Enhanced At Risk Criteria (EARC)

- EARC serves as an authorization/clinical eligibility for up to 90 days for nursing facility or Ventilator SCNF stay for individuals discharged from an acute care hospital directly to a Medicaid certified NF/Vent SCNF.
  - EARC does not establish MLTSS eligibility
- If the individual continues in the NF past 60 days and is not MCO enrolled, OCCO will conduct a PAS to determine MLTSS eligibility.
- Upon completion of financial eligibility for Medicaid, a NJ Family Care MCO will be selected or auto-assigned.
  - Upon enrollment, the MCO is responsible for authorization of NF placement and any other Medicaid services including assessment for Managed Long Term Services and Supports (MLTSS).

Pre-Admission Screening (PAS)

- PAS is an in-person assessment conducted by OCCO to determine NF LOC for individuals seeking long term services and supports.

- PAS establishes eligibility for all long term services and supports including:
  - Nursing Facility – acute or custodial
  - Special Care Nursing Facility (SCNF) – Behavioral, TBI, AIDS, Huntingtons, Ventilator, Pediatric, Neurologically Impaired
  - Assisted Living and Community Residential Services (TBI)
  - Home and Community Based Services (MLTSS)

- PAS is completed for individuals seeking NJ Family Care who are not MCO enrolled.

OCCO vs. MCO Assessment – What's the difference?

- OCCO (or ADRC) conducts assessments for individuals not currently enrolled in NJ FamilyCare (New to Medicaid)
- MCOs are conducting assessments for individuals already enrolled in NJ FamilyCare and who request or may benefit from MLTSS
- OCCO Reviews the MCO assessment and makes a determination
  - Authorized for MLTSS
  - Not Authorized - requires OCCO to conduct an in-person reassessment, at which point a final determination is made – Approved/Denied.
- MCO conducts yearly reassessment with OCCO review for continued MLTSS clinical eligibility
- MCO also utilizes the NJ Choice to determine eligibility for Medical Day Care services which is a State Plan benefit outside the MLTSS program

NJ Family Care Managed Care Organizations

- Effective July 1, 2014, individuals admitted to a NF are auto-enrolled into a NJ Family Care MCO.
  - If an individual was admitted pre-July 1, 2014 but has financial and/or clinical eligibility established after 7/1/14 is also enrolled into an MCO.
- NF services is a covered state plan benefit for NJ Family Care members
- The NJ Family Care MCO is responsible for authorization and payment of individuals from the date of admission through discharge
- NF Custodial Care is defined as non-rehabilitative with no reasonable expectation of discharge. Once a NJ Family Care member reaches this level, an assessment for MLTSS should be initiated by the MCO.
  - The MCO is responsible for custodial care payment regardless of MLTSS status.

Managed Care Organization Contract

The NJ Family Care Organizations enter into a contract biannually with the Department of Human Services, Division of Medical Assistance and Health Services

4.1.2 BENEFIT PACKAGE

- A. The following categories of services shall be provided by the Contractor for all Medicaid and NJ FamilyCare A, B, C and ABP enrollees, except where indicated. See Section B.4.1 of the Appendices for complete definitions of the covered services.

  - 26. Nursing Facility Services (NF) – shall be a covered benefit for all Medicaid/NJ FamilyCare A Members, and for any NJ FamilyCare ABP Members who meet the Medically Frail standard and elect LTC services. For NJ FamilyCare ABP Members who do not meet Medically Frail or do not elect LTC services, the Contractor is responsible for inpatient rehabilitation and hospice services only. The Contractor shall be financially responsible for all Nursing Facility services for NJ FamilyCare A Members and those eligible services for NJ FamilyCare ABP Members from the date the Member enters the Nursing Facility to the date of discharge. Special Care Nursing Facilities (SCNF) residents currently receiving NJ FamilyCare through Fee-for-Service will convert to Managed Care on July 1, 2016.

http://www.state.nj.us/humanservices/dmahs/info/resources/care/

Pre-Admission Screening Resident Review (PASRR)

PASRR Level I screening and Level II determination (if applicable) is a federal requirement for all individuals seeking nursing facility admission regardless of payer source.

A Level I negative screen indicates an individual does not require specialized services through the Division of Mental Health and Addictions (DMHAS) or the Division of Developmental Disabilities (DDD) and they may enter a nursing facility.

A positive Level I screen requires a Level II determination prior to admission to a NF.

- Individuals expected to stay fewer than 30 days may receive a physician exemption
- It is the responsibility of the NF to identify those who stay beyond the 30 days and refer for the Level II Resident Review prior to the 40th day from admission

PASRR

The NF is responsible to keep all Level I screens and Level II determinations in the resident medical record

The State is in the process of evaluating reporting mechanisms and quality audits to ensure compliance

LTC-2 Notification of Admission

The Notification of Admission Form (LTC-2) is used to notify OCCO of admission for current or potentially eligible Medicaid beneficiaries

- The LTC-2 prompts a clinical assessment while the financial eligibility is being processed for those who are in the application process and not yet MCO enrolled
  - EARC is designed to eliminate the need for an on-site PAS upon admission to a NF

- Individuals who are MCO enrolled:
  - Check off "Notice of Admission" for Type of request
  - Check off "MCO" in Section I and indicate which MCO
  - Do not fill out Section IV (Request for PAS)
    - The MCO is responsible for the Authorization and Assessment

- The LTC-2 serves as the facility's identification of need for Medicaid Billing and notification to the State in accordance with regulation N.J.A.C. 8:85
  - Email is the preferred delivery method of LTC-2
  - Faxing – save the fax confirmation sheets with the cover page photo as proof of submission

New Jersey Department of Human Services
Division of Aging Services
NOTIFICATION FROM LONG-TERM CARE FACILITY
ADMISSION OR TERMINATION OF A MEDICAID BENEFICIARY

Type:
☐ Request PAS
☐ Notice of Admission
☐ Notice of Termination
☐ Notice of Transfer

I. PATIENT INFORMATION

1. Name: ________ (Last) ________ (First)
2. Social Security No.: ____ - ____ - ____
3. Sex: ☐ Female ☐ Male
4. Date of Birth ___ / ___ / ___

5. HSP# (Medicaid) Case No. if applicable: ________

Confirmed By (CWA): ________ ☐ NJ Family Care ☐ MLTSS ☐ MCO ________

II. PROVIDER INFORMATION

1. Provider Number: ________
2. LTCF Name: ________
3. Address: ________
4. City, State, Zip: ________
5. Provider Phone #: ________
6. ☐ SCNF: ________

III. PASRR STATUS (COMPLETE FOR ALL NEW ADMISSIONS)

1. Date of PASRR Level I ___ / ___ / ___
2. Outcome of PASRR Level I Screen – For Positive Screens Check all that Apply
   - ☐ Negative
   - ☐ Positive: ☐ MI ☐ ID/DDD ☐ MI and ID/DDD ☐ 30-Day Exempted Hospital Discharge ☐ Categorical
3. If Positive, Date of PASRR Level II Evaluation: ___ / ___ / ___

   Outcome of PASRR Level II Evaluation - Client Needs Specialized Services: ☐ Yes ☐ No

IV. REQUEST FOR PAS

☐ Private to Medicaid ☐ SCNF to NF ☐ Transfer
☐ PAS Exempt >20 Days ☐ NF to SCNF ☐ E-ARC PAS
☐ Medicare to Medicaid ☐ Out of State Approval Admission ☐ Other: ________

V. ADMISSION INFORMATION

1. Admission Date: ___ / ___ / ___
2. Date of PAS, if applicable: ___ / ___ / ___
3. Admitted from: ☐ Community/Boarding Home ☐ Psychiatric Hospital
   - ☐ Private to Medicaid - Anticipated Medicaid Effective Date: ___ / ___ / ___
   - ☐ Hospital ☐ Other LTCF ☐ Other ________
4. Name of Hospital/LTCF: ________ Admission Date: ___ / ___ / ___

   Address: ________
5. If admitted from Hospital/LTCF, give the name/address of previous residence (Hospital Name and Address or Home Address): ________

VI. TERMINATION INFORMATION

1. Discharge Date: ___ / ___ / ___
2. Discharged to:
   - ☐ Home-Community (including relative's home)/ County of residence: ________
   - ☐ Facility Name: ________ County of NF: ________
   - ☐ Other (specify): ________ County of Residence: ________

   Telephone Number of Discharge Site: ________
3. Death (Date): ___ / ___ / ___ ☐ In LTCF ☐ In Hospital

VII. CERTIFICATION: The facility certifies that the patient will reside only in those areas of the facility which are certified for participation in the New Jersey Medicaid Program at the level of care authorized for this patient by the New Jersey Medicaid Program. The facility also certifies that upon discharge to a hospital, the patient's room/bed will be reserved for the full period of time covered by the New Jersey Medicaid Bed Reserve Policy. If nursing facility bills Medicaid for long term care services, the person signing this form certifies that the facility has a valid PAS on file. **This form completed by:**

Name: ________ Phone Number: ________

LTC-2 Notification of Admission

- Northern Regional Office – csessexltcfo@dhs.state.nj.us
  - Bergen, Essex, Hudson, Morris, Passaic, Sussex, Warren
- "Central Regional Office" – csmiddlesexltcfo@dhs.state.nj.us
  - Hunterdon, Middlesex, Monmouth, Somerset, Union
- Southern Regional Office - csatlanticltcfo@dhs.state.nj.us
  - Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Ocean, Salem

NF Resident FFS to MLTSS Triggers

A presentation on individuals in NFs prior to 7/1/14 with Medicaid eligibility are exempted from MCO enrollment unless a trigger event occurs.

The presentation is available at the following links:

- http://www.state.nj.us/humanservices/dmahs/home/mltss_resources.html
- http://www.state.nj.us/humanservices/dmahs/home/MLTSS_Overview_July%20_15th_2014.pdf

Person Centered Planning

Options Counseling &Discharge Planning

Identifying Long Term care goals and Discharge Planning

Individuals admitted from an acute care hospital stay are generally eligible for rehabilitative services to regain their prior level of functioning following an acute care episode.

Determination of MLTSS eligibility for individuals in sub-acute rehab is a proactive process by which individuals can be safely and effectively transitioned to a community setting.

The initiation of the EARC as a 90 day screening tool allows individuals to begin to meet their rehab goals before MLTSS eligibility is determined. This aids in identifying the long term care needs and the level of services that will be needed to support the individual in the least restrictive environment.

Assessment of MLTSS Needs

- The NJ Choice is conducted to determine MLTSS eligibility for individuals in a Nursing Facility when the below guidelines are met:
-
- Individual has received at least 20 days of rehabilitation under any payer source.
- Upon the 21st day, discharge planning discussions and identification of long term care needs should begin if not already initiated. Options Counseling is an ongoing process that can occur at any time and should begin upon hospitalization.
- The NJ Choice Assessment should be initiated after the 20th day for the following individuals:
  - Members seeking discharge to the community and identified as meeting MLTSS eligibility criteria upon discharge.
  - Members seeking long term nursing facility services **and** have been identified as approaching their rehab discontinuation date (within the next 7 days).

Conducting Options Counseling

- OC is conducted for all individuals assessed via the NJ Choice for NJ Medicaid Programs
- The NJ Choice HC Assessment, CAPs, individual preference and assessor's professional judgment will guide OC
  - Identification of needs and goals
  - Discussion of service options
  - Completion of Interim Plan of Care (IPOC)
- The CAPS are further utilized to guide the development of the Plan of Care for all MLTSS individuals.

Person-Centered Planning

- Focuses on the preferences and needs of the individual.
- Empowers and supports the individual in defining the direction for his/her life.
- Promotes self-determination and community involvement.

Section Q

Under Section Q, nursing facilities must now ask residents directly if they are interested in learning about the possibility of returning to the community and speaking to someone from the Local Contact Agency.

Q0500 Return to Community MDS Assessment Guidelines

- Q0500.B. – resident is asked if he/she would like to speak to someone about the possibility of returning to community.
- Family, significant other, guardian or legally authorized representative are consulted if resident is unable to communicate preferences.
- Q0600.0.-3. – referral made to LCA, YES or NO response
  - Q0600.2. YES – make LCA referral
  - Q0600.0. NO – resident and care planning team decide that contact is not required – OR –
  - Q0600.1. NO – referral not made for some reason even though resident and care planning team decide that the LCA needs to be contacted
  - If responding NO, there should be documentation why referral was not made

Custodial Care vs Discharge to Community

NF Social Workers are responsible for identifying discharge plans for their residents. This is an ongoing process as the individual's needs change.

MCOs are responsible for a NF to Community Transition plan to proactively address the discharge needs of members placed in a NF/SCNF.

The State's goal is to maintain individuals in the least restrictive setting to meet their long term care needs.

Individuals in need of custodial care should be assessed for MLTSS.

Individuals seeking discharge to the community may or may not be eligible for MLTSS.

Care Planning Process

MLTSS

Role of the MCO Care Manager (MCO CM)

Individuals enrolled in MLTSS receive coordination of care through a Managed Care Organization Care Manager (MCO CM)

- The Care Manager shall be responsible for coordination of the individual's physical health, behavioral health, and long term care needs.
- They will visit the individual at least bi-annually.
- Monitor services, as specified in the Plan of Care.
- Meet with facility/program staff to revise POC as necessary.
- Complete a NJ Choice Assessment annually to determine continued clinical eligibility (NF LOC).
  - Reviewed by OCCO.
  - Approval letter issued to MCO who is responsible for submitting to the Member and Provider (if applicable)

The MCO Plan of Care

- An agreement to ensure that the health and related needs of the individual are clearly identified, addressed, and reassessed.
- At a minimum, the POC shall be based upon:
  - Assessed ADL need,
  - The face-to-face discussion with the individual that includes a systematic approach of the individual's strengths and needs.
  - Recommendations from the individual's primary care provider (PCP), and
  - Input from service providers, as applicable.
- Identify:
  - unmet needs,
  - informal supports, and
  - individual's personal goals.

The MCO Plan of Care (continued)

- In addition to the required elements as defined in section 9.2.2.B of the MCO contract, the plan of care, at a minimum, shall document;
  - Each service to ensure that the frequency, duration or scope of the services accurately reflects the Member's current need and updates the plan of care as necessary.
  - Indicates whether the Member agrees or disagrees with each service authorization and signs the plan of care at initial development, when there are changes in services and at the time of each review (every 180 calendar days).
  - A copy of the plan of care shall be provided to the Member and/or authorized representative and maintained in the Member's electronic Care Management record.

Transition to the Community

NF Transitions

In coordination with the NF Social Worker, OCCO or the MCO is responsible for assisting in the transition of individuals to less restrictive settings as requested/identified.

- Community Choice Counselors from OCCO collaborate for:
  - All Money Follows the Person (MFP) Transitions
  - Discharge planning for non-MCO residents
- NJ Family Care MCOs collaborate for:
  - Discharge planning for MCO members

NF Transitions

Upon identification of a discharge plan to the community, a NJ Choice assessment is conducted to determine eligibility for MLTSS.

- If no Medicaid or MCO enrollment, OCCO will conduct the assessment
  - If the individual is Medicaid eligible, the MLTSS eligibility will trigger MCO enrollment
  - An IDT will be scheduled with the MCO, OCCO, and the NF upon MCO enrollment
    - An IDT is not mandatory prior to discharge, but Medicaid services may not be easily accessible upon discharge
- If MCO enrolled, the MCO Care Manager will conduct the assessment
  - The IDT will be scheduled with the MCO and the NF
    - OCCO will participate if MFP
    - A person centered care plan will be created and services arranged upon discharge

What is Money Follows the Person (MFP) I Choose Home NJ (ICH)?

- Nationwide initiative created by the Federal Government known as the Money Follows the Person Demonstration Project.
  - NJ's MFP Program is called I Choose Home NJ.
- Helps low-income seniors and individuals with disabilities transition from institutions to the community that meet the following criteria:
  - Sign an informed consent;
  - Reside in an institution for 90 consecutive days or more;
  - Eligible for Medicaid 1 day prior to transition;
  - Transition to a "qualified residence";
  - Is eligible for MLTSS on day 1 of discharge.
- Savings resulting from individuals residing in the community allows states to develop more community based long term care opportunities.

MFP/ICH Transitions

- The Division of Aging Services, Office of Community Choice Options has an Associate Project Manager and 7 dedicated MFP/ICH Liaison positions.
- They are the Division's subject matter experts on Nursing Facility Transitions.
- They conduct Options Counseling for Section Q referrals, follow up on NF residents interested in transitioning, assessments on spend down and Fee for service individuals, and conduct in-services for Nursing Facilities.

MFP Transition Process

MFP Eligibility Criteria:

- Sign an informed consent for MFP;
- Meet clinical and financial eligibility for MLTSS;
- Reside in a Nursing Facility for 90 days or more at time of discharge;
- Complete a Quality of Life Survey
- Transition to a MFP qualified Community Setting;
- Eligible for MLTSS on day of discharge.

MFP Transition Process

The MCO Care Manager's Role:

- Identify Members who have been in the Nursing Facility for 2 months or more and are interested in transitioning to a qualified Community Setting.
- Complete a NJ Choice Assessment System
- Complete MFP Eligibility Screening tool (MFP- 77), and submit all assessment information and forms to the appropriate OCCO Regional office.
- OCCO MFP Liaison and/ or OCCO designated staff (ODS) review assessment for eligibility.

MFP Transition Process

- Schedule Transition IDT with OCCO MFP Liaison or ODS, NF staff (Social Worker, Unit RN, Physical Therapy and other staff as needed) Member, family and/or Responsible party as appropriate.
- OCCO MFP Liaison completes the Quality of Life Survey and serves as the subject matter expert.
- Identify Transitional Service Needs:
  - On site home visit
  - Furniture
  - Household Goods (microwave, sheets, towels, pots, pans, silverware, pillows, etc.)
  - Clothing
  - Food (enough for at least a week)
  - Security Deposit
  - Utility Deposit

Financial Eligibility: County Welfare Agency (CWA)

Overview:

- Application process
  - Income and Resources
  - Documents and Verifications
- QIT links to Resources
- Post-eligibility Treatment of Income
- Redeterminations

Application Process

- It is important that potentially eligible individuals contact the County Welfare Agencies and submit an application for Medicaid.
- An individual can apply for Medicaid up to 2 months prior to spending down their resources.
- The County Welfare Agency has 45 days to process a case for an individual 65 years or older and 90 days for an individual in need of a disability determination.
- Applicants must supply documents in a timely manner. If they are having difficulty in obtaining documentation, then they should contact the Agency to ask for an extension of time. It is important that the applicant and the Agency keep an open line of communication.

Income and Resources

- If an individual's NJ Choice Assessment verifies that they are in need of an institutional level of care, they qualify for a higher income standard. In 2015 that institutional income standard is $2,199 per month. Their resources must be less than $2,000.
- According to federal regulations the CWA must do a five year look-back for transfers of assets for less than fair market value. If a transfer is found, the CWA will impose a penalty period which begins when the individual is found to be otherwise eligible.
- If the total gross income is at or below 100%FPL ($981 per month in 2015) the individual can submit a self-attestation form, which states that they did not transfer any resources in the past five years. This allows the County Welfare Agency (CWA) to forgo the 5 year look back and process the case.
- Individuals whose income is over the 100% FPL cannot self-attest to transfers and must supply documentation for the look back period.

Documents and Verifications

- The next slide is a listing of items an applicant should be gathering to provide verification for Medicaid eligibility requirements such as proof of age, income, resources, citizenship, residency, marital status and more.
- This information can also be found at the following links:

www.state.nj.us/humanservices/dmahs/clients/medicaid/abd/abd_fact_sheet.pdf

www.state.nj.us/humanservices/dmahs/clients/medicaid/what_you_need_to_know_medicaid.pdf

- Some information can be verified electronically, Example- If an individual loses their Medicare card, the Agency caseworker can access a database and print out the information for the case record. There would be no need for the individual to contact the Social Security Office for a letter to verify the information.

Medicaid Program
Check List

This is the type of information that you will need to bring with you when applying for Medicaid. The more information you are able to provide the faster your Medicaid application can be processed.

1. Proof of Age:
One of the following documents should be provided to verify your age:

- ☐ US Passport
- ☐ Birth Certificate
- ☐ Driver's License
- ☐ Baptismal Certificate
- ☐ Other______________

2. Proof of Citizenship:
One of the following documents should be provided to verify your citizenship:

- ☐ US Passport
- ☐ Birth Certificate
- ☐ Naturalization Papers
- ☐ Alien Registration Card
- ☐ Voter's Registration Card
- ☐ Medicare Card
- Other_______________

3. Marital Status:
One of the following documents should be provided to verify your marital status:

- ☐ Marriage Certificate
- ☐ Separation Papers
- ☐ Divorce Decree
- ☐ Spouse's Death Certificate
- ☐ Other___________

4. Income
In order to verify your **Income**, please provide copies of all that are applicable:

- ☐ Most recent pay stubs
- ☐ Social Security Award Letter
- ☐ Railroad Retirement Letter
- ☐ Temp. Disability Check or Award Letter*
- ☐ Pension Checks
- ☐ Unemployment Notification
- ☐ Workers Comp.Notification
- ☐ Support/Alimony Checks or Court Order
- ☐ VA Award Letter
- ☐ Reparation Payments
- ☐ Payments from Boarders
- ☐ SSI Award Letter
- ☐ Dividend Checks
- ☐ Federal Income Tax Returns including schedules:
  - ☐ Schedule C – Net Profit from Business
  - ☐ Schedule D – Capital Gains
  - ☐ Schedule E – Rental Real Estate
  - ☐ Schedule K-1- Partner's Share of Income
- ☐ Other_______________________________________

5. Financial Resources
To provide the most accurate picture of your **Financial Resources**, you must provide copies of all that is applicable:

- ☐ Checking Acct. Statements
- ☐ Savings Acct. Statements
- ☐ Stocks or Bonds
- ☐ Certificates of Deposit
- ☐ Amount of Cash on Hand
- ☐ List of Valuables (jewelry, etc.)
- ☐ IRA, 401K, 403B, Keogh Accounts
- ☐ Trusts or other Financial Instruments
- ☐ Money Market Accounts
- ☐ Annuities
- ☐ Deeds to Property Owned
- ☐ Property Proceeds
- ☐ Mortgages
- ☐ Prepaid Funeral Contracts
- ☐ Christmas/Vacation Clubs
- ☐ Credit Union Shares
- ☐ Burial Plot Information
- ☐ Funds set aside for Burial
- ☐ Special Needs Trusts
- ☐ Life Insurance Policies with Cash Value Statement
- ☐ Other____

The following **Living Expenses** will be taken into account if the Medicaid recipient is placed in a nursing facility but the SPOUSE remains living in the community. Please provide copies of the following:

- ☐ Mortgage Statements
- ☐ Electric Bills
- ☐ Telephone Bills
- ☐ Outstanding Loans
- ☐ Other___________________
- ☐ Real Estate Tax Bills
- ☐ Gas / Oil Bills
- ☐ Connection Charges
- ☐ Health Insurance Bills
- ☐ Other___________________
- ☐ Rent Receipts
- ☐ Water / Sewer Bills
- ☐ Home / Renter's Insurance
- ☐ Unpaid Medical Bills (past 3 months)

Qualified Income Trust (QIT) Resources

- QITs are for individuals with income in excess of $2,199 per month and less than $2,000 in resources.
- QITs are financial devices used in conjunction with the Medicaid Only eligibility rules and have replaced the Medically Needy program for individuals in nursing facilities.

- For more information on QITs , please see the following link at: http://www.state.nj.us/humanservices/dmahs/clients/mtrusts.html

This link includes the QIT Template, Bank Letter and Frequently Asked Questions (FAQs).

Any additional questions may be emailed to DMAHS staff : MAHS.QIT@dhs.state.nj.us The questions submitted will be added to the FAQ section of the website.

Post-eligibility Treatment of Income

- After an individual is determined eligible for MLTSS, their information is entered into a Personal Responsibility form (PR-1) web application that calculates their cost of care (cost share).
- Cost Share calculations are determined by federal regulations at

  42 CFR 435.725.
- Copies of the PR-1 forms are sent by the CWAs to the NF facilities and to the Medicaid recipient and/or their representative(s).
- The post-eligibility order of income exemptions on the PR-1 include but are not limited to the following categories in the following order: Personal Needs Allowance (PNA); Community Spouse Maintenance Allowance; Family Deductions; and Health Insurance Premiums.

Redeterminations

- Medicaid financial eligibility redetermination are completed every 12 months by the CWAs.
- It is important for NFs to inform the CWAs when a Medicaid eligible resident moves to their facility or from their facility in order to ensure their eligibility continues.
- When a redetermination packet is sent to a facility, it is important for the Medicaid recipient and/or their representative to receive the packet and complete the required documentation in a timely manner. Failure to do so may result in a period of ineligibility.

CWA Contact Information

- Please contact your CWA for more information on the Medicaid financial eligibility process for MLTSS.

- CWA listing is maintained at the following link:

www.state.nj.us/humanservices/dfd/programs/njsnap/cwa/

Overview of MLTSS Provider Responsibilities

- Confirm Member Eligibility
  - Clinical
  - Financial
- Claims Submission
  - Coordination of Benefits
  - Timely Filing

Confirming Members NJ Family Care Eligibility

Provider's Requirement to Confirm NJ Family Care Eligibility

- Providers must confirm NJ Family Care Eligibility each month to ensure that member is currently enrolled
- Provider must confirm that member is enrolled in Health Plan and that they have an active authorization
- If Member has changed MCO, provider must contact existing Health Plan regarding authorization update

Responsibilities of the Medicaid Nursing Facility Provider for Private Pay Residents

- Refer private pay residents to OCCO for clinical assessment, 6 months before spend down occurs

- Refer to the County Welfare Agency (CWA) 6 months before spend down occurs by providing CWA phone number and Medicaid checklist

Options to Confirm Beneficiaries NJ Family Care Eligibility

- NJ Family Care FFS Service Enrolled Providers
  - NJMMIS-E-MEVS

- Providers not enrolled as NJ Family Care Fee for Service Provider must access individual Health Plan site for confirmation

- Note: Members will only be displayed in Health Plan site if enrolled in specific Health Plan

E-Mevs

- Providers access eMEVS through "**Login**" on the NJMMIS website www.njmmis.com
- In order to login, individual *must* have a secure username and password
- Users ids and passwords are requested through Provider Registration link on the NJMMIS navigational bar on main screen.

Search: Go

Home
Site Requirements
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Contact Webmaster
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Provider Registration

Information
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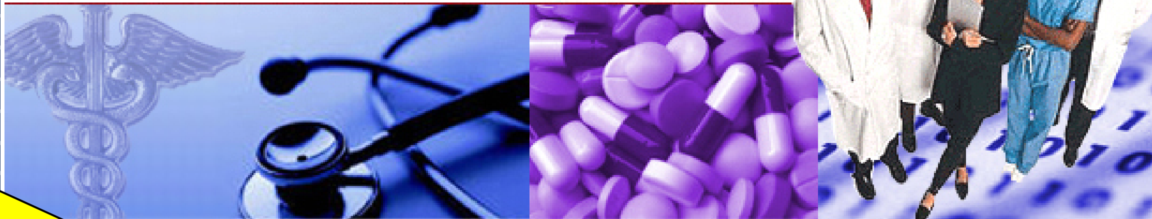
Newsletters & Alerts
NJMMIS Website Tutorial



Users access eMEVS by selecting Login

HE...
Click he... dlines

Temporary ... vider Numbers: The Division of Medic... alth Services will no longer assign temp... to pharmacy applicants.

Morato... Medicaid/... services, ... medical s... 2006 is in... unless the... necessar... Medical A... The State will continue to accept pharmacy applications to provide services to beneficiaries enrolled in Pharmaceutical Assistance for the Aged and Disable (PAAD), Senior Gold, AIDS Drug Distribution Program (ADDP) and Cystic Fibrosis.
For additional information please call Unisys Provider Enrollment at 609-588-6036.

HBID Card Program Kicks Off! The Health Benefits Identification (HBID) Card program implementation continues. All New Jersey beneficiaries will have plastic HBID cards by February 2007.

- Please click here for the newsletter and details on the program.
- Click here for Frequently Asked Questions concerning the HBID cards.

ANNOUNCEMENTS
Click here for more announcements

New Click here to access and search for New Jersey health care professional information (including physician's medical license number).

New Click here for information on the new CMS 1500 ...

Providers will be notified via future newsletters regarding when the only provider identifier that will be accepted is the NPI. Providers still must register their NPI with New Jersey Medicaid and can email their NPI information to New Jersey Medicaid by clicking here.

Internet

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Information
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Edit Codes
FAQ
Forms & Documents
Hospital Information
Newsletters & Alerts
NJMMIS Website Tutorial

Welcome to New Jersey Medicaid

Please login below.

UserName: 123456789

Password ●●●●●●●●●●●●●

Forgot your password, click here

Need a username, click here

Reset Submit

Enter your secure Username and Password

Internet

NJMMIS

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Secured Options
- CCF
- Clear Claim Connection
- eMevs
- LTC Census
- NPI
- Report Distribution
- Request Judge Run

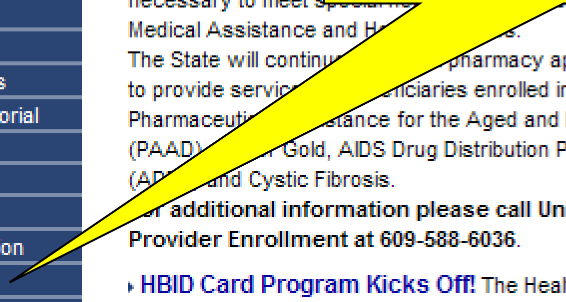
Welco ID will appear HEA, to njmmis.com. You have been authenticated.

Headlines

- **Temporary Pharmacy Provider Numbers:** The Division of Medical Assistance and Health Services will no longer assign temporary provider numbers to pharmacy applicants.
- **Moratorium Noti**... Medicaid/NJ FamilyC... services, pharmace... medical supplies, or... 2006 is ineligible for... unless their services... necessary to meet sp... Medical Assistance and H... The State will contin... pharmacy applications to provide servic... ficiaries enrolled in Pharmaceuti... stance for the Aged and Disable (PAAD)... Gold, AIDS Drug Distribution Program (AD... and Cystic Fibrosis. **...r additional information please call Unisys Provider Enrollment at 609-588-6036.**
- **HBID Card Program Kicks Off!** The Health Benefits Identification (HBID) Card program implementation continues. All New Jersey beneficiaries will have plastic HBID cards by February 2007.
  - Please click here for the newsletter and details on the program.
  - Click here for Frequently Asked Questions

Announcements

- **New** Click here for information on the new CMS 1500 form.
- **New Claim Check News!** Click here for ...nd latest information/messages.
- ...blishes National Provider Identifier (NPI) ... Providers may continue to use New ... provider numbers on all health care ... o New Jersey Medicaid for payment. ... notified via future newsletters ... he only provider identifier that will be accepted is the NPI. Providers still must register their NPI with New Jersey Medicaid and can email their NPI information to New Jersey Medicaid by clicking here.
- **New** Providers have the ability to include their NPI on their HIPAA 837 transaction. Click here for corresponding Submitter Letter.



Search: [ ] Go

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Communication
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Secured Options
- CCF
- Clear Claim Connection
- eMevs
- LTC Census
- NPI
- Report Distribution
- Request Judge Run

Welcome to the New Jersey Medical Assistance Program's Medical Eligibility Verification Service.

Enter your eligibility criteria below. Be certain to select and complete one of the following sets of criteria.

- (•) Recipient Id Number
- ( ) SSN and Date of Birth
- ( ) Name and Date of Birth
- ( ) Name and SSN
- ( ) Card Control Number and Date of Birth

Select the search method

Search By:

Service Period Begin Date: [ ]
Service Period End Date: [ ]
Recipient Medicaid ID Number: [ ]
First Name: [ ]
Last Name: [ ]
Middle Initial: [ ]
SSN: [ ]
Date of Birth: (mm/dd/ccyy) [ ]
Card Control Number: [ ]

[Reset Page] [Submit Request]

Date Format *must* include slashes 01/01/2006

Benefits of Checking Eligibility each month

- E-mevs records Provider queries electronically
- E-mevs record may provide documentation for Provider if eligibility was updated after provider confirmed monthly eligibility and claims are denied based on updated eligibility.
- **Note: If provider does not check Eligibility DHS can not assist with claims resolution that involve eligibility changes**

Updates to E-MEVS Display 2015

If the Member's Eligibility is terminating month of inquiry date, the date and an Eligibility Termination message will be displayed for the following Provider Types

- 20 - Physician
- 35 – Assisted Living
- 37 – Managed care
- 44 – Home Care/CSOC/DDD Supports/CCW
- 51 - Transportation
- 73 – Case management
- 80 – LTC facilities
- 92 – Adult day health services

Updates to E-MEVS Display 2015

The eligibility terminating message will display as follows:

- "Coverage will end on mm/dd/ccyy
- Due to: "termination code description"

  (see list on next slide)

E-MEVS Display Important Data

- Medicaid Eligibility Data
  - Termination Date –displayed if members eligibility scheduled to term month eligibility is verified
  - Termination Code Descriptions
- MCO Name –Begin Date
- Special Program Code
- Eligible Services
- Medicare Part A-Data
- TPL Information

E-MEVS
Termination Code Descriptions

00 - Recipient record closed due to death with potential of recoverable assets

01 - Recipient did not show up for a re-determination appointment

02 - Recipient voluntarily disenrolled from the New Jersey Family Care program

03 - Recipient record closed because he/she lives out of state.

04 - Recipient record closed due to duplicate eligibility segment (updated by DMAHS staff only)

05 - Recipient record closed due to death - no assets

06 - Recipient record closed due to transfer to another county

07 - Recipient record closed due to transfer to another program

08 - Recipient record closed due to ineligibility

09 - Recipient record closed for other reasons

10 - Eligibility was terminated due to newly added private comprehensive TPL coverage

11 - Recipient failed to pay their share of the insurance premium payment for Family Care

12 - HCFA program cap has been reached

13 – Recipient failed to comply with Premium Support Program stipulations

14 – Eligibility terminated due to lack of managed care enrollment

15 – recipient in LTCF

50 - Eligibility segment terminated due to change of Program Status Code

Edit View Favorites Tools Help

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https://www.njmmis.com/mevs.aspx Go

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uest Judge Run

Reset Page | Submit Request | Print Result

Results:

Last Name: ******** First Name: ******** Middle Initial:

Submitted Recipient Id #: ******** Eligible: Yes

Date of Birth: 6/27/1919 SSN:

Card Control Number:

Medicaid Eligibility Data:

Begin Date: 2/1/2007 End Date: 2/28/2007

Recipient Id # for Billing: 041072107101 Message:

Medicaid Recipient Lockin Data:

Lockin Begin Date: Lockin End Date:

Message:

Medicaid Special Program Enrollment Data:

Begin Date: End Date:

Message:

Medicaid Managed Care Enrollment Data:

MCO Name: MCO Phone Number:

Begin Date: End Date:

MCO Patient ID Number: Plan Code:

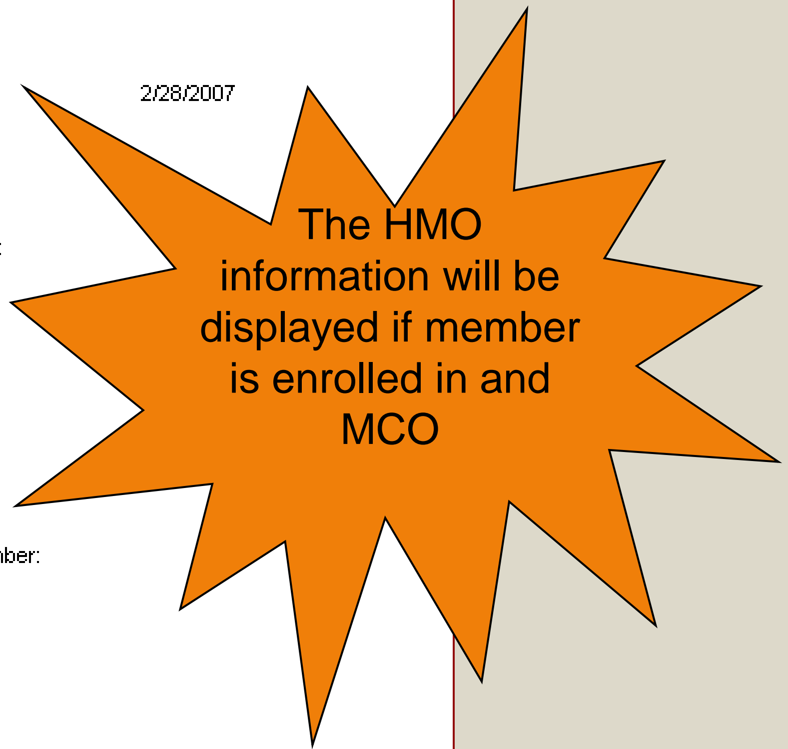
Message:

Medicare Part A Data:

Begin Date: 6/1/1984 End Date: 12/31/9999

HIC Number: ********

Medicare Part B Data:



Edit View Favorites Tools Help

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https://www.njmmis.com/mevs.aspx Go

Lockin Begin Date: Lockin End Date:

Message:

Medicaid Special Program Enrollment Data:

Begin Date: End Date:

Message:

Medicaid Managed Care Enrollment Data:

MCO Name: MCO Phone Number:

Begin Date: End Date:

MCO Patient ID Number: Plan Code:

Message:

Medicare Part A Data:

Begin Date:	6/1/1984	End Date:	12/31/9999
HIC Number:	********		

Medicare Part B Data:

Begin Date:	6/1/1984	End Date:	12/31/9999
HIC Number:	********		

Medicare Part D Data:

Start Date:	1/1/2006	End Date:	12/31/2007
Contract Number:	S5967	Plan Id:	038
Name:	WELLCARE SIGNATURE	Policy Number:	
Group Number:		NJ Insurer Code:	DWE

Commercial Third Party Coverage Data:

Begin Date: End Date:

Policy Number: Group Number:

Carrier Name: Message:

- Information
  - Approved Vendor List
  - Billing Supplements / Training
  - Recent Newsletters
  - Edit Codes
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  - Forms & Documents
  - Physician Administered
  - Rate and Code Information
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  - NJ State MAC
- Secured Options
  - Change Password
  - Change Email
  - Clear Claim Connection
  - eMevs
  - eMevs History
  - LTC Census
  - Report Distribution
  - Request Judge Run
  - EHR Incentive Program
  - Non-Billing Provider Directory
- Claims Mgmt
  - CCF
  - Submit DDE Claim
  - Adjust a Claim
  - Void Claim

SSN: | Date of Birth: (mm/dd/ccyy) | Card Control Number:

Reset Page | Submit Request | Print Result

Results as of 6/18/2015 11:10 AM:

Last Name: First Name: Middle Initial:
Submitted Recipient Id #: Eligible: Yes
Date of Birth: SSN:
Card Control Number:

Medicaid Eligibility Data:

Begin Date: 3/1/2014 End Date: 6/30/2015
Recipient Id # for Billing: Message: PROGRAM 120
Eligible Services: 1-Medical Care, 33-Chiropractic, 35-Dental Care, 47-Hospital, 48-Inpatient Hospital, 50-Outpatient Hospital, 86-Emergency Services, 88-Pharmacy, 98-Physician Visits, AL-Vision, MH-Mental Health, UC-Urgent Care

Medicaid Recipient Lockin Data:

Lockin Begin Date: Lockin End Date:
Message:

Medicaid Special Program Data:

Begin Date: 12/1/2014 End Date: 6/30/2015
Message: EN
Special Pgm Code: 61

PSC	Begin Date	End Date	County of Res	Term Code	Term Description
120	03/01/2014	06/30/2015	02	08	CASE RECORD CLOSED DUE TO INELIGIBILITY

Medicaid Managed Care Data:

MCO Name: HORIZON NJ HEALTH MCO Phone Number: 8006829091
Begin Date: 12/1/2014 End Date: 6/30/2015
MCO Patient ID Number: Plan Code: 086
Message:

Medicare Part A Data:

Begin Date:
HIC Number:

Medicare Part B Data:

Begin Date:
HIC Number:

Medicare Part D Data:

Start Date: End Date:
Contract Number: Plan Id:
Name: Policy Number:
Group Number: NJ Insurer Code:
Copay Level:

Commercial Third Party Coverage Data:

Begin Date: End Date:
Policy Number: Group Number:
Carrier Name:
Message:

Anticipated changes to eligibility display to include description of termination reason.

Claims Processing

Claims process components for Nursing Facility for MLTSS Members

- Collect individual Room and Board and any applicable Cost Share from MLTSS members
- Contact CWA and/or family member regarding cost share calculation for MLTSS members
- Keep room available for 10 days if individual is hospitalized report bed hold
- Follow individual MCO billing guidelines for members with relevant cost-share

Universal Billing Format for MLTSS Services Paper Submission

- Providers need to use the 1500 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" lite for NFs and SCNFs.

Universal Billing Format for MLTSS Services Electronic Submission

- Providers need to use the 837 P 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 for NFs and SCNFs.

Claim Submission Requirements

- MCO claims are considered timely when submitted by providers within 180 days of the date of service as per (HCAPPA) P.L. 2005, c.352

Claim Submission Requirements with Explanation of Benefits

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

Coordination of Benefits

- If a NJ Family Care beneficiary has another health or casualty insurer the MCO is responsible for coordinating benefits to maximize the utilization of third party coverage.
- The contractor is responsible for payment of the enrollee's coinsurance, deductibles copayments, and other cost-sharing expenses, but the contractor's total liability cannot exceed what it would have paid in the absence of Third Party Liability (TPL).
- The MCO is responsible for the costs incurred by the beneficiary with respect to care and services which are included in the contractor's capitation rate, but which are not covered or payable under the TPL.

Coordination of Benefits if Member has Medicare Fee-for-Service and/or a Medicare Supplemental Plan

- 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 including custodial care in a Nursing Facility (NF); Medical Day Care (MDC); Social Day Care and Personal Care Assistance (PCA) 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 Nursing Facility.

Coordination of Benefits if Member has Medicare Advantage and/or another commercial coverage

- 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.

Balance Billing

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 service does not meet criteria referenced in NJAC 10:74-8.7(a).

Balance Billing details are also outlined in NJ Family Care Newsletter:

Volume 23 No. 15 **September 2013**

Limitations Regarding the Billing of NJ Family Care (NJFC) Beneficiaries

All Medicaid/NJ Family Care newsletters posted on http://www.njmmis.com

NJ FAMILY CARE MANAGED CARE PROVIDER RESOURCES

NJ Family Care Managed Care Provider Reference Information

- Below is the link where the NJ FamilyCare MCO contract is posted:

  http://www.state.nj.us/humanservices/dmahs/info/resources/care/

- The link below will provide connection to individual MCO sites.

  http://www.state.nj.us/humanservices/dmahs/info/resources/hmo/

  - Contact phone number for Member and Provider Relations is listed
  - Link for MCO Member Manual is posted

NJ Family Care Managed Care Provider Reference Information

- Human Services website - MLTSS: **http://www.state.nj.us/humanservices/dmahs/home/mltss_resources.html**
  - Provider Frequently Asked Questions (FAQ) posted
  - Provider Education PowerPoints
- Molina –NJMMIS website: **http://www.njmmis.com**
  - Medicaid Newsletters posted-sample below
  - SUBJECT: Managed Long-Term Services and Supports (MLTSS) **https://www.njmmis.com/downloadDocuments/24-07.pdf**
  - SUBJECT: Fee for Service (FFS) Coverage of Assisted Living Programs and Managed Long Term Services and Supports(MLTSS)
  - **https://www.njmmis.com/downloadDocuments/24-14.pdf**

State Resource for Managed Care Providers
Office of Managed Health Care (OMHC)
Managed Provider Relations Unit

- The OMHC, Managed Provider Relations Unit addresses Provider Inquires and/or Complaints as it relates to MCO contracting, credentialing, reimbursement, authorizations, and appeals
- Conducts complaint resolution tracking/reporting
- Provides Education & Outreach for MCO contracting, credentialing, claims submission, authorizations, appeals process, eligibility verification, TPL, MLTSS transition and other Medicaid program changes
- Addresses stakeholder inquiries on network credentialing process, network access, and payment compliance
- Provider inquiries should be e-mailed to the **State Office of Managed Health Care** at: **MAHS.Provider-Inquiries@dhs.state.nj.us**

Provider Inquiries

- The Managed Care Provider Relations Unit will work with necessary staff at DMAHS, Molina, DOBI, other State Departments and/or HMO to address inquiry
- Prior to contacting the State directly, individuals should contact **Member** and/or **Provider Relations Office at the Managed Care Organization (MCO)**
- If matter is unresolved, state staff will review and assist as necessary

Provider Inquiry

Enrollment and claims payment questions should be addressed directly with the NJ FamilyCare Managed Care Organization (MCO) prior to contacting the Division of Medical Assistance and Health Services.		
Inquiries should be emailed to MAHS Provider-Inquiries at MAHS.Provider-Inquiries@dhs.state.nj.us		
Provider Name		
Date		
Representatives Name:		Phone: E:Mail
Member Information	Member's Name	
	Member's Medicaid Number	
	Member's Date of Birth	
Service Information	Service Type	
	Date of Service	
	MCO	
	Provider (if different than submitting provider)	
Inquiry Summary	Summary of Contact with NJ FamilyCare MCO	
Enrollment Information (if applicable)	Date of Admission to LTC Facility	
	PAS Date	
	PAS Action Code	
	Date of Financial Eligibility	
Other Information		

Provider and Member Resource Information

Division of Aging Services Care Management Hotline	**1- 866-854-1596**
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**
NJ State Health Insurance Assistance Program	**1-800-792-8820**