



# Essential Information for New Jersey FamilyCare Providers

*Office of Managed Health Care*

*NJ Department of Human Services*

*Division of Medical Assistance and Health Services*

# Presentation Topics

- Overview of New Jersey Medicaid/NJ FamilyCare
- Confirmation of Member Eligibility
- Provider Relations Overview- DMAHS /OMHC
  - Balance Billing
  - Authorization and Claims Processing
  - Continuity of Care
  - Utilization Appeals
- Provider /Stakeholder Resources

# What is Medicaid?

- Medicaid is a joint Federal and State program that helps pay medical costs if individuals have limited income and resources or meet other requirements
- Medicaid is a voluntary program. If you want to participate, you must know, accept and abide by the rules and regulations
- New Jersey Medicaid is referred to as NJ FamilyCare in member and provider communication

# New Jersey Medicaid Managed Care Contracts

- The New Jersey Department of Human Services, DMAHS, has a contract with the following Managed Care Organizations:
  - Aetna Better Health of New Jersey
  - Fidelis
  - Horizon NJ Health
  - UnitedHealthcare Community Plan
  - Wellpoint

# Administration & Oversight

- The Medicaid program in New Jersey is administered and/or overseen by:*



# Confirmation of Members NJ FamilyCare Eligibility

# Provider's Requirement to Confirm NJ FamilyCare Eligibility

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

# Medicaid Eligibility Verification System (MEVS) E-Mevs

- Medicaid Eligibility Verification System (**MEVS**) is an electronic system used to verify recipient Medicaid eligibility. This electronic verification process will provide date specific eligibility which will help reduce claim denials related to eligibility. It can help to eliminate Medicaid fraud.
- NJ Providers access eMEVS through “**Login**” on the NJMMIS website [www.njmmis.com](http://www.njmmis.com)
- In order to login, individual *must* have a secure username and password
- Users ids and passwords are requested through Provider Registration link on the NJMMIS navigational bar on main screen.

- Home
- Site Requirements
- Help Index by Topic
- State & Fed Web Sites
- Account Links
  - HIPAA Submitter Login
  - Reset Password
  - Login**
- Communication
  - Contact Provider Services
  - Contact Webmaster
  - Forgot My Password
  - Provider Directory
  - Provider Enrollment Application
  - Provider Enrollment Application Status
  - Provider Registration
- Information
  - Approved Vendor List
  - Billing Supplements / Training Packets
  - Recent Newsletters
  - Edit Codes
  - FAQ
  - Forms & Documents
  - Physician Administered Drugs (UOM)



### Headlines

[Click here for more headlines](#)  
 Having difficulty logging into the secure area of the website? [Click here](#) for a frequently asked questions.

### Technologies

1-800-  
[Click here for](#)

### Announcements

[Click here for more announcements](#)  
 ▶ [Click here To Report Fraud or Abuse In the Medicaid Program or Call 1-888-937-2835.](#)

▶ **New: MEDICAID PROVIDER TRAINING:**  
 Lessons for Avoiding Medicaid Fraud, Waste and Abuse:  
 A presentation for New Jersey Allergy and Immunology Providers  
**Wednesday, February 25, 2026** from 10am-11:30am  
 Virtual via Zoom Webinar

and registration information.  
**com Users: On or after November 13th,**  
 your password expires or you perform a password  
 create a new password that is at least 15  
 at least two letters, one number, and one  
 continue to expire every 90 days and cannot be  
 logged in once every 90 days to remain

**Primary Account Administrators** must ensure each user has a separate sub-account - shared logins are not HIPAA compliant. Admins are responsible for maintaining accurate details of each sub-account.  
[Click here](#) for instructions and support.

▶ [Click here](#) for the **2026** Charity Care Claims Submission Schedule.

**Users access eMEVS by selecting Login**

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  - Provider Enrollment Application
  - Provider Enrollment Application Status
  - Provider Registration

**Welcome to New Jersey Medicaid**

**Attention PROVIDERS! Click [here](#) for important information regarding your web site access.**

Please login below.

UserName:

Password:

Forgot your password, [click here](#)

Need a username, [click here](#)

**Enter your secure Username and Password**

# Balance Billing

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

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

**Volume 23 No. 15      September 2013**

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

All Medicaid/NJ Family Care newsletters posted on [njmmis.com](http://njmmis.com)

# Managed Care Organization Provider Relations Unit Requirements

- Create an annual provider manual and preparing updates as necessary;
- Offer provider education and outreach, and
- Provide a call center for claims troubleshooting for providers
- Establish process for claims and utilization appeals
- Assign Provider representative or contact to address Provider contract

# Prior Authorization Parameters

- Prior authorization decisions for non-emergency services shall be made within 14 calendar days
- Prior authorization denials and limitations must be provided in writing in accordance with the Health Claims Authorization Processing and Payment Act, P.L. 2005, c.352.
- Source: Health Claims Authorization Processing and Payment Act, P.L. 2005, c.352.

# Prior Authorization Guidelines for NJ Family Care Services

<b>New Member No Existing Plan of Care</b>	<b>Member Transitions to MCO with existing Plan of Care for LTCE</b>
<p>MCO must prior-authorize service</p>	<p>MCO must honor continuity of care parameter of contract</p>
<p>Provider must be in Network with MCO and/or have a single case agreement to serve member</p>	<p>MCO and Provider must set up SCA or join network. Approved services as per existing plan will be reimbursed until new plan of care established</p>

# Managed Care Organization Claim Submission Requirements

- Capture and adjudicate all claims submitted by providers
- Support NJs NJ Family Care's encounter data reporting requirements
- Comply with "Health Claims Authorization, Processing and Payment Act" (HCAPPA) for all Medical Services
- Ensure Coordination of Benefits (exhaust all other sources of payment before NJ Family Care pays)

# Claim Processing Compliance with Federal and State Laws and Regulations

1. The Provider/Subcontractor shall submit claims within 180 calendar days from the date of service.
2. The Provider/Subcontractor shall submit corrected claims within 365 days from the date of service.
3. The Provider and Subcontractor shall submit Coordination of Benefits (COB) claims within 60 days from the date of primary insurer's Explanation of Benefits (EOB) or 180 days from the dates of service, whichever is later.

# Claim Dispute

- **Adjudicate** – the point in the claims/encounter processing at which a final decision is reached to pay or deny a claim, or accept or deny an encounter.
- **Contested Claim** – a claim that is denied because the claim is an ineligible claim, the claim submission is incomplete, the coding or other required information to be submitted is incorrect, the amount claimed is in dispute, or the claim requires special treatment.

# Continuity of Care

# Continuity of Care

- **Definition:** The plan of care for an enrollee that should assure progress without unreasonable interruption
- The Contractor shall ensure continuity of care and full access to primary, behavioral, specialty, MLTSS and ancillary care as required under this contract and access to full administrative programs and support services offered by the Contractor for all its lines of business and/or otherwise required under this Contract.
- *Source: Article 2.B of the July 2017 NJ FamilyCare Managed Care Contract*

# Utilization Appeals

# UM Appeal Process: Definitions

- **UM Appeal:** An appeal of an adverse Utilization Management determination, initiated by the Member (or a provider acting on behalf of a Member with the Member's written consent)
- **Utilization Management Determination:** A decision made by a Managed Care Organization (MCO) to deny, reduce, suspend or terminate a service based on medical necessity

# Utilization Appeals Guidelines for NJ Family Care Services

	IURO (External Appeal) Time Frame	Medicaid Fair Hearing	Continuation of Benefits
<b>NJ FamilyCare A and ABP Members</b>	Yes*	Yes	Member and/or Provider on behalf of member must request within appeal timelines
<b>Appeal Process for NJFC B, C, and D Members</b>	Yes	Not Available	Member and /or Provider on Behalf of member must request within appeal timelines
(Select services are not eligible for IURO: Adult Family Care, Assisted Living Program, Assisted Living Services, Caregiver Participant Training, Chore Services, Community Transition Services, Home Based Supportive Care, Home Delivered Meals, PCA, Respite, Social Day Care, Structured Day Program )			

# Resources for Providers and Stakeholders

# Mobile Friendly & Browser Independent

**NJ FAMILYCARE**  
Affordable health coverage. Quality care.

Home | Timeline | Eligibility | Medicaid Expansion | LTC | HEDIS | CAHPS | More Information

### Introduction

The Division of Medical Assistance and Health Services is pleased to present the NJ FamilyCare data analytics dashboards. The objective of these web-based dashboards is to enable greater transparency to the Medicaid program. Users can gain a more timely and in-depth knowledge of key demographic and performance metrics. Assistance and guidance for the development of the dashboards was received under the umbrella of the CMS Data Analytics Medicaid Innovator Accelerator Program.

[For more information on the Medicaid Innovator Accelerator Program, click here.](#)

#### NJ FamilyCare Highlights

<b>1,756,136</b> Total Enrollment	<b>94.1%</b> Managed Care Enrollment	<b>47.4%</b> Long Term Care Population in Home and Community Based Services	<b>92</b> New Behavioral Health Providers Added Since Rate Increase
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#### Monthly Enrollment Reports

**NJ FAMILYCARE**  
Affordable health coverage. Quality care.

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**NJ FamilyCare Highlights**

# Link to Website with Enrollment Information

[njfamilycare.org](http://njfamilycare.org)

[njfamilycare.org/analytics/home.html](http://njfamilycare.org/analytics/home.html)

Call 1-800-701-0710  
TTY: 1-800-701-0720

Hours of Operation:  
Monday and Thursday  
8:00 A.M. - 8:00 P.M.  
Tuesday, Wednesday, Friday  
8:00 A.M. - 5:00 P.M.



Welcome to the NJ FamilyCare website.

NJ FamilyCare - New Jersey's publicly funded health insurance program - includes CHIP, Medicaid and Medicaid expansion populations. That means qualified NJ residents of any age may be eligible for free or low cost health insurance that covers doctor visits, prescriptions, vision, dental care, mental health and substance use services and even hospitalization.

If you are a NJ resident and you need [more information](#) on this program, please read through the pages of this website and see how to become a member of NJ FamilyCare.

Individuals ineligible for NJ FamilyCare can find information on other insurance affordability programs at [www.healthcare.gov](http://www.healthcare.gov).

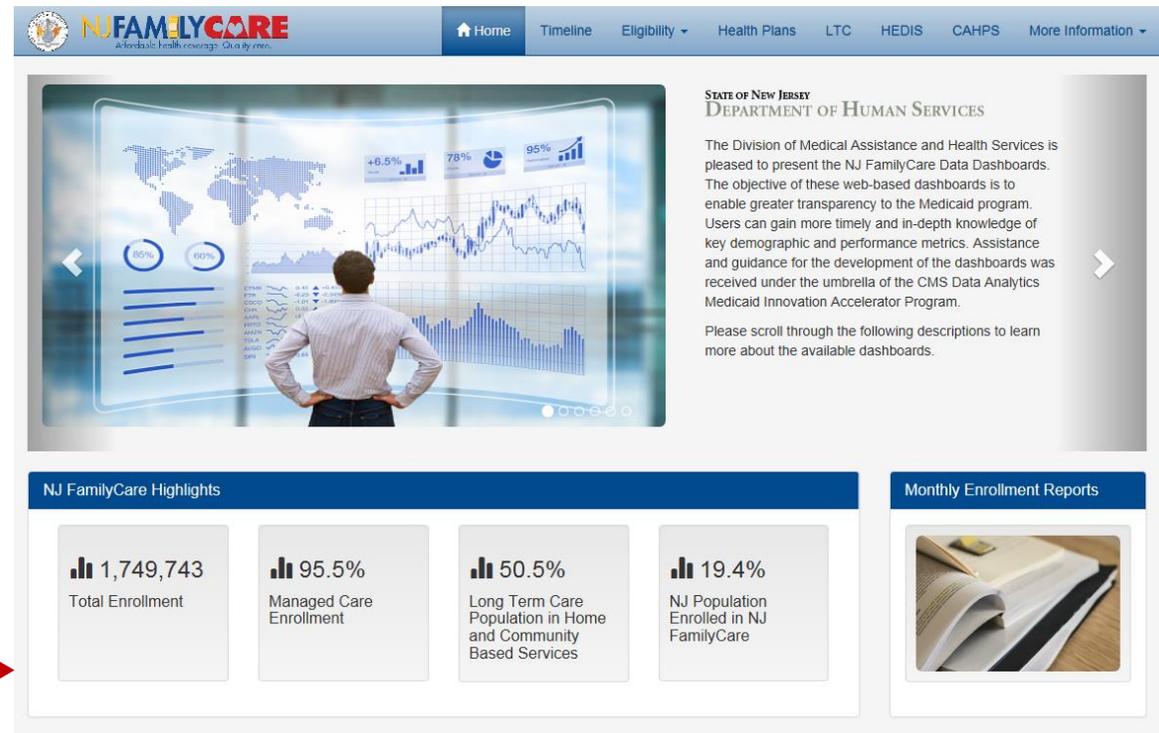
New Jersey Department of Human Services notifies certain NJ FamilyCare clients of data breach.

Multilingual Support

Arabic	Bengali	Chinese	Creole	English	French
Gujarati	Hindi	Italian	Japanese	Korean	Polish
Portuguese	Russian	Spanish	Tagalog	Turkish	Urdu
		Vietnamese			

You will need to have the appropriate character sets to see each individual language.

**NEW Enrollment Statistics and NJ FamilyCare Data Dashboards**



**STATE OF NEW JERSEY DEPARTMENT OF HUMAN SERVICES**

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Please scroll through the following descriptions to learn more about the available dashboards.

**NJ FamilyCare Highlights**

1,749,743 Total Enrollment	95.5% Managed Care Enrollment	50.5% Long Term Care Population in Home and Community Based Services	19.4% NJ Population Enrolled in NJ FamilyCare
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**Monthly Enrollment Reports**

# DMAHS Office of Managed Health Care (OMHC) Provider Relations Inquiry Process

- Provider must follow guidelines below
  - check eligibility monthly
  - request prior authorization,
  - timely claim submission
  - Submission of appeal timely

Providers must submit detail indicating that NJ FamilyCare/Medicaid guidelines were followed and MCO was contacted prior to outreach to OMHC send detail to [mahs.provider-inquiries@dhs.nj.gov](mailto:mahs.provider-inquiries@dhs.nj.gov)

OMHC will create an inquiry on behalf of the Provider and request that MCO outreach provider and forward copy of response to OMHC

# DMAHS Office of Managed Health Care (OMHC) Member Services inquiry process

- Member/Member representative contacts DMAHS:
  - Submits copy of balance bill
  - Detail regarding outreach to MCO member services call center
- DMAHS will contact the MCO on behalf of the member and request a copy of outreach to the member for resolution
- Submit detail to [MAHS.Provider-Inquiries@dhs.nj.gov](mailto:MAHS.Provider-Inquiries@dhs.nj.gov) .
- Emails sent directly to [DMAHS.Referrals@dhs.nj.gov](mailto:DMAHS.Referrals@dhs.nj.gov) regarding MCO member services will also be sent to the MCO for resolution

# DMAHS Office of Managed Health Care (OMHC) Provider Relations Inquiry Process

- OMHC completes inquiry upon receipt of detail indicating that MCO contract guidelines were followed
- OMHC will review and follow-up with MCO on behalf of the Provider if initial response does not meet contract guidelines. All inquiries sent to MCO are logged into a SharePoint database

Example: Claim inquiries are closed upon receipt of claim number and amount and /or letter to Provider.

# MCO Provider Relations Reporting

- MCO Contracted Quarterly Report (Table 3C) includes all inquires submitted to MCO on behalf of Provider by the Office of Managed Health Care (OMHC)
- DMAHS prepares a Quarterly Provider Inquires Report (Feb 15th, May 15th, Aug 15<sup>th</sup>, and Nov 15th )
- Quarterly Report documents all reported inquiries and identify inquiries that remain open beyond a designated quarterly period

# DMAHS Follow-up

Based on trends across plans and /or service types:

- Develop Provider Education
- Develop policy guidance
- Develop contract changes / updates
- Present MCO Notices of Deficiencies or Corrective Action Plans if necessary

# NJ FamilyCare MCO Resources

- NJ FamilyCare Health Plans Currently Under Contract and Providing Medicaid Managed Care Services in New Jersey  
[nj.gov/humanservices/dmahs/clients/medicaid/hmo/](https://www.nj.gov/humanservices/dmahs/clients/medicaid/hmo/)
- Member Relations- Access Member Manual
- Provider Relations -Provider Quick Reference Guide

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

- MLTSS Resources: [nj.gov/humanservices/dmahs/home/mltss\\_resources](https://nj.gov/humanservices/dmahs/home/mltss_resources)
- Behavioral Health Resources: [nj.gov/humanservices/dmahs/news/ebhb](https://nj.gov/humanservices/dmahs/news/ebhb)
- Form to submit inquiry is located by clicking on highlight
  - [DMAHS Provider Relations Inquiry Information](#)
  - [Provider Relations Inquiry Request form – single case](#)
  - [Provider Relations Inquiry Request form – multiple cases](#)
- Email detail via secure email to [mahs.provider-inquiries@dhs.nj.gov](mailto:mahs.provider-inquiries@dhs.nj.gov)
  - Separate emails should be sent for individual MCOs.
  - Multiple cases must include excel summary of information.



# Questions