Housing Supports Provider Guidance Packet

NJ FamilyCare Housing Supports Program

NJ Department of Human Services

Prepared by the NJ Division of Medical Assistance and Health Services (DMAHS)

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Housing Supports Program

Provider Guidance

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1. About This Guide

This guidance document serves as a resource for current and prospective Housing Supports providers who provide or are seeking to provide housing supports services. Within this guide, providers will find:

Introduction

- A brief introduction to NJ FamilyCare
- Overview of Housing Supports Program

Detailed program guidance

- Enrollment with NJ FamilyCare
- Joining Managed Care Organization (MCO) Networks (i.e., credentialing and contracting)
- Service authorization
- Payment model, service requirements, and claims
- Coordinating care with MCOs
- Quality and data reporting

Additional readiness guidance and resources

- List and links to additional resources
- Provider readiness checklist to use as a self-assessment tool
- Important contact information for State and managed care organizations

This guide sits in conjunction with the Housing Supports Managed Care Organization (MCO) Guidance. It is not intended to replace detailed guidance provided by each MCO, such as information included in MCO provider manuals, which are an essential resource for any provider seeking to join a specific MCO.

Please see linked here for the MCO guidance

DMAHS reserves the right to update this document as necessary. The update history is noted in **Section 15.**

2. Introduction to NJ FamilyCare

NJ FamilyCare is the name of the Medicaid Program in New Jersey, and includes core Medicaid, the Children's Health Insurance Program (CHIP), and Medicaid expansion populations. The NJ FamilyCare website can be found at the following link: https://njfamilycare.dhs.state.nj.us/.

A. Who is eligible for coverage?

New Jersey residents who meet certain criteria[1] are eligible to enroll in NJ FamilyCare, including:

[1] Criteria below from the NJ FamilyCare website as of 2023

- **Adults (19-64):** with income up to 138% Federal Poverty Level (FPL) ($1,732/month for singles, $2,351/month for couples). In general, immigrants must have five years of Legal Permanent Resident status to qualify, but some immigrants (e.g., asylees) may qualify sooner.
- **Children under 19:** with family income up to 355% of the FPL ($9,230/month for a family of four), regardless of immigration status. Coverage requires annual renewal.
- **Pregnant Individuals:** with income up to 205% FPL ($5,330/month for a family of four), with no entry-date restrictions for lawfully present immigrants.
- **Seniors (65+), Blind, Disabled, Long-Term Care Recipients, and Adults with Medicare**: Eligible based on specific criteria.

Most individuals experiencing homelessness, and many individuals at-risk of homelessness qualify for Medicaid or are Medicaid members; ~60-80% of individuals experiencing homelessness are Medicaid enrolled, and a larger share are Medicaid eligible[2]. Please see the NJ FamilyCare website for a comprehensive list of eligibility criteria.

If you are unsure if an individual is enrolled in NJ FamilyCare, please see **Section 7.B** for information on how to find an enrolled individual's MCO.

B. What services are covered?

NJ FamilyCare is a comprehensive healthcare coverage program that provides a wide range of services, including:

- Doctor visits
- Eyeglasses
- In-patient and outpatient hospital treatment
- Lab tests
- X-rays
- Prescriptions
- Regular check-ups
- Mental health and substance use services
- Dental services
- Preventive screenings
- Autism services
- Community doula services
- Help with personal care needs

DMAHS is adding housing supports services to the above services list.

C. How is the program delivered?

Today, NJ FamilyCare is delivered using two different models:

[2] "Changes in Medicaid Enrollment Associated with the ACA Eligibility Expansion among Adults Experiencing or at-Risk of Homelessness." *Rutgers Center for State Health Policy*, 2024.

- **Fee-for-service (FFS)** – traditional model where providers bill the state of NJ directly for services delivered
- **Managed care** – value-based model, predominant for medical services in NJ, where services are managed by five managed care healthcare plans, also known as managed care organizations (MCOs): Aetna, Fidelis Care, Horizon, UnitedHealthcare, and Wellpoint

The Housing Supports program is delivered using Managed Care only to drive whole person care, ensuring members receive well-rounded, personalized support. Key features and differences between the two models are highlighted in the table below:

Fee for service (FFS)	Managed care
• Managed by NJ State • Providers bill state Medicaid directly for services • Used for members not enrolled in a MCO and members with presumptive eligibility	• Managed by one of 5 MCOs, under contract with NJ State: Aetna, Fidelis Care, Horizon, UnitedHealthcare, Wellpoint • Providers bill MCOs for services; MCOs receive funding from state to manage total cost of care • ~95% of NJ FamilyCare is enrolled in managed care[3]

D. Why become a NJ FamilyCare provider?

Providers must be enrolled with NJ FamilyCare in order to provide services to NJ FamilyCare members.

Your organizations may have experience supporting individuals in securing and maintaining stable housing. By enrolling as a NJ FamilyCare provider, your organization can access additional resources and financial support while expanding the work you're already doing. As a NJ FamilyCare provider, you will continue making a meaningful contribution to public health by helping to serve some of the most vulnerable residents in New Jersey. Your participation is crucial in ensuring that all New Jersey residents have access to high-quality health services and comprehensive housing support services necessary to maintain long-term wellbeing.

3. Housing Supports Program Overview

A. Background

With the Centers for Medicare and Medicaid (CMS) approval of New Jersey's Section 1115 Waiver Demonstration in April 2023, the Division of Medical Assistance and Health Services (DMAHS) obtained authorization to develop a Housing Supports program. The Housing

[3] New Jersey Department of Human Services. NJ FamilyCare. State of New Jersey, https://njfamilycare.dhs.state.nj.us/analytics/home.html.

Supports program is a set of housing services created to ensure Medicaid/NJ FamilyCare members can live in a safe, healthy, and affordable home. The program is intended to provide much needed support to some of Medicaid's most vulnerable members including those with complex medical or behavioral health needs who are also homeless or at-risk of homelessness.

The Housing Supports program consists of four services:

- Pre-tenancy Services (case management)
- Tenancy Sustaining Services (case management)
- Move-in Supports
- Residential Modifications and Remediation Services

To be considered eligible for the Housing Supports program an individual must meet each of the following:

- Enrolled with an MCO
- Meet at least one of the social-risk criteria (as defined in **MCO guidance Section 4.A**)
- Meet at least one of the clinical-risk criteria (as defined in **MCO guidance Section 4.A**)

B. Purpose and Principles

Housing is a driver of disparate health and quality of life outcomes among racial and ethnic groups, individuals with disabilities, and other vulnerable populations. Housing is also one of the primary social determinants of health, and research has shown that lack of or inadequate housing is a critical barrier to wellness and raises health care costs.[4] As such, in 2015, CMS began allowing states to add housing services to their Medicaid programs.[5] Once DMAHS' 1115 waiver renewal was up for submission, DMAHS sought an opportunity to leverage this new CMS flexibility and added Housing Supports to the 1115 waiver.

For many Medicaid beneficiaries, lack of affordable, appropriate housing is a critical barrier to wellness. Lack of stable housing may lead to unnecessary hospitalization, institutionalization, or other avoidable instances of high-cost care, negative clinical outcomes, worsening of chronic conditions, and inability to achieve key life goals.

Accordingly, DMAHS has two primary goals for the Housing Supports program:

- Provide access to Housing Supports services that help homeless and other housing insecure members find homes and remain in their homes, thereby improving health outcomes.
- Drive greater connection of the housing and health care ecosystems by integrating member coordination of care in MCO and Medicaid funding into the housing ecosystem.

[4] Taylor, Lauren A., Housing and Health: an Overview of the Literature; DeLia D, et al. Effects of Permanent Supportive Housing on Health Care Utilization and Spending Among New Jersey Medicaid/NJ FamilyCare Enrollees Experiencing Homelessness. Med Care. 2021

[5] Wachino, Vikki., Coverage of Housing-Related Activities and Services for Individuals with Disabilities. Centers for Medicare and Medicaid Services. 2015.

- MCO will better deliver whole-person care for vulnerable members.
- Medicaid funding will augment, not supplant, existing funding and programs for homeless and other housing insecure populations.

C. Roles and Responsibilities

Community based organizations ("Housing Supports providers"):
Housing Supports providers are responsible for delivering services; more specifically including:

- Delivering Housing Supports services (i.e., Pre-tenancy Services, Tenancy Sustaining Services, Move-in Supports, or Residential Modifications and Remediation Services) consistent with requirements in the services dictionary (e.g., documenting touchpoints for services in New Jersey's Homeless Management Information System [HMIS]).
- Enrolling with DMAHS as a provider.
- Contracting and credentialing with MCOs.
- Billing MCOs for services delivered.
- Communicating with MCO care management, Housing Specialist, and utilization management staff (authorization team) to provide authorization requests and updates on changing member needs (e.g., member is housed, member's level of need changes).

MCOs
The MCO is responsible for administrative functions, including:

- Contracting and credentialing Housing Supports providers to ensure that there is a sufficient network of providers to cover member needs.
- Paying valid claims to Housing Supports providers according to required timeframes.
- Reporting encounter data to DMAHS.
- Making service authorization determinations, consistent with DMAHS guidance.
- Making timely referrals, monitoring member outcomes, and providing care management via care managers and Housing Specialists.
- Coordinate 'warm-handoffs' or transitions to other housing or social services, if the member is not eligible or no longer eligible for Housing Supports.
- Delivering Move-in Supports, as appropriate (See **Section 9.A** for details)
- Reporting on required metrics to DMAHS.

DMAHS
DMAHS is responsible for:

- Overall program design, including setting provider rates for program services.
- Providing overall oversight, monitoring and evaluation of the program.
- Ensuring standards and guidance are enforced according to the contractual obligations.

4. Definitions

The following terms shall have the meaning stated, unless the context clearly indicates otherwise.

- **Business Day** – Any weekday, excluding Saturdays, Sundays, NJ State or Federal legal holidays, and State-mandated furlough days
- **Household** – An individual or group of individuals who seek to live in a house together, including related and non-related family members. For the purposes of the Housing Supports program and this guidance, a member is not part of a household with those they currently live with if the member no longer seeks to live with the other individuals in the house (e.g., domestic violence victim; individual couch surfing seeking stable housing).
- **Housing Case Manager** – staff of a Tenancy Provider who is responsible for direct member-facing services; may also be referred to as a housing navigator.
- **Housing Services Manager** – MCO housing services manager staff overseeing MCO Housing Specialists.
- **Housing Specialist** – MCO Housing Specialist staff working 1:1 with members in Housing Supports program ensuring member is referred to relevant Housing Supports providers and that services are being delivered. (see Housing Specialist responsibilities in **MCO Guidance Section 9.B**)
- **Housing Stabilization Plan** – Document that includes the member's goals and action plan to achieve stable housing. The plan is created with a member and their Tenancy Provider's housing case manager. The Tenancy Provider then submits the housing stabilization plan to the MCO to request authorization to continue Tenancy Services.
- **Housing Supports** – includes Pre-Tenancy Services, Tenancy Sustaining Services, Residential Modifications & Remediation Services, and Move-in Supports. See Housing Supports Services Dictionary for detailed service descriptions list.
- **Initial Assessment Tool** – Tool used to assess member's eligibility for Housing Supports and request service authorization from the MCO.
- **In-Network Tenancy Provider** – providers of Pre-Tenancy and Tenancy Sustaining Services who are contracted and credentialed with an MCO.
- **Level of Need Assessment** - To be used by Tenancy Provider to assess member eligibility for Tenancy Services and level of need (i.e., higher or lower level of need). The Level of Need Assessment is used to request authorization to continue Tenancy Services.
- **Tenancy Provider** – providers of Pre-Tenancy and Tenancy Sustaining Services.
- **Tenancy Services** – includes Pre-Tenancy and Tenancy Sustaining Services.

5. Covered Services

A. Overview of Covered Services

Housing Supports includes 4 main services:

- Pre-tenancy Services (case management)
- Tenancy Sustaining Services (case management)
- Move-in Supports
- Residential Modifications and Remediation Services

For definitions of the services listed above, please refer to the **Housing Supports Services Dictionary**.

6. Covered Populations

A. Overview of Covered Populations

To be considered eligible for the Housing Supports program an individual must meet each of the following:

1) Enrolled with an MCO
2) Meet at least one of the social-risk criteria (as defined in **MCO guidance Section 4.A**)
3) Meet at least one of the clinical-risk criteria (as defined in **MCO guidance Section 4.A**)

MCOs must accept attestations of social and clinical eligibility criteria by the submitter of the assessment. That is, third party documentation of the member's clinical risk criteria and/or social risk criteria is not required to complete the form or obtain approval from the MCO.

For more detail on the eligibility requirements listed above, please refer to the MCO guidance linked here.

7. Service Authorization

A. Overview of Service Authorization

Tenancy Services | High-level member journey

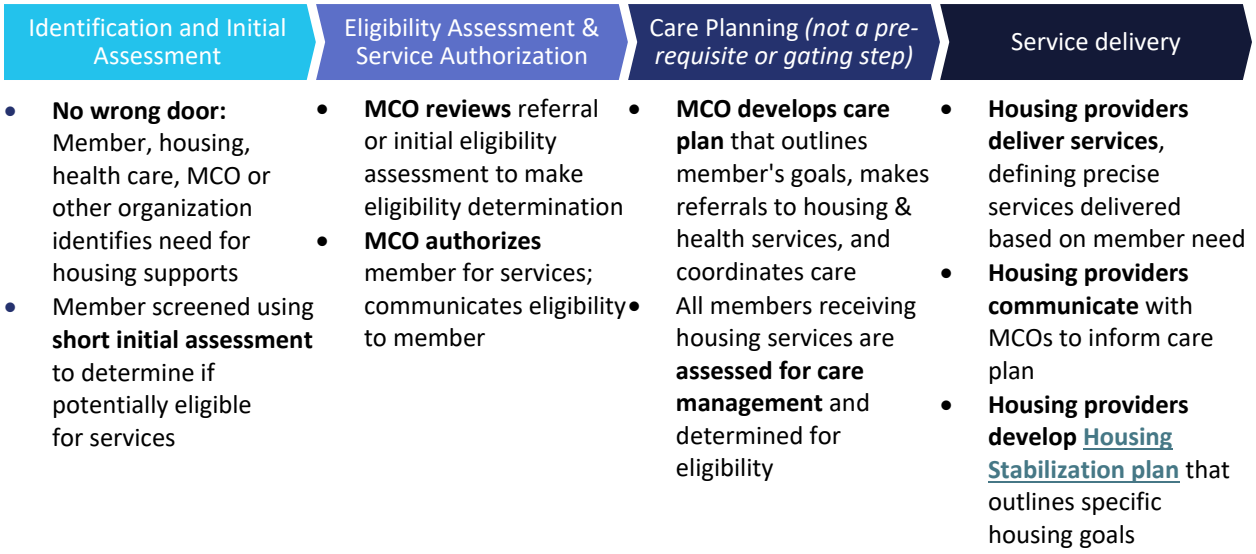


Exhibit 1. High-level member journey for Pre-tenancy and Tenancy Sustaining Services.

The Housing Supports program member journey flows from identification of need to assessment of member eligibility, to service authorization, to an optional care management step, to delivery of services.

Tenancy Services: authorization process | Providers assess level of need, billing accordingly; MCOs conduct oversight

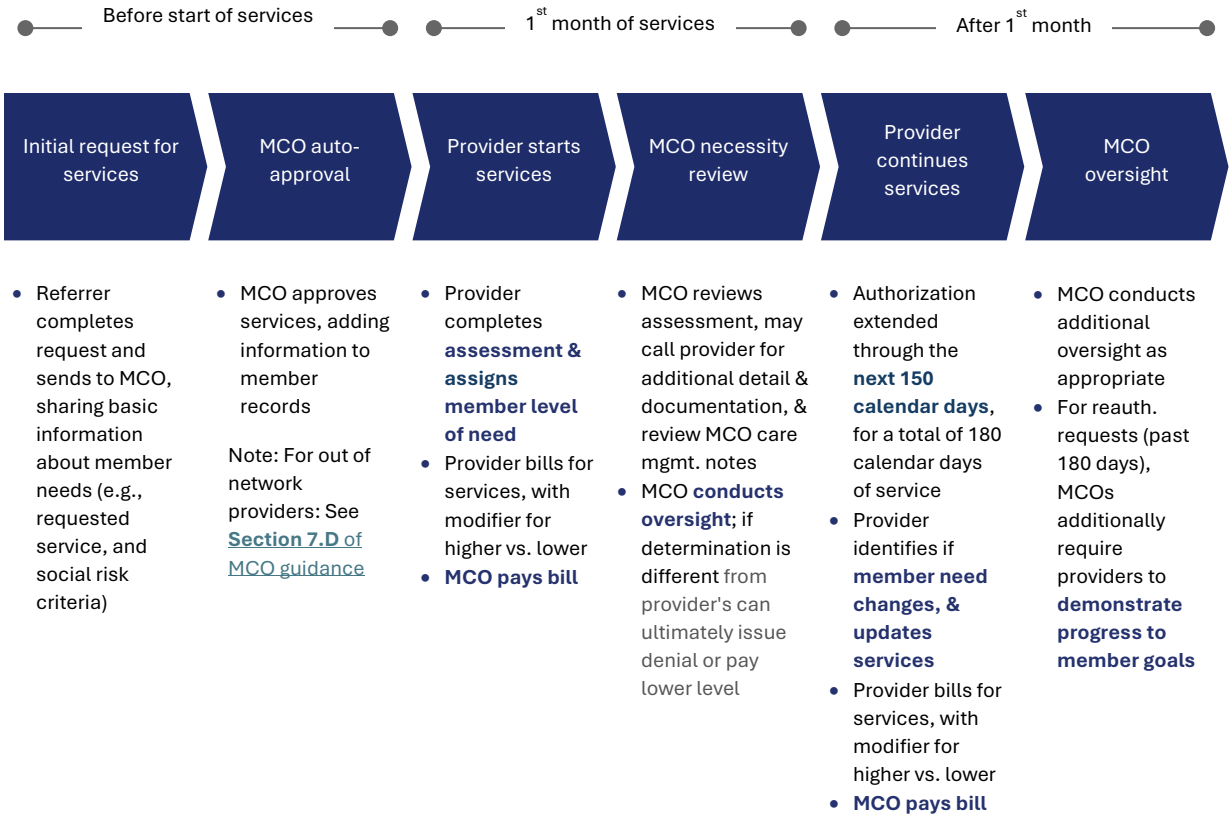


Exhibit 2. Authorization process for Pre-tenancy and Tenancy Sustaining Services.

The authorization process depicted above is for Pre-tenancy and Tenancy Sustaining Services. Details for Housing Supports Residential Modifications and Remediations and Move-in Supports can be found in **Section 7.E below.**

B. Connecting Members to Care

This section details the various pathways in which members may be connected and obtain Housing Supports services, including referral pathways. This section is relevant for any individual or organization seeking to connect a member to care or for a provider receiving a referral from an MCO.

There are broadly 3 pathways to care; one or more may be involved to successfully facilitate a member to an in-network provider who is ready to deliver services:

1) **In-network provider ready to support the member submits initial request for services to MCO:** In-network Tenancy providers who are in contact with eligible members and are comfortable supporting members with the Housing Supports "Initial Assessment Tool" are encouraged to initiate a request for authorization by submitting the "Initial Assessment tool" to the MCO rather than use the pathways below; this facilitates quicker approval and

connection to services. To initiate Residential Modifications and Remediation Services or Move-in Supports, an in-network provider credentialed to deliver these services who is in contact with an eligible member should submit the "Initial Assessment Tool" or submit a referral via other MCO-approved forms and processes; note: these services have different authorization requirements than Tenancy Services (i.e., the service is not auto-approved).

2) **Other outreach to MCOs, including referrals:** Any member interested in the Housing Supports program may reach out to their MCO to receive help in accessing services; this is called a "self-referral." In addition, any individual or organization seeking to refer a member to Housing Supports services may reach out to the MCO on the member's behalf. This can include any community organizations not in-network with the member's MCO and in-network Housing Supports providers who may be at capacity.

   The interested member or organization on the members' behalf are encouraged to submit an "Initial Assessment Tool" or equivalent to initiate an authorization request to facilitate a quicker connection to service delivery; however, they may also refer the member to their MCO to facilitate the authorization request.

   To send a referral, **the referrer should send the following information to the member's MCO via telephone, fax or email**:
   - Name of the member
   - Referring individual's name
   - Referring individual's provider organization
   - Date of outreach
   - Indication of interest in receiving tenancy services

   See **Section 14.B** for information on where to share the referral.

   In this scenario, referrers are strongly advised to refer via telephone if present with the member. This facilitates a quicker process for the member to obtain services, as it bypasses the need for MCOs to separately follow up with the member to confirm interest.

   If the referrer or member is unclear who the member's MCO is, they can identify their MCO and MCO ID number via the following methods:
   - **Log into eMEVS** (the electronic Medicaid eligibility verification system) via NJMMIS.com and search for the member based on their name and other identifying information (e.g., birthday) – Please note: This method is only available for organizations enrolled as NJ FamilyCare providers
   - **Log into the NJ FamilyCare website (njfamilycare.org)** if the member has set up an account – this website includes personal information including Medicaid ID and MCO details
   - **Visit their County Social Services Agency** (with some form of identification)
   - **Check correspondence from NJ Medicaid** (enrollment letter, emails, etc.), as most correspondence will also have this information

MCOs are required to accept referral outreach by any individual or organization even if they are unsure of their program eligibility (e.g., hospital, primary care physician, public housing agency). After receiving the referral, the MCO will review the information and reach out to the member within **7 business days** to confirm interest, if not already provided, and facilitate the process to obtain authorization by phone or by directing them to a nearby Tenancy Provider.

Note that community organizations not in network with the member's MCO may reach out to the MCO to initiate joining the network should they be interested in providing the member with Housing Supports services; however, referrals and/or service authorizations received from out-of-network providers may be redirected to an in-network provider to ensure timely services.

3) **MCO identifies member need for Housing Supports:** The MCO may identify a need for services or receive a request for services in which the member is not connected to an in-network provider. This may occur if the MCO identifies member need via care management data and/or treatment or other internal data. This may also occur if a referral or "Initial Assessment Tool" is submitted by a member without an in-network provider or by a community organization on behalf of the member, who is not in-network with the MCO.

   If receiving a member referral, the MCO may request that an in-network Housing Supports provider aides the member in obtaining authorization. This may be the case if the MCO receives referral outreach and the member or MCO decides it is in the member's interest for an in-network provider to conduct the initial assessment.

   The MCO will reach out to an in-network provider to confirm capacity to support the member and share the referral details. When confirmed, the provider should reach out to the member to begin facilitating an authorization request (**see Section 7.C or 7.E below**).

   In other cases, the MCO may have approved a member for authorization, but the member needs to be connected to an in-network provider for service delivery. This may occur if the MCO identifies a member is eligible, conducts the initial assessment itself, and connects the member to a provider. Alternatively, this scenario may occur if a member without an in-network provider, a community organization that is not in-network with the member's MCO, or an in-network provider who is at capacity submits an authorization request that is later approved by the MCO.

   The MCO will reach out to an in-network provider to confirm capacity to support the member and share the authorization details. When confirmed, the provider should reach out to the member to begin services; for Tenancy Services, the date of authorization will be applied to the first touchpoint recorded.

Care Connections | Members have multiple pathways to obtain services

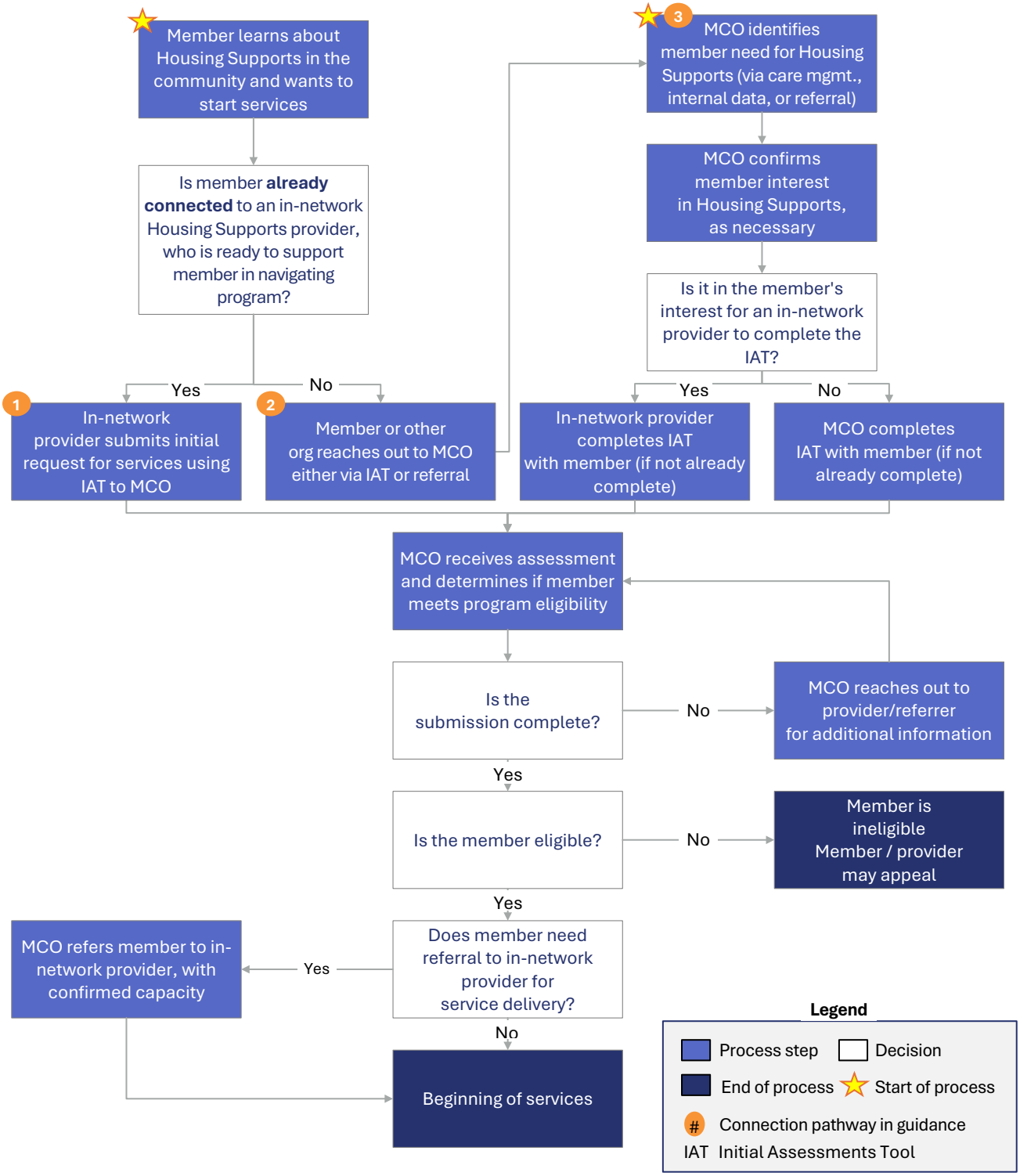


Exhibit 3. Connecting Members to Care. See Section 7.B. for full description of the referral pathways.

C. Obtaining Authorization for Pre-tenancy and Tenancy Sustaining Services for the First Thirty (30) Calendar Days of Service

This section is for providers who are looking to obtain initial authorization of Pre-tenancy and Tenancy Sustaining Services for a member's first 30 calendar days of service.

Before submitting an initial authorization for Pre-tenancy and Tenancy Sustaining Service, providers should first check if the member is already authorized for and served by an in-network provider for Tenancy Services. See **Section 8.D** for additional detail.

Forms:
To request the start of Housing Supports program services and authorize a member to receive services, a **'Housing Supports Initial Assessment Tool'** must be submitted to the MCO. This is a standardized authorization form across MCOs.

Submission guidance:
The MCO must accept this standardized authorization form. This form can be submitted by any organization or individual on behalf of the member, including the member themselves or a Tenancy Provider. If a member's 'Housing Supports Initial Assessment Tool' was not submitted by an in-network tenancy provider, the MCO is required to additionally reach out to the member to confirm their interest in receiving Tenancy Services before proceeding with service authorization (see "Initial Assessment turnaround time" in **Section 7.C**).

If a Tenancy Provider would like to submit the form on behalf of a member, they should follow the three steps below:

- **Step 1**: Review the form in its entirety, with a focus on social and clinical risk criteria definitions. A member may not categorize their experiences neatly into the risk criteria; it is important for providers to be prepared to probe and ask clarifying questions to fully understand and accurately reflect a member's circumstances.

- **Step 2**: Complete a 'Housing Supports Initial Assessment Tool' on behalf of the member. If a provider completes the form and submits it without a member signature, the MCO is required to additionally reach out to the member to confirm their interest in receiving Tenancy Services before proceeding with service authorization (see "Initial Assessment turnaround time" in **Section 7.C**).

  In general, it is a best practice to include member signature on the submission of the 'Housing Supports Initial Assessment Tool' to document member interest in services. However, this may not be practical in all cases, and verbal agreement is allowed in the following cases:
  - If the MCO completes the initial assessment or documents member interest over the phone with the member without requiring a signature; MCOs can accept the member's verbal agreement in place of a signature. After the member begins services, member signature must be collected by the provider

to continue services past the first month (e.g., member signs Housing Stabilization Plan or statement of interest in the program).
- An in-network provider may collect and document the member signature, then submit an authorization request with the MCO over the phone. The provider must keep a record of the member's signature.

Note that MCOs must accept attestations of eligibility criteria by the submitter of the assessment. That is, third-party documentation of the member's clinical risk criteria and/or social risk criteria is not required to complete the form or obtain approval from the MCO.

A high-level, non-exhaustive summary of **key information requirements** is below, but providers are encouraged to review the form more comprehensively:

- Member Name (as written on Medicaid ID)
- Member Date of Birth
- Member Medicaid ID
- Member MCO
- County of Member
- Member Social Risk Factors
- Member Clinical Risk Factors
- Services the member needs
- If the member or other members in the household are receiving duplicate Medicaid-funded housing services
- Member household information

There is an optional field for the provider to indicate the member's provider of choice for delivering services. It is encouraged to fill this field out to facilitate a faster connection to services.

- **Step 3**: Once a 'Housing Supports Initial Assessment Tool' has been completed, the provider must send the completed form to the member's MCO. The MCO will allow pathways for form submission through their provider portal, fax, and telephone.

Initial Assessment turnaround time.
The following turnaround time policies have been standardized across MCOs.

The time between MCOs receiving a request for initial authorization via a 'Housing Supports Initial Assessment Tool' and issuing an authorization decision (i.e., approval or denial) is known as the 'initial assessment turnaround time.'

Initial assessment turnaround time will depend on if the submitter of the 'Housing Supports Initial Assessment Tool' is an in-network Tenancy Provider. See **Section 7.D** of the MCO Guidance for additional turnaround time by scenario.

Administrative review (auto-approval):
After receiving the submission of a 'Housing Supports Initial Assessment Tool,' the MCO will check if the following criteria are met:

- All required fields are filled out completely (including that the member has signed the assessment)
- Member is Medicaid and MCO enrolled in their plan
- Member demonstrates clinical and social risk in line with program eligibility criteria
- Member is not already receiving duplicative Medicaid services

If the above criteria are met, the submitted 'Housing Supports Initial Assessment Tool' will trigger an auto-approval and the member will be authorized for services.

Duration:
The approval of the 'Housing Supports Initial Assessment Tool' provides authorization for services for **30 calendar days**. The start of services is defined as:

- **If an in-network Tenancy Provider submitted the 'Housing Supports Initial Assessment Tool'**: Start of services begins from the date the provider submitted the initial request for services.
- **If the 'Housing Supports Initial Assessment Tool' was not submitted by an in-network Tenancy Provider**: Start of services from the day an in-network provider starts delivering services[5]. Providers should contact the member's MCO directly when they start services via their provider portal, fax, or telephone.

Incomplete submission:
In the case a member or provider submits an incomplete 'Housing Supports Initial Assessment Tool' submission, the MCO will reach out to the member or provider at least 3 times within 5 business days to finish the form. If a member or provider does not finish the form within 5 business days, the MCO will provide an authorization denial.

Denials:
The MCO may deny an authorization request as outlined in the MCO guidance. Please refer to the **MCO guidance Section 7.D** for further information on Denials and Appeals.

D. Obtaining Authorization for Pre-tenancy and Tenancy Sustaining Services Past the First Thirty (30) Calendar Days of Service (Necessity Review Service Authorization Process)

This section is for providers looking to request the continuation of Housing Supports program services beyond the first 30 days of authorization.

Forms:

To request the continuation of Housing Supports program services beyond the first 30 days, a necessity review service authorization process must be followed. This means, that both a **'Level of Need Assessment'** (to determine "high" versus "low" need member billing) and a **'Housing Stabilization Plan'** (to ensure appropriateness of services) must be submitted to the MCO.

For reauthorizations beyond the first 180 days of service, the provider should follow a necessity review service authorization process again with updated forms to check for continued member eligibility and need for program services**.**

Submission guidance:
The MCO must accept these standardized authorization forms. For the necessity review service authorization process, both the **'Level of Need Assessment'** and the **'Housing Stabilization Plan'** must be submitted to the MCO by their **in-network tenancy service provider** authorized to give the member their services.

A **'Level of Need Assessment'** will be used to confirm member eligibility and determine a member's level of need for member billing.

A **'Housing Stabilization Plan'** will be used to ensure the appropriateness of service authorization.

If an in-network tenancy service provider is looking to complete a 'Level of Need Assessment' and a 'Housing Stabilization Plan' for an authorized member, they should follow the three steps below:

- **Step 1**: Review the forms in their entirety. A member may not categorize their experiences neatly into the provided answer choices; it is important for providers to be prepared to probe and ask clarifying questions to fully understand and accurately reflect a member's circumstances.

- **Step 2**: Complete a 'Level of Need Assessment' with the member.

  Third-party documentation of the member's housing and social history or health history is not required to complete the forms or obtain approval from the MCO. MCOs **will not require any additional documentation** to come to an authorization decision, but can utilize their internal systems data (e.g., claims data), HMIS data, and ask questions of providers to clarify and validate eligibility and/or member need for program services.

  A high-level, non-exhaustive summary of **key information requirements** is below, but providers are encouraged to review the form more comprehensively:

  - Member Name (as written on Medicaid ID)
  - Member Date of Birth

    - Member Medicaid ID
    - Member MCO
    - Member household information
    - Housing and Social History (e.g., how many times has the member been homeless, etc.)
    - Health History (e.g., does the member have any mental health conditions, etc.)

- **Step 3**: Complete a 'Housing Stabilization Plan' with the member.

  A 'Housing Stabilization Plan' has 3 plan components (housing, health, income). Providers should ensure at least 1 goal and action are filled out for each of the 3 plan components as well as ensuring that the plan has all necessary signatures and responses to questions.

  MCOs will be evaluating the completeness of the plan in their review. Note that DMAHS aims to provide a more robust rubric for a 'Housing Stabilization Plan' in the future.

- **Step 4**: Once a 'Level of Need Assessment' and a 'Housing Stabilization Plan' have been completed, the provider must send the completed forms to the member's MCO prior to the end of a member's initial authorization period. The MCO will allow pathways for form submission through their provider portal and fax. If a provider submits a complete request for authorization after the end of a member's initial authorization period, the member is not authorized to receive services after expiration and before future authorization from the MCO.

Necessity review turnaround time:
The time between MCOs receiving a request for authorization via both a 'Level of Need Assessment' and a 'Housing Stabilization Plan' and issuing an authorization decision (i.e., approval or denial) is known as the 'necessity review turnaround time.'

After receiving the submission of a fully completed 'Level of Need Assessment' and 'Housing Stabilization Plan,' the MCO must complete review of the forms, make an authorization determination, and inform the member and provider within **7 calendar days from the provider's submission** of both completed forms.

Duration:
The initial necessity review authorizations extend authorization for the **next 150 calendar days** past the first 30 days of service, for a total of 180 calendar days of service.

If the member is requesting authorization beyond the first 180 calendar days of services through a reauthorization request, the approval of the necessity review forms provides authorization for services for the **next 180 calendar days**.

Change in member authorization elements:

It is possible that a member's authorization elements may change during the course of their authorization for services. Providers should adhere to the following guidance to ensure a continuation of services for the member.

Change in member's provider:
A member can select a provider during their initial assessment for services. **If a member wants to change their authorized provider, they can request a change mid-service**. Their new provider must request service authorization for 180 calendar days using the **necessity review procedure in this section**. The member's MCO will then end the previous authorization from the old provider with the member's consent if the authorization is approved, and with notice to the existing provider, indicated through written communication with the MCO (e.g., email, mail, fax) or through a verbal conversation with their MCO Housing Specialist and make a determination on the new provider's authorization request. The original provider will have to submit a discharge form in HMIS for the member.

Change in member's MCO:
If the member has a **change in MCO mid-services**, the provider must first **call the new MCO and submit a new authorization request** through the necessity review service authorization process **for 180 calendar days of services**. As per continuity of care guidelines, the new MCO is required to allow an in-network provider to continue providing services until a new reauthorization request is submitted; however, note that the provider is encouraged to submit a new authorization request as soon as possible to prevent any denials in claims due to lack of recorded authorization.

MCOs are also required to allow a provider who is out of network with the new MCO but in-network with the old MCO to continue providing the service until a new MCO plan of care is identified (note that the MCO may require provider to submit a new request for services to make its own service authorization determination).

Change in member's level of need:
If the **member has a change in need** (e.g., billing at a "low" rate originally and has had major life changes and now meets criteria for billing at a "high" rate), the **provider should submit a new authorization request** with relevant updates through the necessity review service authorization process **for 180 calendar days of services**.

If approved, the member will receive authorization for the new level of need when the current 30-day billing period under the previous authorization ends (i.e., on the 1st day of the next billing period). If the new authorization is not approved due to not demonstrating need for the new level of need, then the previous authorization will remain as is.

Change in member's services:
If the **member requests a change in services** (e.g., from Pre-tenancy and Tenancy Sustaining Services), the **provider should submit a new authorization request** with relevant updates through the necessity review service authorization process **for 180 calendar days of services**.

If approved, the member will receive authorization for the new service when the current 30-day billing period under the previous authorization ends, same as above for change in member level of need. If the new authorization is not approved due to not demonstrating need for new services, then the previous authorization will remain as is.

General Notes:

In any of the scenarios above, the new authorization request must be conducted under the necessity review process, and the MCO should authorize services for the next 180 days, if approved. For example, if on a member's current authorization ends on day 100 and the new authorization begins, the member now has an additional 180 days of service, allowing them to continue receiving services, if necessary, until day 280.

Denials and Appeals:
The MCO may deny an authorization request as outlined in the **MCO guidance Section 7.E**. A provider or member may submit an appeal through the relevant MCO systems. Please refer to the MCO guidance for further information on Denials and Appeals.

E. Obtaining Authorization for Residential Modifications and Remediation Services, and Move-in Supports

This section is for providers looking to obtain authorization for Residential Modifications and Remediation Services and Move-in Supports.

Authorization:
Residential Modifications and Remediation Services, and Move-in Supports, must be authorized by MCOs. The authorization process is not the same as is used for Pre-tenancy and Tenancy Sustaining Services, described above.

The authorization process takes place in 5 steps:

- **Member Referral:** A member is connected to Residential Modifications and Remediation Services or Move-in Supports as described in **Section 7.B** above. A member, family member, Housing Supports provider, or other interested party including the member's care manager or Housing Specialist may submit the **"Initial Assessment Tool"** to the MCO. **Note**: these submissions are not auto-approved by the MCO like the initial request for Tenancy Services, as described above.

- **1st MCO Decision:** The member's MCO decides if the member meets program eligibility, demonstrates necessity for these services and does not have any other program limitations (e.g., already exceeded lifetime caps). The MCO will communicate its decision to the referrer. The member's MCO may collect additional information on member needs; this process and decision criteria varies by MCO. The MCO must communicate its determination to the member and the referrer. In addition, if the

provider delivering the service is separate from the referrer, the MCO must communicate its determination to the member, the provider delivering the service, and the referrer.
    - For **Move-in Supports**, if the member already has an in-network provider through Pre-tenancy or Tenancy Sustaining Supports, the provider has the option to deliver Move-in Supports. If not, the member's MCO may decide who will deliver the services (i.e., the member's MCO itself or an in-network Tenancy provider or Residential Modifications and Remediation provider).
    - For **Residential Modifications and Remediation Services**, the member's MCO will authorize 1 or more in-network Residential Modifications and Remediations Providers to conduct evaluations (i.e., price quotes on the cost of services).
- **Request for Info:**
    - For **Move-in Supports**, the party designated to deliver services in the step above (i.e., the member's MCO or provider) develops an itemized goods/service list for member needs, including the cost of goods/services. If the provider is delivering the services, they must share the list to the MCO for review.
    - For **Residential Modification and Remediation Services**, the providers authorized to prepare evaluations conduct and submit their evaluations to the member's MCO. Note: the Services Dictionary includes 'approval requirements' that may be collected at this stage, or earlier in the process (e.g., property owner consent).
- **2nd MCO Decision:**
    - For **Move-In Supports**, the member's MCO makes an authorization decision to approve the service and total spending amount.
    - For **Residential Modifications and Remediation Services**, the member's MCO selects a provider based on the evaluations and authorizes the provider to deliver the service.
    - See **Section 7.F** in the MCO Guidance for additional detail on the turnaround time for authorizations for these services.
- **Service delivered:** The approved provider or member's MCO delivers the services.
- **MCO Follow-Up**: The member's Housing Specialist or care manager should communicate with the member to ensure successful delivery of services.[6]

Limitations on service authorization:
MCOs will make an authorization determination in accordance with limitations as outlined in the **MCO guidance Section 7.F**.

Move-in Supports is defined as "non-recurring, one-time transitional expenses provided to a member during the transition period to their own home." Move-in Supports are limited to one 'moving experience' per lifetime per member. A 'moving experience' may entail multiple service authorizations and does not have a state-determined time limit.

[6] If the member has neither a MCO Care Manager or Housing Specialist, the MCO may follow up with the provider to confirm delivery of services.

F. End of Service Authorization

Members can end service authorization from the Housing Supports program at any time. To officially end service authorization, a member may call their MCO. A provider may also call the MCO on behalf of a member to end service authorization with the member's permission and knowledge.

If a provider is unable to contact a member within a 30-day authorization period, the member's authorization is still open until the end of the current authorization period, or until one of the reasons listed below.

Possible reasons a member's service authorization ends
The member:

- Is stably housed – completion of program
- Has lost program eligibility and did not submit an authorization request
    - No longer eligible for Medicaid/NJ FamilyCare
    - No longer enrolled with an MCO
    - No longer fits social-risk criteria
    - No longer fits clinical-risk criteria
- Has not been reauthorized for services
- Has opted out
- Has been reassigned to another Housing Supports provider
- Switched health plans
- Switched to another Housing Services program
- Has moved out of state
- Is deceased
- Is incarcerated
- Has lost contact/lost to follow-up (i.e., provider/MCO unable to contact member after aggressive outreach)
- Exhibits unsafe behavior or environment

G. Providing a Warm Handoff at the End of Service Authorization

If a member's authorization request has been denied or if a member no longer qualifies for the Housing Supports program due to a change in condition, a provider must facilitate a warm handoff in conjunction with the member's MCO as outlined below.

Provider responsibilities:

- Provide notice within 14 days of services ending to member once provider is notified by MCO that authorization request has been denied or that a member no longer qualifies
- Complete discharge form in HMIS at the end of services provided by a specific provider (Note: Must be filled out even if the member is remaining in the program and transitioning to a different provider)
- Refer member to other paths for more aid within Medicaid (directing member to MCO care manager or Housing Specialist)

- Supply additional relevant paths for member aid outside of Medicaid

MCO responsibilities:

- Provide housing supports providers notice of member service authorization denial within turnaround time and its rationale for denial
- Provide member notice of approval or denial of services to the member within 14 days
- Follow up with member to help connect them to other housing services and health care services as needed
- Provide member information about the appeal process in case they believe services should be continued
- Work through appeal process at member request

8. Payment Model, Service Requirements, and Claims

A. Payment Model

This section overviews the payment model for Housing Supports Services, including rate structure and amounts for all services.

Rate structure and amounts:
Payment structure and amount for Housing Supports services is described in the **MCO guidance Section 15.A**.

The **rate amounts for Pre-tenancy and Tenancy Sustaining Services are standardized across all MCOs**. Payment for Pre-tenancy and Tenancy Sustaining Services is structured as a per member per month (PMPM).

- **Payment Structure:** For Pre-tenancy and Tenancy Sustaining Services, the MCO shall pay a per member per month (PMPM) rate, stratified by higher and lower level of need as determined by the standardized Housing Supports Level of Need Assessment Tool completed by the Tenancy Provider and approved by the MCO during service authorization.
    - A provider must be authorized for services and meet the minimum service requirements for a member each billing period in order to submit a claim for the PMPM rate. Please see **Section 8.B** below for more detail on minimum service requirements.
- **Billing Period:** For the purposes of billing, a "month" is defined as a 30-day billing period, that aligns to the member's service authorization period.
    - The 30-day billing period starts on the first day of the service authorization and continues for 30 days or until the service authorization ends, whichever is later.
    - For example, if a member receives a 180-day authorization for Pre-tenancy Services, this service authorization will be defined by six 30-day billing periods.
- **Billing for a household:** Tenancy providers cannot submit claims for **Pre-tenancy or Tenancy Sustaining services** for multiple members of the same household. However, Tenancy Providers have the **flexibility to define a household** in specific cases concerning violence and safety issues (i.e., a victim of domestic violence should be

considered a distinct household). Claims should be associated with a specific member who is a member of the household. The Tenancy Provider has discretion to decide which program eligible household member they submit a claim for. It is **recommended that Tenancy Providers bill for the head of the household**.

- **No authorization past the first 30-days of services:** If Pre-tenancy and Tenancy Sustaining Services are not authorized past the 1st month (30-day period) of services, then the provider must submit the claim for Pre-tenancy and Tenancy Sustaining Services for a PMPM rate associated with the lower level of need for the 1st month (30-day period) of services, as long as the minimum service requirements are met (see **Section 8.B** below).
- **Shortened billing periods:** In scenarios in which a billing period may be shortened (e.g., member changes providers, changes MCOs, or no longer participates in Medicaid), the MCO should pay the claim at the full amount if the touchpoint requirements are met within the shortened billing period. There will be no pro-ration of rates for Housing Supports at this point in time.
- **Billing for a different level of need than authorized for:** Tenancy providers may not bill for a higher level of need than the member is authorized for. If there is a change in the member's need (e.g., due to a major life event), the provider should submit a reauthorization request (see MCO guidance **Section 7.E**). If a member is authorized for a lower level of need, and the Tenancy provider does not meet the touchpoint requirement in the billing period, they may not be paid for that billing period. If a member is authorized for a higher level of need, and the Tenancy provider delivers touchpoint requirements meeting a lower level of need (e.g., 2+ touchpoints), they may be paid at the rate for a lower level of need.
- **Credentialing requirements:** Providers may only be paid for Tenancy services if they are credentialed with the MCO as a Pre-tenancy or Tenancy Sustaining provider. This may not apply if the MCO has an established Single Case Agreement with the provider.

Payment for Residential Modifications and Remediation Services and **Move-in Supports** is structured as a cost-based reimbursement up to a lifetime cap, with an additional payment for evaluations or administration.

- There is a **lifetime cap for Residential Modifications and Remediation Services**. Members eligible or receiving MLTSS Residential Modifications and Remediation Services may not combine or add spending caps across programs or with their household members.
- There is **a lifetime cap for Move-in Supports**. Members eligible or receiving MLTSS Community Transition services may not combine or add spending caps across programs or with their household members.
- Providers may only be paid for Residential Modifications and Remediation Services if they are credentialed with the MCO as a Residential Modifications and Remediation Services provider. Providers may only be paid for Move-in Supports if they are credentialed with the MCO as either a Pre-tenancy / Tenancy Sustaining Services provider or Residential Modifications and Remediation Services provider. These may not apply if the MCO has an established Single Case Agreement with the provider.

- Residential Modifications and Remediation Services Providers and Tenancy Providers will submit an authorization request to spend a proposed amount on services. If authorized, the providers can spend this amount and be reimbursed by the MCO.
- Providers may also be paid for evaluation and administration services. These rates are set by the MCOs and not standardized by DMAHS.
    - For **Residential Modifications and Remediation Services**, providers may also be paid for evaluation services such as evaluating the member's needs & their housing setup and submitting a price quote to the MCO for review.
    - For **Move-in Supports**, providers may also be paid for administrative services such as arranging or purchasing the supports for the member (e.g., renting a moving truck, etc.).

B. Service Requirements

Tenancy Service requirements

A Tenancy Provider must deliver the qualifying number of touchpoints to properly serve a member and submit a valid claim.

- If a member is authorized for a **higher level of need**, then the Tenancy Provider must deliver **4 or more qualifying touchpoints per month** (billing period) and document those touchpoints. Touchpoints must occur on separate days.
- If a member is authorized for a **lower level of need**, then the Tenancy Provider must deliver **2 or more qualifying touchpoints per month** (billing period) and document those touchpoints. Touchpoints must occur on separate days.

For a touchpoint to qualify as **a valid touchpoint for claim submission**, the following requirements must be met:

- The touchpoint date must be within the 30-day billing window for claim submission.
- At least half of the required minimum number of touchpoints for a level of need must be face-to-face with a member (i.e., for a low level of need member, 1 out of the minimum 2 touchpoints must be face-to-face).
- Face-to-face, telephone, email, text, or another electronic format is accepted for touchpoints that are not face-to-face with a member.
- The touchpoint must have occurred in a county in New Jersey.
- There must be one and only one service indicated for a touchpoint in a claim submission. Service options are:
    - Pre-tenancy Services "high" need
    - Pre-tenancy Services "low" need
    - Tenancy Sustaining Services "high" need
    - Tenancy Sustaining Services "low" need
- The touchpoint must be documented in HMIS based on requirements set forth by DMAHS. Touchpoints must be documented with all required fields and case notes completed, unless the member is protected (e.g., victims of domestic violence or intimate partner violence).

- If a member's circumstances or provider's circumstances disallow the use of HMIS, the touchpoint must be documented within an existing provider system or database and stored locally subject to audit by DMAHS or the MCO.
- DMAHS reserves the right to update the HMIS reporting and documentation standards.

These are the minimum requirements for a touchpoint, not the standard expectation of a touchpoint. Providers can and should meet with a member as needed to address their needs, in modalities that are appropriate and preferred by the member (e.g., telephonic, face-to-face, virtual). It is highly encouraged that providers document case notes that reflect the touchpoint activity that occurred.

Case manager caseloads
There are no requirements for how many members a case manager's caseload will consist of, but the estimate is a caseload of 15 for members with a "high" level of need and a caseload of 30 for members with a "low" level of need.

The difference between calculation for "high" and "low" need members is based on the different service requirements for each level of need.

C. Claims Process

Overview of claims process:
All Housing Supports services require authorization. Authorization should occur before any claims are submitted.

The Medicaid claims process consists of seven essential steps that providers should follow to ensure reimbursement for services delivered to MCO Medicaid members:

Exhibit 4. MCO claims process

1. **Form Selection:** Select the CMS 1500 Billing Form for submission.
2. **Form Fields:** Ensure all required fields are complete to create a "clean claim." Providers are also encouraged to fill out suggested fields. Please see "Claim / Billing Form Fields" below for more detail.
3. **Billing Codes:** Determine the appropriate billing codes for the service delivered and confirm any additional coding requirements, such as modifiers or authorization numbers. Please see "Billing Codes" below for more details.
4. **Claim Submission:** Decide on the method of submission (manual or electronic).

5. **Adjudication & Processing:** Track the progress of the claim and understand the expected processing time.
6. **Denials & Appeals:** If needed, learn common reasons for denial and understand the steps for filing an appeal.
7. **Reimbursement:** Know the reimbursement amount and confirm the timeline and method of payment.

Some of these steps are more standard across MCOs, while others vary. Please refer to the Housing Supports **MCO guidance Section 12.C** and guidance provided by specific-MCOs on claim submission.

Claim / Billing Form Fields:
Required fields: Required fields must be complete to create a "clean claim" for submission. Required fields may include the following:

- Member and insurer's information, such as:
  - Name
  - Address
  - Date of Birth
  - Sex
  - Medicaid ID number
- Services information, such as:
  - Date(s) services were provided
  - Relevant HRSN Service HCPCS code(s)
  - Modifiers
  - Place of service code
  - Cost of service or charged amount
  - Unit amount
- Provider information, such as:
  - Name
  - Address
  - Tax ID
  - NPI
  - Taxonomy code

Suggested fields: Suggested fields are not required to create a "clean claim" but may provide useful information for MCOs or members. Suggested fields include:

- **International Classification of Diseases, 10th Revision Codes (ICD-10 Diagnosis Code)**: System used by physicians to classify and code all diagnoses or conditions in the case of HRSN Providers, symptoms, and procedures for claims processing. These codes capture social determinants of health (SDoH) influencing a member's health status or reasons for utilizing health services.

It is suggested that providers use the following ICD-10 codes (Z code) when billing for Housing Supports services:

Service	ICD-10 code (Z code)
Pre-tenancy Services	Z59.01; Z59.02
Tenancy Sustaining Services	Z59.811; Z59.2
Move-in Supports	Z59.01; Z59.02
Residential Modifications and Remediation Services	Z59.10; Z59.11; Z59.12; Z69.19

For reference only, below is an overview of applicable Z codes for different housing situations.

For **Pre-tenancy Services and Move-in Supports** – Experiencing Homelessness

Enrollee housing situation	Z codes that may be applicable
Homeless, Shelter/Safe Haven	• Z59.01 Sheltered Homelessness
Homeless, Unsheltered	• Z59.02 Unsheltered Homelessness
Homeless, Transitional Housing	• Z59.01 Sheltered Homelessness
Homeless, residing in a hotel or motel paid for by charitable organizations or by federal, State, or local government programs for low-income individuals	• Z59.01 Sheltered Homelessness

For **Tenancy Sustaining Services** – Unstable Housing

Enrollee housing situation	Z codes that may be applicable
Housed, but at risk of homelessness (e.g., housing instability, alleged lease violations etc.)	• Z59.811 Housing instability, housed, with risk of homelessness • Z59.2: Discord with neighbors, neighbors and landlord

For **Residential Modifications and Remediation Services** – Residing in Unhealthy Housing

Enrollee housing situation	Z codes that may be applicable
Housed, living in unhealthy housing (e.g., unsanitary conditions) or housing that is physically unsafe due to an Enrollee's disability or medical condition	• Z59.10: Inadequate housing, unspecified • Z59.11: Inadequate housing environmental temperature • Z59.12: Inadequate housing utilities • Z69.19: Other inadequate housing

Billing codes:

There are different types of billing codes that a claim requires:

- **Relevant HRSN Service HCPCS code(s)**: Uniform coding system that identifies and describes medical and other procedures. See table below.
- **Modifiers**: 2 characters (letters or numbers) appended to a HCPCS code to provide additional information about the procedure. See table below.

- **Place of service code**: 2 digits that describe where a service is provided. See CMS list here. Common place of service codes for housing supports services:
    - Homeless shelter: 04
        - A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
    - Home: 12
        - Location, other than a hospital or other facility, where the patient receives care in a private residence.
    - Temporary lodging: 16
        - A short-term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.
    - Outreach Site/Street: 27
        - A non-permanent location on the street or found environment, not described by any other POS code, where health professionals provide preventive, screening, and/or treatment services to unsheltered homeless individuals.

Note that for Tenancy Services, the date(s) of services provided in the claim must align to the authorization **and** billing period that the claim is being submitted for.

Service	Rate Structure	HCPCS Code	Service specification	Modifier
Pre-tenancy Services	Once per member per 30-day billing period	H0044	Lower level of need	U1
			Higher level of need	U3
Tenancy Sustaining Services	Once per member per 30-day billing period	H0044	Lower level of need	U4
			Higher level of need	U6
Move-in Supports	Cost-based reimbursement up to a cap	T2038	MLTSS Community Transition	No modifier
			Move-in Supports	U1
	Payment for administration	T2038	MLTSS Community Transition and Move-in Supports	U6
Residential Modification and Remediation Services	Cost-based reimbursement up to a cap	S5165	MLTSS modification services	No modifier
			Housing Supports modification services	U2
			Housing Supports remediation services	U3
	Payment for evaluation	T1028	MLTSS and Housing Supports	No modifier

D. Duplication

A provider cannot get paid twice (in full or in part) for a Housing Supports service provided to an individual. Double billing or duplicative reimbursement for the same service is not permitted. Medicaid Housing Supports services should not be duplicative with other federal, state, or locally funded programs.

Duplication of Provider Services

For Tenancy Services, a member may only have **one authorized Tenancy Services provider at a time**. The Housing Supports program utilizes a **First Come, First Served model**, where the first provider to submit services authorization is the only provider allowed to bill for member services unless the member requests a change. An example of a duplicate service is two authorized Tenancy Services providers serving one member at the same time.

Providers who are interested in serving a member through the Housing Supports program should first check if a member is already being served using the following methods:

- Ask the member during initial conversations.
- Check in HMIS via consumer look up for current Housing Supports providers, though a member may be hidden due to sensitivity of their situation. Like in other programs in HMIS, domestic violence victims and other protected groups might be hidden from others in the consumer lookup function.
- Ask the member's MCO if another provider is already serving them.
- Submit an authorization request and be denied.

If a new provider determines that a member is already receiving Tenancy services, they are encouraged to discuss with the member and reach out, as appropriate, to the previous provider to collaborate on path that best serves the members' interest (e.g., staying with the previous provider or submitting an authorization under the new provider).

MCOs will check for duplicate Medicaid providers during a service authorization request as defined in **MCO guidance Section 7.C**.

If a **new provider serves a member despite duplicative services**, they can expect the following:

- Their Housing Supports authorization request would be denied by the MCO. Any claims submitted by the new provider for the Housing Supports program would be denied by the MCO.
- They can serve the member under a different non-Medicaid program if the member is eligible for that program. These non-Medicaid services should augment the Medicaid-funded services.
- They should coordinate with the authorized Housing Supports provider, referring the member back to their original provider when necessary.

Duplication of Medicaid housing services

Additionally, the Housing Supports program seeks to avoid duplicating other state and federal services and to connect members to the more appropriate resources to meet their needs. As such, the Housing Supports program seeks to supplement, not supplant other government-funded housing services.

MCOs must check for duplicate Medicaid housing services. Duplicate Medicaid housing services are defined if:

- For Pre-tenancy and Tenancy Sustaining Services:
    - A member or individuals in the same household are authorized for more than 1 Tenancy Provider at a time.
    - A member is authorized for Tenancy Services and Community Supports Services (CSS)[7] and Integrated Case Management Services (ICMS) at the same time[8].
- For Move-in Supports:
    - A member or individuals in the same household exceed the lifetime cap for Move-in Supports, including if a member changes MCOs, and including spending on MLTSS Community Transition Services.
    - A member is simultaneously authorized for CSS or ICMS, or if the member is currently enrolled in MLTSS.
- For Residential Modifications and Remediation Services:
    - A member or individuals in the same household exceed the lifetime cap for Residential Modifications and Remediation Services, including if a member changes MCOs, and including spending on MLTSS Residential Modifications and Remediation Services.
    - A member is simultaneously authorized for Residential Modifications and Remediations Services and currently enrolled in MLTSS.
    - A member who participated in or is receiving services through Division of Development Disabilities (DDD) Community Care Program or Supports Program similar to Housing Supports Residential Modifications services (note: this limitation does not apply to Residential Remediation Services).

In some cases, households will be enrolled across MCOs. Providers should only submit one authorization per household for Housing Supports services. For example, if a household includes a mother enrolled in Horizon and a child enrolled in Aetna, both eligible for the Housing Supports program, the provider should submit just one authorization request. The provider is encouraged but not required to submit the authorization request on behalf of the head of household (i.e., the mother). MCOs may use their own systems data to verify household members submitted and ask providers questions if identifying a differing definition of the member's household.

Providers may provide Housing Supports services, noting the limitations above, to members who are eligible for or receiving other non-Medicaid/NJ FamilyCare housing services. These

[7] Community Support Services (CSS) consist of mental health rehabilitation services and supports necessary to assist consumers in achieving the goals identified in their individualized rehabilitation plans. These include: achieving and maintaining valued life roles in the social, employment, educational and/or housing domains, restoring a consumer's level of functioning to that which allows community integration, and remaining in an independent living setting of his/her choosing.

[8] MCOs can check CSS by looking at the respective special program codes (SpecialProgramCodes.pdf) Understanding that ICMS does not have a special program code but is still considered a duplicative service, MCOs are not required to check for ICMS through special program codes when authorizing services but should deny authorization if, from other sources such as the member care plan, they believe that the member is receiving ICMS.

other non-Medicaid/NJ FamilyCare services **may supplement**, not supplant services received by the member.

- Complementary programs include, but are not limited to, shelter stays, PATH, Social Services for the Homeless, or any non-Medicaid/NJ FamilyCare community-based service.
- For example, where a county or local provider may access funding for comparable housing under another program, they are not required to use that funding before providing and seeking payment or authorization for Housing Supports.

Duplication of claims

Claims submitted by a provider must be accurate and used to bill only for the Housing Supports program.

The program disallows double billing and duplicative reimbursement; therefore, a provider cannot get paid twice (in full or in part) for a Housing Supports service provided to an individual.

- A provider **cannot get paid twice by any funding source** (in full or in part) for a Housing Supports service provided to an individual, including across Medicaid and non-Medicaid sources. Double billing or duplicative reimbursement for same service is not permitted. Other available funding should be used to provide additional and complementary services or supports that may benefit NJ FamilyCare members or other community residents depending on the purposes of the funds.
- For example, a provider may not use Residential Modifications and Remediation Services and Children's System of Care environmental modification services to collect double payment for the same modifications to the home.

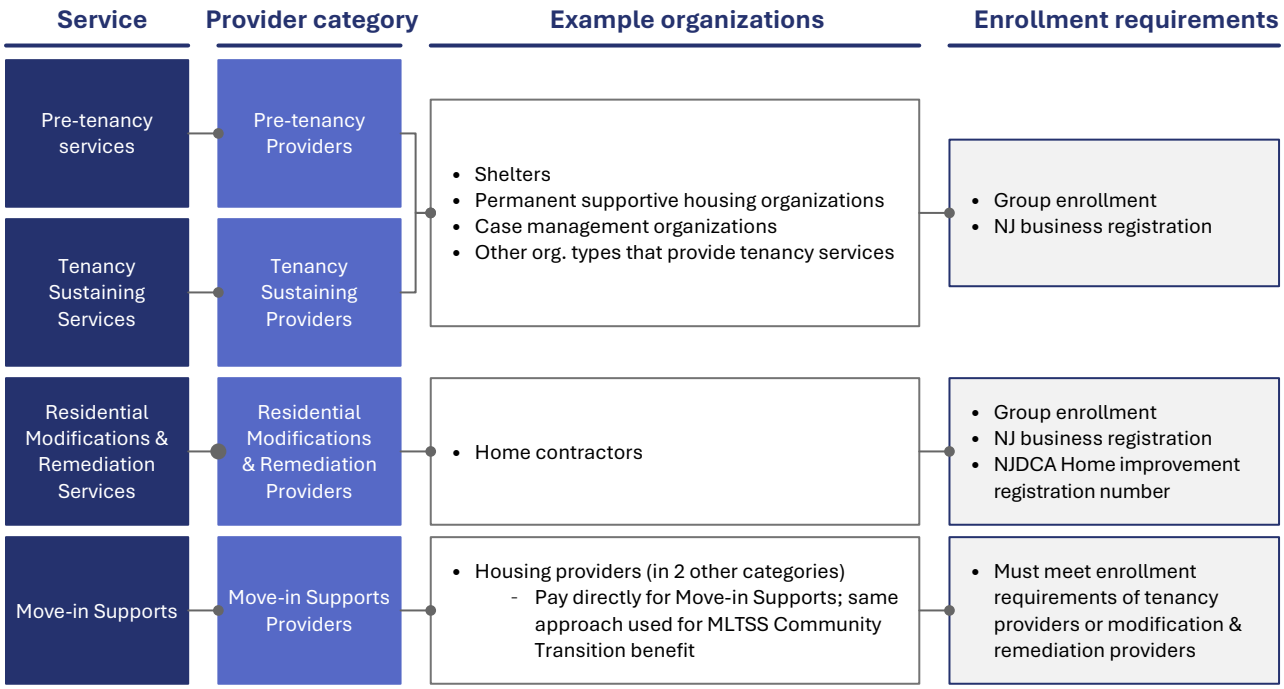
Fraud

If a claim is found to be inaccurate or duplicative, MCOs have the responsibility to review further and ask questions. If a resolution is not reached or if a provider is consistently under further review, the MCO reserves the right to disallow the provider from participating in the Housing Supports program. Providers who are found to have committed fraud are subject to consequences including but not limited to fines, restitution, exclusion from Medicaid/Medicare programs, revocation or suspension of licenses, and imprisonment.

9. Enrollment, Credentialing, and Contracting

A. Overview of Provider Types and Qualifications

4 housing provider categories based on the 4 housing services



1. Note: Move-in Supports includes paying for security deposits and moving costs. Tenancy Services providers, Residential Modifications & Remediation providers, and MCOs are well-positioned to arrange for these kinds of wide-ranging goods and services. As a result, DMAHS is not creating another distinct set of provider qualifications for Move-in Supports, but instead allows MCOs and other Housing Supports providers to deliver these services

Exhibit 5: Provider categories based upon type of housing service offered. Provider categories are not mutually exclusive (i.e., providers may provide both Pre-Tenancy and Tenancy Sustaining Services)

The Housing Supports program includes four provider categories based on the four housing services (Exhibit 5). Pre-tenancy Services are delivered by Pre-tenancy Providers. Tenancy Sustaining Services are delivered by Tenancy Sustaining Providers. Residential Modifications and Remediation Services are delivered by Home Modification and Remediation Providers. Move-in Supports are delivered by Move-in Supports Providers, who may be any of the above three provider categories (or the service may be delivered by MCOs themselves).

Housing Supports are MCO-covered services – meaning these services are paid for and authorized by MCOs; they are not paid FFS. To become an in-network Housing Supports provider with an MCO, an organization must complete the following steps:

i. **Obtain an NPI number**
   - Organizations can apply via <NPPES>.
   - Organizations should apply for a Type 2 NPI
   - Taxonomy codes:
     - 251B00000X (Case Management): Pre-tenancy and Tenancy Sustaining Services
     - 171W00000X (Contractor): Residential Modifications and Remediation Services

ii. **Enroll with Medicaid/NJ FamilyCare** via the Housing Supports Group Provider application available on NJMMIS.com
   - Enrollment is at the organizational level only; individual housing case managers are not required to enroll individually.

iii. **Credential and contract with a managed care organization**
   - See **Sections 9.D-F** for additional detail on this process
   - Similar to enrolling with NJ Medicaid, credentialing and contracting is at the organizational level only; individual housing case managers are not required to credential and contract with MCOs individually.

B. Obtaining an NPI Number

To enroll with Medicaid or to become credentialed as an in-network MCO provider, organizations should obtain a National Provider Identifier (NPI) number with the appropriate taxonomy codes that correspond to the services they intend to provide.

For existing providers:

Prospective Housing Supports providers who are currently enrolled as a NJ FamilyCare provider under another provider specialty with a Type 2 NPI will not need to obtain a new NPI for their Housing Supports program enrollment. Existing providers with just a Type 1 NPI will need to obtain a new Type 2 NPI.

If prospective Housing Supports providers already have an existing Type 2 NPI, they must update the information associated with their existing NPI to add new taxonomy codes consistent with the guidance below for new providers. Adding new taxonomy codes is intended to supplement, not replace, existing taxonomy codes associated with services for current programs. These added taxonomy codes align with new services or specialties associated with the Housing Supports program.

For new providers:

Organizations that do not yet have an NPI number should apply via <NPPES>. Refer to CMS how-to guide here: https://nppes.cms.hhs.gov/assets/How_to_apply_for_an_NPI_online.pdf.

There are two types of NPI numbers: Type 1 is for individual providers, while Type 2 is for healthcare organizations and businesses. Housing Supports services are only delivered by organizations and businesses. **As such, your organization must apply for a Type 2 NPI to become a Housing Supports provider**.

Organizations must select at least one taxonomy code when applying for an NPI. Organizations should select the primary taxonomy code that best aligns with the work they do and the services they provide when completing their NPI application. Organizations that already have an NPI should update the information associated with their NPI to **add new taxonomy codes consistent with new services or specialties**.

The following taxonomy codes will be used for the following services:

- Pre-tenancy and Tenancy Sustaining Services: 251B00000X (Case Management)
- Residential Modifications and Remediation Services: 171W00000X (Contractor)

C. Enrolling as a Medicaid Provider

Providers that are new (organizations that are not yet enrolled with Medicaid/NJ FamilyCare) and existing (enrolled with Medicaid/NJ FamilyCare under other programs) both must complete a Housing Supports enrollment application. Organizations that are already enrolled as Medicaid/NJ FamilyCare providers can use their existing NPIs and Medicaid IDs.

Medicaid/NJ FamilyCare enrollment is managed by NJ DMAHS and its vendor Gainwell Technologies. Enrolling in Medicaid/NJ FamilyCare is a pre-requisite to joining managed care networks and to billing for housing supports services provided to Medicaid/NJ FamilyCare members, even though all services are paid for and coordinated by MCOs. The re-validation timeline for Housing Supports providers is every five years.

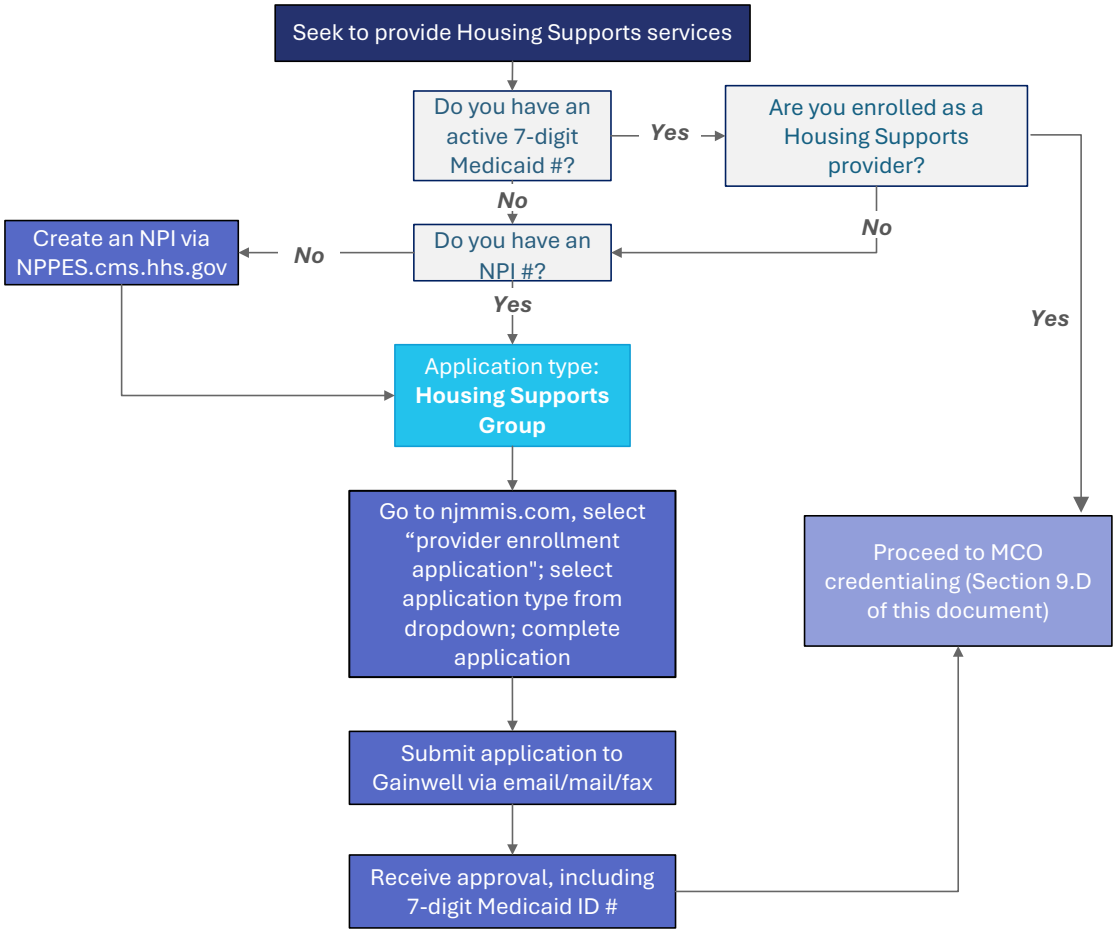


Exhibit 6: High-level Medicaid/NJ FamilyCare enrollment

Step 1: Enroll with Medicaid/NJ FamilyCare via the Housing Supports Group Provider Application
Housing Supports providers must enroll via the Housing Supports Group Provider Application. The enrollment application can be found on the NJMMIS website: https://www.njmmis.com/providerEnrollment.aspx.

Step 2: Complete Housing Supports Group Provider Application
The enrollment process requires providers to submit detailed information about your organization and background to the state for validation and record-keeping.

A high-level, non-exhaustive summary of **key documentation requirements** is below, but providers are encouraged to review the application specific to your provider type:

- **Information to compile**:

    - NPI
    - TIN (SSN or EIN)
    - Registration
        - New Jersey business registration
        - Residential Modifications and Remediation providers: NJDCA Home Improvement Registration
        - Address
- **Forms**
    - Signature authorization form
    - Provider agreement
    - Provider application form
    - Copy of IRS 147C Letter
    - Agreement of Understanding
    - Disclosure of Ownership and Control Interest Statement

Prospective providers are also required to identify which services they intend to provide by checking one or more provider specialty types (corresponding to the respective provider categories below) in the enrollment application.

Housing Supports providers can be classified into **one or more provider categories** during enrollment. Providers should be classified for the category that they intend to deliver services (and be credentialed) for:

Provider category	Service(s)	Example organizations	Enrollment requirements
Pre-tenancy Providers	Pre-tenancy Services	• Shelters • Permanent supportive housing organizations • Case management organizations • Other organization types that provide Pre-tenancy Services	• Group enrollment • NJ business registration
Tenancy Sustaining Providers	Tenancy Sustaining Services		
Residential Modifications & Remediation Services Providers	Residential Modifications and Remediation Services	• Home contractors	• Group enrollment • NJ business registration • NJDCA Home Improvement registration number
Move-in Supports Providers	Move-in Supports	• Housing providers (in 2 other categories)	• Must meet enrollment requirements of Tenancy Services providers or Residential Modifications & Remediation Services Providers

Step 3: Submission and next steps
You must either email, fax, or mail a copy of your enrollment application to Gainwell to complete submission. Please only submit via one of these methods:

- **Address:** Gainwell Technologies Provider Enrollment, P.O. Box 4804, Trenton, NJ 08650
- **Email:** njmmisproviderenrollment@gainwelltechnologies.com
- **Fax number:** 609-584-1192

If you would like to check the status of your application, please contact Gainwell via the above email address or by phone:

- **Phone number**: 609-588-6036

Housing Supports Providers will also need to be credentialed. MCOs have different requirements regarding the completion of the Medicaid enrollment process prior to credentialing (summarized below). See **Section 9.D** of this document for more information on credentialing.

Aetna, United, Horizon	Require providers to complete Medicaid/NJ FamilyCare enrollment **before** completing the credentialing process.
Fidelis, Wellpoint	Encourages providers to complete Medicaid/NJ FamilyCare enrollment before completing the credentialing process but **allows** for proof of a submitted Medicaid/NJ FamilyCare provider application **during** the credentialing process.

D. Credentialing with MCOs

Joining MCO networks is a pre-requisite to delivering services in the Housing Supports program. MCOs require that Housing Supports Providers are credentialed to ensure that the provider has the necessary qualifications to join the MCO's network.

If the provider is already credentialed for a non-housing service (e.g., as an FQHC), then the MCOs must still credential for Housing Supports via the same process. If the provider is already credentialed for MLTSS modifications, then it is up to MCO discretion to waive the formal credentialing process for Housing Supports Residential Modifications and Remediation Services. We recommend that you reach out to the relevant MCO representative to determine the process for reviewing the terms of your agreement.

1. Determine which MCOs you need to credential with

There are five NJ FamilyCare MCOs: Aetna, Fidelis, Horizon, United Healthcare, and Wellpoint. To serve the broadest set of members, and to prevent problems with continuity of care as eligibility and member MCO enrollment frequently changes, **we strongly encourage you to credential and contract with all five MCOs to avoid delays in care provision and payment.**

MCOs must credential Housing Supports Providers as organizations. Individual housing case managers and individual contractors (i.e., individual employees who work for Tenancy Providers and Residential Modifications and Remediation Providers) are not required to credential with the MCOs individually or to be included in a roster.

2. Compile relevant information and documents

The credentialing process includes validating multiple types of data about a provider. According to current NJ state standards (N.J. Admin. Code § 11:24C-1.3), the credentialing process for providers at a minimum must include validation of:

- **Experience:**
  - Work history
- **Liability, sanctions, and insurance:**
  - Liability Insurance with minimum amounts of $1M per aggregate and $3M per occurrence
  - Any suspension of state license or DEA number
  - Any sanctions imposed by Medicaid & Medicare
  - Any loss of license or hospital privileges and felony convictions (See **Section 9.F** for additional details on validation)
- **Attestations:**
  - Completeness and correctness of application

3. Select the appropriate credentialing application

Providers should complete the appropriate credentialing application based on the services they intend to deliver under the Housing Supports program:

Provider category	Application form
Providers delivering Pre-tenancy and Tenancy Sustaining Services	Housing Supports Provider Credentialing Application Form for Pre-Tenancy and Tenancy Sustaining Services **(standardized across all five MCOs).** See application form here
Providers delivering Residential Modifications and Remediation Services	New Jersey Medicaid Non–Traditional Provider Application **(not standardized across the MCOs)**

Organizations offering both Pre-Tenancy/Tenancy Sustaining Services **and** Residential Modifications and Remediation Services need to complete credentialing for **both** services using the appropriate application forms.

4. Submit credentialing applications

Providers have several options to submit their credentialing applications, summarized below.

Electronic Submission	Providers must credential with each MCO separately, with applications available through each MCO's website or via email with the relevant MCO contact.
	
	Application submissions:
	• Aetna:
	  ○ Link: Join Our Provider Network | Aetna Medicaid New Jersey
	  ○ Email: NJHousingServices@aetna.com
	• Fidelis:
	  ○ Link: Become a Provider
	  ○ Email: marlene.g.mercado@fideliscarenj.com
	• Horizon
	  ○ Link: Join Our Networks - Horizon Blue Cross Blue Shield of New Jersey
	  ○ Email: Alana_McDonald@horizonblue.com
	• United
	  ○ Link: Join Our Network
	  ○ Email: hcbsprovidernetwork@uhc.com
	• WellPoint
	  ○ Link: Home | Wellpoint New Jersey, Inc.
	  ○ Email: NJHousing@wellpoint.com

5. Expected credentialing timeline

Most applications should be approved or denied within 60 days. Examples of why an application may require additional review include:

- Required **fields are missing** from the application or have **errors**
- A provider has been flagged as having **past sanctions/suspension of licenses** that require further investigation

To avoid processing delays, providers are strongly encouraged to conduct a careful review of all information submitted in the credentialing application and work with MCO representatives on any questions prior to application submission.

Re-credentialing must take place every 36 months.

See **Section 14.B**. for MCO contact information for joining each MCO's network.

E. Contracting with MCOs

In addition to credentialing with the MCO, your organization will need to contract with the MCO. Some MCOs require contracting before credentialing, while others conduct both processes concurrently:

Aetna, Fidelis, Wellpoint	Conduct credentialing and contracting simultaneously
Horizon	Conduct contracting before credentialing
United	Conduct credentialing before contracting

Providers should work with the network contracting teams at each MCO to confirm and initiate the contracting process relative to the credentialing process.

See **Section 14.B**. for MCO contact information for joining each MCO's network.

F. Other Requirements to Join MCO Networks

Housing Supports providers must abide by each MCO's background check policies. These policies may occur outside of the credentialing process and may require fingerprint-based background checks. MCOs may meet their requirements to validate that providers have met their background check requirements by accepting an attestation that Housing Supports providers have completed criminal background checks for the authorized representatives of the organizations and member-facing employees.

MCOs may require Housing Supports providers to comply with MCO-specific HIPAA-compliance during their contracting processes. Non-compliance from providers may result in failure to be provided a contract.

G. Subcontracting

Housing Supports providers may consider subcontracting to support specific business functions (e.g., back-office functions, such as data management or claims/billing support). Housing Supports providers must abide by each MCO's subcontracting policies. Additionally, the Housing Supports program requires that member-facing staff who provide Housing Supports services must be employed by a credentialed Housing Supports provider.

10. Coordinating Care with MCOs

A. Housing Case Management Versus MCO Care Management

A member authorized to receive Tenancy Services may be assessed for complementary supports from MCO-led care management, in addition to provider-led case management services from their tenancy provider. While there are similarities between housing supports provider-led housing case management and MCO-led care management, they are distinct supports and have different values to the member. MCOs connect a member served by housing supports providers to the behavioral health and physical health care that the member needs.

Roles

There are 3 roles involved in coordinating member care for Tenancy Services: a member's MCO care manager, a member's MCO Housing Specialist, and a member's Tenancy Services provider.

Members benefit differently from MCO and Tenancy Services provider, with Housing Specialist responsible for most housing care mgmt. responsibilities

	MCO care managers All services	**MCO Housing Specialist** Tenancy Services	**Housing Supports Providers** Tenancy Services
Definition	**Office-based** care managers help members achieve **biopsychosocial goals and health outcomes** Make **referrals** to physical health and behavioral health providers	**Office-based Housing** Specialists help members achieve **housing goals** Make **referrals** to Housing Supports program providers[1]	**Field-based services** to connect members to resources and to **find & maintain housing**, by: ○ Searching for housing ○ Completing applications for government assistance ○ Assisting with lease renewals
Unique benefit to members	Access member's medical history and health data Connect member to health care providers/experts to ensure access to care encompassing all aspects of member needs	Provide regional expertise on the housing ecosystem, key organizations and players Connect members to most relevant housing services	Find and maintain member's housing Provide deep expertise on the housing ecosystem On-the-ground understanding of member's needs and environment

Exhibit 7. MCO Housing Specialists handle most member-facing MCO interactions for the Housing Supports program instead of the MCO care manager.

Housing case management:
Tenancy Services provider-led case management consists of delivering Pre-tenancy and Tenancy Sustaining Services.

Pre-tenancy Services include developing an individualized housing support plan, assisting with navigating the complexities of the housing application process through the progression of prospective tenant to tenant, assisting with the housing search, as well as Identifying, coordinating, and securing resources to assist with housing costs and other expenses.

Tenancy Sustaining Services include developing or revising an individualized housing support plan, assisting with the housing recertification processes, educating and training on the roles, rights and responsibilities of the tenant and landlord, supporting the member in development of independent living and tenancy skills, identifying and helping secure benefits or supports to help pay for rent and utilities, and providing assistance in addressing circumstances or behaviors that may jeopardize housing.

MCO care management:
MCO-led integrated care management consists of a set of member-centered, goal-oriented, culturally relevant and logical steps to assure that a member receives needed services across providers/settings in a timely and cost-effective manner. MCO-led integrated care management is a free service for all eligible members of each MCO, with numerous screening opportunities. If eligible, members will be assigned an MCO care manager to support their care needs.

MCO-led integrated care management is intended to supplement a member's existing care providers, including provider care/case management services (such as Housing Supports Services). MCO-led integrated care management is differentiated from provider case management due to the MCO's purview over a member's physical and behavioral health needs, access to comprehensive member data, and role in overseeing and coordinating all member services.

For Housing Supports program services, **MCO care managers and Housing Specialists will work collaboratively** by sharing member updates (i.e., provider referrals, service monitoring, and any engagement with providers).

- A Housing Specialist will focus on helping members achieve their housing goals. MCO care management will leverage the Housing Specialist's expertise when more specialized housing knowledge would prove beneficial to the member.
- An MCO care manager will focus on helping members achieve biopsychosocial goals and health outcomes. MCO care managers can connect members to physical health and behavioral health providers. However, both physical and behavioral health MCO care managers will receive training on housing topics including the Housing Supports program to ensure successful care management for members receiving Housing Supports services.

B. MCO Care Management Enrollment and Assessment Tools

All members authorized for Pre-tenancy and Tenancy Sustaining Services are eligible and assessed for care management services. Members who are enrolled in care management should be assigned a care manager (if not already assigned) to have a complete assessment within 30 days after the initial approval for Pre-tenancy and Tenancy Sustaining Services.

C. MCO Housing Specialist Responsibilities

The MCO Housing Specialist is a position that currently exists in the MCO and has responsibilities coordinating Healthy Homes program placement[9] and providing housing services to the MLTSS population. The Housing Specialist will retain all previous responsibilities and will now also have responsibilities for the Housing Supports program.

For the Housing Supports program, the **Housing Specialist will be a member- and provider-facing position assigned to those receiving Housing Supports program Pre-tenancy and Tenancy Sustaining Services**. The Housing Specialist is responsible for the following responsibilities:

- Follow up on program referrals
- Where applicable, support the MCO care manager's development of the housing aspects of the member's MCO care plan
- **Make informed Housing Supports program provider referrals**
- **Ensure timely delivery of services**
- **Monitor member services**
- **Monitor providers**
- Provide a warm handoff to members at the end of program services
- **Build meaningful relationships with the provider community**

Members have the option of opting out of Housing Specialist communications; in these cases, the Housing Specialist will not have touchpoints with the member but will still reach out to the provider for communication as described below.

Please refer to the **MCO guidance Section 9** for a more detailed description of Housing Specialist responsibilities.

D. Tenancy Services Provider Responsibilities

Tenancy Services providers should work collaboratively with MCO care managers (if applicable) and MCO Housing Specialists to provide the appropriate, necessary care for a member according to a member's care plan.

Tenancy Services providers should provide updates to a member's MCO Housing Specialist if there are significant changes to a member's health or housing status. Providers should discuss what information to share with a member's Housing Specialist; if a provider does not know, they should use their best judgment on what information to communicate to a member's Housing Specialist.

Tenancy Services providers must respond to MCO Housing Specialist outreach in a timely manner.

[9] See Healthy Homes program guidance linked here (https://www.nj.gov/dca/divisions/dhcr/offices/docs/bh/njhealthhomesguidelines.pdf).

11. Quality and Data Reporting

A. Quality and Data Reporting Overview

In addition to documenting member touchpoints as mentioned in **Section 8.B**, providers are also encouraged to track information on members and services in the Housing Supports program, as MCO monitoring of providers may include requesting information on program activity from providers. DMAHS may share further guidance on reporting requirements.

12. Additional Resources

A. State Resources

General information related to NJ FamilyCare:

- **NJ FamilyCare Website:** https://njfamilycare.dhs.state.nj.us/
- **NJ FamilyCare Managed Care Contract:** http://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf
- **DMAHS Provider Newsletters**: https://www.njmmis.com/documentDownload.aspx?fileType=076B9D7D-96DC-4C8A-B9CE-BA46F47DDE1F

Information specific to Housing Supports program:

- **MCO guidance:** https://camdenhealth-website-media.nyc3.digitaloceanspaces.com/wp-content/uploads/2025/04/02123931/Housing-Supports-MCO-Guidance-Standards_vFINAL3-27-2025-1.pdf
- **DMAHS website:** https://www.nj.gov/humanservices/dmahs/home/
- **DMAHS Housing Supports program website:** www.camdenhealth.org/official-HSP-documents
- DMAHS Housing Supports email: DMAHS.HousingSupports@dhs.nj.gov

B. Training and Troubleshooting Supports

Camden Coalition NJ FamilyCare Housing Supports program resource hub:
https://camdenhealth.org/work/nj-familycare-housing-supports-program/

- Includes information about the program, past and upcoming webinars, and resources

C. MCO Resources

MCO	Additional resources
Aetna Better Health of New Jersey	Provider Website Provider Manual Quick Reference Guide Provider Portal New Provider Orientation

Fidelis Care (Formerly Wellcare)	Website Provider Manual (scroll down to 'Resources' to download) Quick Reference Guide (scroll down to 'Resources' to download) Provider Portal Network Directory New Provider Orientation
Horizon NJ Health	Website Provider Manual Quick Reference Guide Provider Portal Network Directory
United Health Care (UHC)	Website Provider Manual Provider Portal Network Directory
Wellpoint (Formerly Amerigroup)	Website Provider Manual Quick Reference Guide Provider Portal Network Directory

13. Provider Readiness Checklist

Category	Contacts and resources Have you reviewed these items?	Readiness steps Have you completed these steps?
Medicaid Enrollment	• DMAHS provider enrollment guidance **(Section 9.C)** • Camden Coalition Enrollment & Credentialing training • Gainwell Provider Unit: 609-588-6036	• Enrolled in Medicaid per guidance instructions
Joining MCOs (Credentialing & Contracting)	• MCO's quick reference guide (QRG) & provider manual • DMAHS provider credentialing and contracting guidance **(Section 9.D and 9.E)** • Camden Coalition Enrollment & Credentialing training • Points of contact at MCO for credentialing & contracting	• Contracted with MCO(s) you wish to join • Completed MCO credentialing process per guidance instructions
Service authorization	• DMAHS service authorization guidance **(Section 7)**	• Identified preferred method to submit service

	• Points of contact at each MCO for service authorization	authorization requests to MCOs
Service delivery	• DMAHS payment model and service delivery guidance **(Section 8.A and 8.B)**	• Identified minimum requirements of service delivery for each member
Claims	• DMAHS claims guidance **(Section 8.C)**	• Created login for MCO portal to efficiently submit claims
Coordinating care with MCOs (strongly recommended)	• Points of contact at MCO for care management • DMAHS coordinating care with MCOs guidance **(Section 10)**	• Identified MCO Housing Specialist and care manager (if applicable) for each member

14. Key Contact Information

For questions or concerns related to the Housing Supports program, please contact the State of the relevant MCO.

A. State

DMAHS

- **Email**: DMAHS.HousingSupports@dhs.nj.gov
- **Address**: New Jersey Department of Human Services (NJDHS), Division of Medical Assistance & Health Services (DMAHS), Office of Policy, P.O. Box 712, Hamilton, NJ 08691
- **Website:** https://www.nj.gov/humanservices/dmahs/home/

For general NJ FamilyCare information (not specific to Housing Supports), contact: **NJ FamilyCare's Medicaid Hotline** at 1-800-356-1561 (TTY: 1-800-701-0720)

Gainwell Technologies

- **Address:** Gainwell Technologies Provider Enrollment, P.O. Box 4804, Trenton, NJ 08650
- **Email:** njmmisproviderenrollment@gainwelltechnologies.com
- **Fax number:** 609-584-1192
- **Phone number:** 609-588-6036

B. MCOs

Aetna Better Health of New Jersey	
Housing Supports Director	**Joel Martinez** Email: martinezj15@aetna.com
Credentialing Contact	**Angelica Miranda** Email: mirandaa2@aetna.com

	Kimberly Lees Email: LeesK1@aetna.com **June-Delina Parkes** Email: ParkesJ@aetna.com
Referral Information	Telephone: 1-855-232-3596 (TTY: 711) Fax: 1-844-219-0223 Email: NJHousingServices@aetna.com Physical mail: Aetna Better Health of New Jersey ATTN: Provider Services PO Box 818003 Cleveland, OH 41181-800
Network Contact	Link: Join Network Email: NJHousingServices@aetna.com
Fidelis Care (Formerly Wellcare)	
Housing Supports Director	**Christina Cullen** Email: Christina.Cullen@fideliscarenj.com
Credentialing Contact	**Marlene G. Mercado** Email: Marlene.G.Mercado@fideliscarenj.com
Referral Information	Telephone: 855-642-6185 Fax: 855-573-2346 Email: HousingSupports@centene.com
Network Contact	Link: Become a Provider Email: Marlene.G.Mercado@fideliscarenj.com
Horizon NJ Health	
Housing Supports Director	**Lauren Jacobs** Email: Lauren_Jacobs@horizonblue.com
Credentialing Contact	**Alana McDonald** Email: Alana_McDonald@horizonblue.com **Jill Volarich** Jill_Volarich@horizonblue.com
Referral Information	**HNJH Member Services** Telephone: 1-800-682-9090 Fax: 973-274-3864 (Attn: Housing Supports Program) Email: HorizonHSPReferrals@horizonblue.com
Network Contact	Link: Join Our Networks - Horizon Blue Cross Blue Shield of New Jersey Email: Alana_McDonald@horizonblue.com
United Health Care (UHC)	
Housing Supports Director	**Hilary Delany** Email: hilary_delany@uhc.com
Credentialing Contact	**Anjanette Williams** Email: hcbsprovidernetwork.com

Referral Information	Telephone: 800-941-4647 Email: NJ_HousingSpecialist@UHC.com
Network Contact	Link: Join Our Network Email: NJ_HCBS_PR@UHC.com
Wellpoint (Formerly Amerigroup)	
Housing Supports Director	**Ebony Washington** Email: Ebony.Washington2@wellpoint.com
Credentialing Contact	**National Provider Services Line** Telephone: (800) 397-1630 Mon-Fri 8AM-8PM EST
Referral Information	**Darcy Hillstrom** Telephone: 640-249-9808 Fax: 855-553-9392 Email: Darcy.Hillstrom@wellpoint.com
Network Contact	**Rhonnda Talton** Link: Home | Wellpoint New Jersey, Inc. Email: NJHousing@wellpoint.com

15. Update History

This is the first published version of the Housing Supports provider guidance. As DMAHS publishes updated versions of this guidance, it will note major changes in this section.