March 2019 Enrollment Headlines

1,704,652 Overall Enrollment

2,622 (0.2%) Net Increase Over February 2019

94.4% of All Recipients are Enrolled in Managed Care


Notes: Net change since Dec. 2013; includes individuals enrolling and leaving NJFamilyCare. Does not include retroactivity.
NJ Total Population: 8,908,520

1,704,652
Total NJ FamilyCare Enrollees
(March 2019)

19.1%
% of New Jersey Population Enrolled
(March 2019)

782,866
Children (Age 0-18) Enrolled
(almost 40% of all NJ children)

Sources:
Total New Jersey Population from U.S. Census Bureau 2018 population estimate at https://www.census.gov/quickfacts/nj
# March 2019 Eligibility Summary

Total Enrollment: 1,704,652

<table>
<thead>
<tr>
<th>Category</th>
<th>Enrollment</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expansion Adults</td>
<td>521,329</td>
<td>30.6%</td>
</tr>
<tr>
<td>Other Adults</td>
<td>97,872</td>
<td>5.7%</td>
</tr>
<tr>
<td>Medicaid Children</td>
<td>570,743</td>
<td>33.5%</td>
</tr>
<tr>
<td>M-CHIP Children</td>
<td>93,702</td>
<td>5.5%</td>
</tr>
<tr>
<td>CHIP Children</td>
<td>119,059</td>
<td>7.0%</td>
</tr>
<tr>
<td>Aged/Blind/Disabled</td>
<td>301,947</td>
<td>17.7%</td>
</tr>
</tbody>
</table>


Notes: Expansion Adults consists of ‘ABP Parents’ and ‘ABP Other Adults’; Other Adults consists of ‘Medicaid Adults’; Medicaid Children consists of ‘Medicaid Children’ and ‘Childrens Services’; M-CHIP consists of ‘MCHIP’; CHIP Children consists of all CHIP eligibility categories; ABD consists of ‘Aged’, ‘Blind’ and ‘Disabled’. Percentages may not add to 100% due to rounding.
Ensuring Access to Health Care

• The Department provided funding and support to five community organizations that will help enroll New Jersey residents in health coverage.

• The initiative is part of Governor Murphy’s effort to enroll more New Jerseyans during the Affordable Care Act’s open enrollment period from Nov. 1 to Dec. 15.

• That effort includes the new www.getcovered.nj.gov web site.
• Applications submitted online can be tracked more efficiently than paper by the CWAs and by DMAHS
• Additional documents can be uploaded into the application portal electronically
• Each application must be registered with a unique email address and in future developments, the process may be monitored by the applicant/authorized representative
• Applications submitted online can be renewed easily online with the rollout of online redeterminations by 2020.
ABD Online Verifications

- AVS
- SSN
- Citizenship
- Verifiable Lawful Presence
- Name & Identity

- DOB
- Death
- Address
- Disability
- SSA Income
- Upload Attachments
E-MEVs and Renewals

- Eligibility information is stored in E-Mevs for all Medicaid Providers
- Bi-monthly reviews of Medicaid eligibility status’ can prevent unnecessary terminations
- When a termination is seen in the system, a provider can notify the Medicaid recipient or their Authorized Representative to take action
- If a Fair Hearing is requested within 20 days of termination, continuation of benefits, if applicable, can be requested to ensure continuous eligibility
Ensuring the Privacy of Personal Information - HIPAA

• Outside vendors/insurance agents should not be provided with personal information
  – Medicaid status is private information
  – Financial and Medical information must be protected
  – Medicaid recipient’s cost share amounts must remain private
Behavioral Health
Effective October 1, 2018, **ALL** admissions to a general acute care hospital, including admissions to a psychiatric unit, shall be the responsibility of NJ Medicaid MCOs for their enrolled members.

The MCOs will not cover State or County psychiatric hospital admissions.
Effective October 1, 2018, in order to align behavioral health benefit coverage, all managed care plans will be providing the behavioral health services currently covered under MLTSS to the beneficiaries enrolled in MLTSS, FIDE-SNP and DDD.

These services include, but are not limited to, the following behavioral health services (see MLTSS Behavioral Health Dictionary):

- Outpatient MH services
- Partial care/Partial Hospitalization/Acute Partial Hospitalization
- Adult mental health rehabilitation (Group Homes)
- Inpatient MH services
To bring the Substance Use Disorder (SUD) benefit in alignment with other BH Services, NJ FamilyCare is including the SUD Benefit for FIDE-SNP, MLTSS and DDD members into the MCO coverage applying ASAM criteria:

- Hospital-based services (ASAM 4.0 and 4.0WM)
- Outpatient SUD services (ASAM 1.0)
- Intensive Outpatient SUD Services (IOP) (ASAM 2.1)
- SUD partial care (ASAM 2.5)
- Residential Detox (ASAM 3.7WM)
- Short Term Residential Treatment (ASAM 3.7)
- Ambulatory Withdrawal Management (AWM) (ASAM 2WM)
- Medication Assisted Treatment (MAT) (ASAM OMT)
The following services **are not included** in the mental health coverage benefits for 2018:

Targeted Case Management (TCM) including:
- Justice Involved Services (JIS)
- Children's System of Care (CSOC) Care Management Organizations (CMOs)
- Integrated Case Management (ICMS)
- Projects for Assistance in Transition from Homelessness (PATH)

Behavioral Health Homes (BHH)
Programs in Assertive Community Treatment (PACT)
Community Support Services (CSS)
NJ FamilyCare Data Dashboards
Developed public-facing NJ FamilyCare dashboards

12-month technical assistance

— CMS IAP partners
  • Truven Health Analytics
  • HealthDataViz

Currently Online *(September 2018 launch)*

  • Eligibility
  • Long Term Care/MLTSS
  • CAHPS
NEW Enrollment Statistics and NJ FamilyCare Data Dashboards

http://www.njfamilycare.org

http://www.njfamilycare.org/analytics/home.html
Mobile Friendly & Browser Independent

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.
Managed Care Claims Reporting – *Expected Launch 2019*

- Total Number of Claims Processed
- Total Number of Clean Claims (MLTSS only) Processed
- Total Number of Claims Processed within/outside Timely Processing Requirements
- Total Number of Clean Claims (MLTSS only) Processed within/outside Timely Processing Requirements

**HEDIS Performance Dashboard - *In Development***

- Plan-by-Plan Comparison and State Weighted Average will be reported
- NJFC Performance compared to National Medicaid Benchmarks
- Data will be updated annually (HEDIS 2015 through current year)
In addition to guidance received from Medicaid Managed Care Final Rule, DMAHS is reviewing available data and known stakeholder requests related to managed care claims (encounters). Currently collected quarterly under Article 7.16.5 of MCO Contract (all items included in draft dashboard):

- Total Number of Claims Processed
- Total Number of Clean Claims (MLTSS only) Processed
- Total Number of Claims Processed within/outside Timely Processing Requirements
- Total Number of Clean Claims (MLTSS only) Processed within/outside Timely Processing Requirements

*MCO Contract Meeting will be used to discuss other requests related to timeliness of payments, denied claim counts, etc.*
Managed Long Term Services and Supports

Cheryl Hogan
Director, Managed Long Term Services and Supports

NJ Department of Human Services
Division of Aging Services
Long Term Care (LTC) and Managed Long Term Services & Supports (MLTSS)
March 2019 LTC Headlines

83.7% of NJFC Long Term Care Population is Enrolled in MLTSS

52.7% of the NJ FamilyCare LTC Population is in Home and Community Based Services*

Prior Month = 52.6%; Start of Program = 29.4%

Number of Recipients Residing in Nursing Facilities** is Down Almost 2,000 Since the July 2014 Implementation of MLTSS

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* Methodology used to calculate completion factor for claims lag in the ‘NF FFS Other’ category (which primarily consists of medically needy and rehab recipients) has been recalculated as of December 2015 to account for changes in claims lag; this population was being under-estimated.

** Nursing Facility Population includes all MLTSS recipients and all FFS recipients (grandfathered, medically needy, etc.) physically residing in a nursing facility during the reporting month.
Long Term Care Recipients Summary – March 2019

<table>
<thead>
<tr>
<th>Total Long Term Care Recipients</th>
<th>57,640</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed Long Term Support &amp; Services (MLTSS)</td>
<td>48,217</td>
</tr>
<tr>
<td>MLTSS HCBS</td>
<td>26,147</td>
</tr>
<tr>
<td>MLTSS Assisted Living</td>
<td>3,091</td>
</tr>
<tr>
<td>MLTSS NF/SCNF</td>
<td>18,979</td>
</tr>
<tr>
<td>Fee For Service* (Managed Care Exempt) NF &amp; SCNF</td>
<td>8,302</td>
</tr>
<tr>
<td>PACE</td>
<td>1,121</td>
</tr>
</tbody>
</table>


Notes: Information shown includes any person who was considered LTC at any point in a given month and includes individuals with Capitation Codes 79399, 89399, 78199, 88199, 78399, 88399, 78499 & 88499, Special Program Codes 03, 05, 06, 17, 32, 60-67, Category of Service Code 07, or MC Plan Codes 220-223 (PACE).

* A portion (~25%) of the FFS NF & SCNF count is claims-based and therefore uses a completion factor (CF) to estimate the impact of nursing facility claims not yet received. Historically, 63.56% of long term care nursing facility fee-for-service claims are received one month after the end of a given service month.

Notes:
- All recipients with PACE plan codes (220-229) are categorized as PACE regardless of SPC, Capitation Code, or COS.
- Home & Community Based Services (HCBS) Population is defined as recipients with a special program code (SPC) of 60 (HCBS) or 62 (HCBS – Assisted Living) OR Capitation Code 79399, 89399 (MLTSS HCBS) with no fee-for-service nursing facility claims in the measured month.
- Nursing Facility (NF) Population is defined as recipients with a SPC 61,63,64,65,66,67 OR CAP Code 78199, 88199, 78399, 88399, 78499, 88499 OR a SPC 60,62 with a COS code 07 OR a Cap Code 79399, 89399 with a COS code 07 OR a COS 07 without a SPC 60-67 (Medically Needy &/or Rehab). COS 07 count w/out a SPC 6x or one of the specified cap codes uses a completion factor (CF) due to claims lag (majority are medically needy recipients).
Nursing Facility Population


Notes: “MLTSS NF” population is defined as recipients with Capitation Code 78199, 88199 or with a SPC 61. “MLTSS SCNF” population is defined as recipients with Capitation Code 78399, 88399, 78499 or 88499 or with a SPC 63, or 64. “NF FFS” population includes all recipients with a Special Program code of 65, 66 or 67 as all other recipients with COS code 07 that do not meet any of the previous criteria (this subgroup uses a completion factor to account for claims which have not yet been received but are forthcoming).
A Look at the June 30, 2014 Waiver Population Today

All Waivers
(6/30/14 = 12,036)

- MLTSS HCBS: 4,094 (34.0%)
- MLTSS NF: 987 (8.2%)
- Other (Non-MLTSS NJ FamilyCare): 333 (2.8%)
- No Longer Enrolled: 6,622 (55.0%)


Notes: Includes all recipients who were in a waiver SPC (03, 05, 06, 17 or 32) on 6/30/14. Where they are now is based on capitation code or PSC. Those without a current capitation code or PSC are determined to be “No Longer Enrolled”. Of the total number no longer enrolled, 93.8% (3,102) have a date of death in the system (current through 7-11-16).
Pre-Admission Screening and Resident Review (PASRR)
Pre-Admission Screening and Resident Review (PASRR) Webinars

• The Division of Aging Services (DoAS) presented three PASRR webinars in January to stakeholders which included Hospitals, Rehab, Nursing Facility, Special Care Nursing Facilities, Assisted Living, MCOs, and PACE Organizations.

• These webinars were provided in collaboration with NJHA, Leading Age, and HCANJ.

• All materials are available on the DoAS website at https://www.state.nj.us/humanservices/doas/services/pasrr/index.html

• FAQs are in the process of being updated
PASRR Reminders

• PASRR is a federal requirement regardless of payer source
• PASRR must be completed prior to admission to a NF or SCNF
• Level I screening may be completed by social workers who are Certified, Licensed Clinical, or Masters Level
• Updated forms and contact information are all available via the DoAS website
• For questions (contact info is in the Power Point on the DoAS website):
  – Level I process: DoAS
  – Level II processes: DDD and/or DMHAS
HCBS Final Rule and Assisted Living Settings
The Home and Community-Based Services (HCBS) Final Rule set forth new requirements under which states may provide home and community-based long-term services and supports.

Information on the Final Rule can be found here;

CMS has identified HCBS settings (ALR, CPCH) that share or are co-located on the same campus as a nursing facility to require further review. These settings will be subject to a “heightened scrutiny” review.

To find out more on heightened scrutiny, settings that can be isolating, and concern for residents who wander, please see:

Any Willing Qualified Provider (AWQP)
Any Willing Qualified Provider (AWQP)

- The Department launched AWQP in 2017 which is a Value Based Purchasing (VBP) initiative
- Communication and data collection with 290 Medicaid certified, non-small volume facilities has been ongoing
- The Annual Designation and progressive accountability actions have not yet occurred
- Stakeholder engagement on the initiative is anticipated in the second/third quarter of the year
AWQP Next Steps

• TBD 2019:
  – NFs receive QPS Reporting including Core Q survey results

• TBD 2019:
  – Appeals and Quality Performance Plan Report submissions required by NFs
  – Core Q survey cycle begins
    • includes Hospital Utilization Tracking certification

• TBD 2019:
  – Stakeholder engagement on next steps
Program of All Inclusive Care for the Elderly (PACE)
The Department remains committed to expanding the PACE Model statewide in New Jersey

- Six PACE Organizations currently serving 10 counties

Shifting focus from individual zip codes to full county coverage

Expansion being handled primarily through public notices of Request for Application for specific counties

Typically a 2 year process for new center development
PACE Expansion: Current Status

- **Union County**: Under development by Lutheran Senior LIFE
- **Ocean County**: Awarded in March 2018 to AcuteCare Health System.
- **Gloucester, Salem, and Cumberland Counties**: Inspira LIFE will be expanding operations to all zip codes in these counties
- **Essex County and Middlesex County**: Notice of Request for Application was posted in the NJ Register on 1/9/19. Awards expected in July. [https://www.state.nj.us/humanservices/providers/grants/public/index.html](https://www.state.nj.us/humanservices/providers/grants/public/index.html)
Managed Provider Relations Overview

Geralyn D. Molinari
Director, Managed Provider Relations Unit
Office of Managed Health Care
NJ Department of Human Services
Division of Medical Assistance and Health Services

June 2019
Presentation Topics

- DMAHS Provider Relations Overview-
- Prior Authorization Parameters
- Continuity of Care
- Claims Appeals /Disputes
- Utilization Appeals
- MCO Reporting for Provider Inquiries
- Resources
Overview Managed Provider Relations

- Addresses provider inquiries and/or complaints as it relates to Managed Care Organization (MCO) contracting, credentialing, reimbursement, authorizations and appeals, and conducts complaint resolution tracking/reporting.

- Provides education and outreach for MCO contracting, credentialing, claims submission, authorization, appeals process, eligibility verification, TPL, MLTSS transition and other Medicaid program changes.

- Addresses stakeholder inquiries related to the network credentialing process, network access, and payment compliance.
Prior Authorization Parameters

Managed Care Contract specifies criteria for Non-Emergency and Emergency authorization

Providers are required to request continuation of service prior to Prior Authorization end date

E. Emergency Care Prior Authorization. Prior authorization shall not be required for emergency services through stabilization. This applies to out-of-network as well as to in-network providers.

Post Stabilization of Care - Authorization

• Post-Stabilization of Care. The Contractor shall comply with 42 C.F.R. § 422.113(c). The Contractor must cover post-stabilization services without requiring authorization and regardless of whether the enrollee obtains the services within or outside the Contractor’s network if:

• a. The services were pre-approved by the Contractor or its providers; or

• b. The services were not pre-approved by the Contractor because the Contractor did not respond to the provider of post-stabilization care services’ request for pre-approval within one (1) hour after being requested to approve such care; or

• c. The Contractor could not be contacted for pre-approval.
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*
## Prior Authorization Guidelines for NJ Family Care Services

<table>
<thead>
<tr>
<th>New Member</th>
<th>Member Transitions to MCO with existing Plan of Care for LTC</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Existing Plan of Care</td>
<td>MCO must honor continuity of care parameter of contract</td>
</tr>
<tr>
<td>MCO must prior-authorize service</td>
<td>MCO and Provider must set up Single Case Agreement or join network. Approved services as per existing plan will be reimbursed until new plan of care established</td>
</tr>
<tr>
<td>Provider must be in Network with MCO and/or have a single case agreement to serve member</td>
<td></td>
</tr>
</tbody>
</table>

**Prior Authorization Guidelines for NJ Family Care Services**

- **New Member No Existing Plan of Care**: MCO must prior-authorize service. Provider must be in Network with MCO and/or have a single case agreement to serve member.
- **Member Transitions to MCO with existing Plan of Care for LTC**: MCO must honor continuity of care parameter of contract. MCO and Provider must set up Single Case Agreement or join network. Approved services as per existing plan will be reimbursed until new plan of care established.
Claim Dispute: Administrative review not based on Medical Necessity

6.5 PROVIDER GRIEVANCES AND APPEALS

• A. Payment Disputes. The Contractor shall establish and utilize a procedure to resolve billing, payment, and other administrative disputes between health care providers and the Contractor for any reason including, but not limited to: lost or incomplete claim forms or electronic submissions; requests for additional explanation as to services or treatment rendered by a health care provider; inappropriate or unapproved referrals initiated by the providers; or any other reason for billing disputes.
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.
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.
Utilization Appeals
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
External (IURO) Appeal

The IURO appeal is an external appeal conducted by an Independent Utilization Review Organization (IURO). The IURO appeal is also referred to as the External Appeal. The associated timeframes are as follows:

• The deadline to request an External Appeal is 60 days from the notification letter advising the member of the outcome of the Internal Appeal.

• The timeframe for the IURO to resolve the External Appeal (either by overturning or upholding the original denial) is 45 days.
Continuation of Benefits while an Appeal is Pending

Benefits can be continued while an appeal is pending. However, for this to occur, all of the following conditions must be met:

a) The appellant must file the appeal request timely;

b) the appeal must involve the termination, suspension, or reduction of a previously authorized course of treatment;

c) the services must have been ordered by an authorized provider; and

d) the appeal request must be made on or before the final day of the previously approved authorization, or within 10 calendar days of the date on the notification of adverse benefit determination (denial letter), whichever is later.

If all of these conditions are met, the MCO must automatically provide continuation of benefits while the appeal is pending.
## Utilization Appeals Guidelines for NJ Family Care Services

<table>
<thead>
<tr>
<th></th>
<th>IURO (External Appeal) Time Frame</th>
<th>Medicaid Fair Hearing</th>
<th>Continuation of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NJ FamilyCare A and ABP Members</strong></td>
<td>Yes*</td>
<td>Yes</td>
<td>Member and/or Provider on behalf of member must request within appeal timelines</td>
</tr>
<tr>
<td><strong>Appeal Process for NJFC B, C, and D Members</strong></td>
<td>Yes</td>
<td>Not Available</td>
<td>Member and /or Provider on Behalf of member must request within appeal timelines</td>
</tr>
</tbody>
</table>

*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*
UM Appeal Process
Appeal Process for NJ FamilyCare A and ABP Members

Initial Denial
- Up to 60 days to request

Internal Appeal (through health plan)
- 30 days to reach decision

External Appeal (through IURO)
- 45 days to reach decision

External Appeal (from outcome of Internal Appeal)
- Up to 120 days from outcome of Internal Appeal

Fair Hearing
- Up to 120 days from outcome of Internal Appeal
Continuation of Benefits
Scenario: Advanced Notification

Scenario 1: *Advance Notification*

**Notification** of Termination, Suspension, or Reduction of previously authorized service

**Expiration Date** of Original Authorization (appellant cannot request continuation after expiration date)

10 days *from date of notification*

Appellant can request continuation of benefits *up until the expiration date of the original authorization* for the service in question

DAYS:
- DAY 1
- DAY 10
- DAY 20

(NJ FamilyCare)
Provider and/or Member contact DMAHS:

• Provider must submit claim detail to DMAHS: Providers must submit detail indicating that Medicaid guidelines were followed and MCO was contacted prior to outreach to OMHC
  – check eligibility
  – request prior authorization,
  – timely claim submission
  – Submission of appeal timely

Member: Submits copy of balance bill
DMAHS will contact the MCO
• OMHC Managed Provider Relations Unit reviews submitted information and creates inquiry upon receipt of detail

• OMHC will contact MCO on behalf of the Provider/Member requesting review of inquiry information and copy of communication to the Provider and/or member

• MCOs requested to outreach Member and/or Provider within 10 business days and forward an update and/or summary to OMHC
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 15th and Nov 15th)

- Quarterly Report documents all reported inquiries and identify inquiries that remain open beyond a designated quarterly period
• 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 Family Care MCO Resources

- NJ FamilyCare Health Plans Currently Under Contract and Providing Medicaid Managed Care Services in New Jersey
  https://www.state.nj.us/humanservices/dmahs/clients/medicaid/hmo/index.html

- 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
  [http://www.state.nj.us/humanservices/dmahs/home/mltss_resources.html](http://www.state.nj.us/humanservices/dmahs/home/mltss_resources.html)

- Behavioral Health Resources
  [https://www.state.nj.us/humanservices/dmahs/news/ebhb.html](https://www.state.nj.us/humanservices/dmahs/news/ebhb.html)

- 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.state.nj.us](mailto:mahs.provider-inquiries@dhs.state.nj.us)
Separate emails should be sent for individual MCOs.
Multiple cases must include excel summary of information.
Questions