

NJ FamilyCare Housing Supports Program: **Billing**

June 25, 2025



Housekeeping

- Please drop your name, organization and role into the chat
- Use the Raise Hand function and we will invite you to come off mute during Q&A

Regional Health Hubs (RHHs) play an important role supporting DMAHS in key initiatives such as the NJ FamilyCare Housing Supports Program.

Camden Coalition will:

- Deliver and curate a training series to support program roll-out
- Serve as a “help line” for providers to field/answer questions and troubleshoot issues through the process
- Liaise between the state, MCOs, and providers to support implementation

All RHHs will:

- Promote the program to recruit a robust network of providers within their regions
- Conduct member/community engagement to inform successful roll-out





About **CSH**

CSH collaborates to advance solutions that use housing as a platform for services to improve the lives of the most vulnerable people, maximize public resources and build healthy communities.



Here is the CSH Team



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Disclaimer

The views, opinions and content expressed herein do not necessarily reflect the official position of the state of NJ's Department of Community Affairs or Division of Medical Assistance Healthcare Services (DMAHS)



Objectives

- Review key steps to take before billing – including documentation in HMIS
- Provide an overview of the billing process
- Identify who to contact for billing assistance
- Meet the billing staff at each MCO

Note: The Camden Coalition and DMAHS will provide additional, detailed billing information in early August

Claims & Billing

- **A claim** is a formal request for reimbursement submitted in a particular format by a provider to an MCO for services provided.
 - Claims compile all relevant information and codes related to the HSP services provided as well as Medicaid member demographics and are submitted to the MCO for review.
- **Billing** is the process of submitting claims to the MCO to obtain payment for services rendered by providers.
 - Billing can also include following up on and rebilling unpaid or denied claims.



Before You Bill

Things to Do Before You Bill

#1: Become an official Housing Supports Program provider

#2: For Pre-tenancy and Tenancy Sustaining Service Providers: Establish your Housing Supports Program HMIS account

#3: Confirm you have delivered and documented the required services

#4: Confirm the time is right to bill

#1: Become an official Housing Supports Program provider

Steps to Becoming an NJ FamilyCare Housing Supporting Provider

1. Obtain an NPI number
2. Complete NJ state enrollment
3. Credential with MCOs
4. Contract with MCOs

*Note: Order of these steps will vary by MCO

#2: Establish your Housing Supports Program HMIS account/project

Pre-tenancy and Tenancy Sustaining Service Providers:

- Attend or view a recording of the initial Housing Supports Program (HSP) HMIS training.
- Once you've contracted with your first MCO, you can gain access to the HSP section or "project" in HMIS.
- For providers who are new to HMIS, you will also need to attend a general HMIS training.
- To do all of these things, contact Candy Brewster at catherine.brewster@dca.nj.gov.

*If a member's circumstance 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.

#3: Confirm you have delivered and documented the required services

Pre-tenancy and Tenancy Sustaining Service Providers:

You must deliver and document the qualifying number of touchpoints to properly serve a member and submit a claim

- **Higher level of need members**
 - Providers must deliver a minimum of 4 touchpoints per 30-day billing period
 - At least 2 of the touchpoints must be face-to-face
 - Touchpoints must be documented in HMIS
- **Lower level of need members**
 - Providers must deliver a minimum of 2 touchpoints per 30-day billing period
 - At least 1 of the touchpoints must be face-to-face
 - Touchpoints must be documented in HMIS

Remember: 1) Touchpoints must occur on separate days for them to count towards the total minimum amount, and 2) Touchpoints may be documented locally if the provider is prohibited from using HMIS (e.g. working with survivors of domestic violence).

#3: Confirm you have delivered and documented the required services (con't)

Before submitting a claim, confirm the following requirements are met:

The touchpoint date is within the 30-day billing window

At least half of the touchpoints are face-to-face

The touchpoint occurred within a county in New Jersey

Only one of the four service types for touchpoints is selected

- Pre-tenancy Services "high" need
- Pre-tenancy Services "low" need
- Tenancy Sustaining Services "high" need
- Tenancy Sustaining Services "low" need

The touchpoint is documented in HMIS*

*If a member's circumstance 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

#3: Confirm you have delivered and documented the required services (con't)

Move-in Supports and Residential Modifications & Remediations Providers: You will not document touchpoints in HMIS

- You will already have provided the necessary documentation during the authorization process
- If approved, you will deliver the services and then submit a claim for reimbursement

#4: Confirm the time is right to bill

Pre-Tenancy and Tenancy Sustaining Services

- **Claim form:** CMS 1500
- **Payment format:**
 - per member per month (PMPM) reimbursement after you provide the service
 - \$320 PMPM for a person with a low level need and \$640 for a person with high level of need
- **When to submit claim:**
 - The 30-day billing period starts on the first day of the service authorization (date of Initial Assessment Tool submission) and continues for 30 days.
 - You can submit a claim after the 30-day billing period and within 180 days of the 1st day of that 30-day billing period.



NJ 1115 Waiver Implementation

Housing Support Camden/DMAHS meeting

JUNE 23, 2024

For clarification | HMIS workflow details

Context:

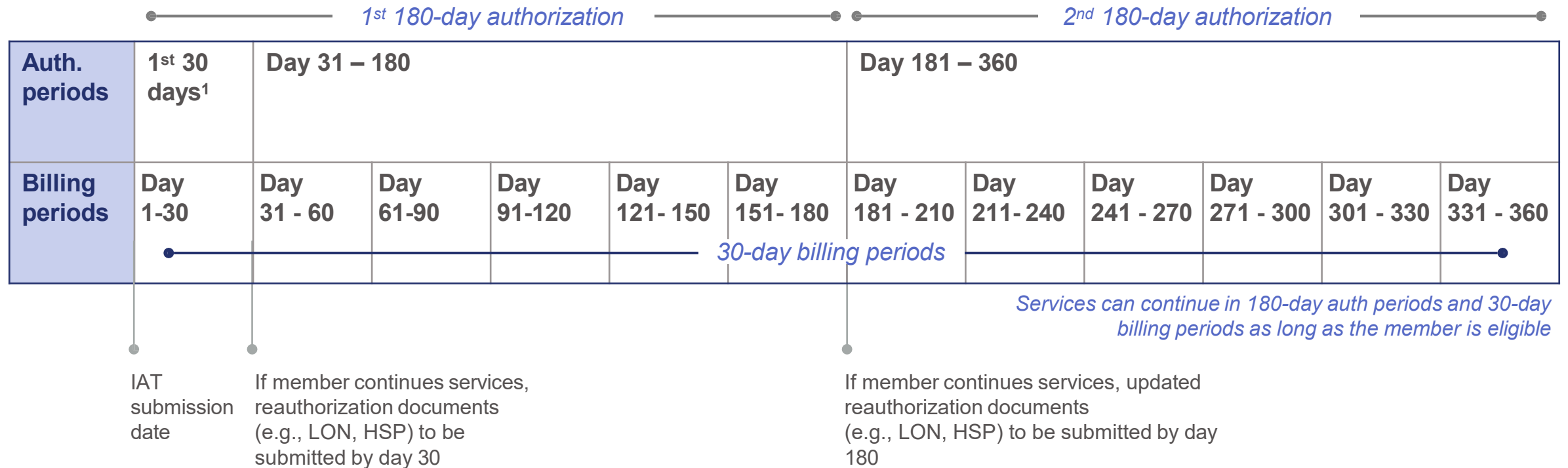
- **Provider HMIS trainings** were conducted on June 16 and June 18
- During these sessions, providers raised detailed questions regarding how **HMIS workflows interact with authorization and claims workflows**

Objectives:

- To provide guidance on how providers **should conduct these parallel workflows** (e.g., when should providers enter a member in HMIS?)
- To clarify which **elements are part of the HMIS workflow** (i.e., HMIS intake form, contact logs, discharge form are part of workflow, **does not include** submitting IAT/LON to MCOs)

For tenancy services, 180-day authorization periods are made up of 30-day billing periods

Example timeline of authorization and billing periods – illustrative for 2 180-day authorizations



1. Initial auto-approval

HMIS, authorization, and claims workflows proceed in parallel

Example timeline of 1st 30-day billing unit – *dates are illustrative*

	May 26	May 28	June 5	June 11	June 24	June 25	Auth end date
Auth workflow	Complete and submit the IAT via MCO portal, phone, or fax for the initial 30-day auth period Please note: This is the first day of the auth period	Receive approval of the 1 st 30-day auth period ¹	Submit the LON and Housing Stabilization Plan for the continuing authorization period (day 31 – 180)	Receive approval for the day 31 – 180 authorization period ¹			Member authorization ends
HMIS workflow	Enter member in HMIS (i.e., fill out HMIS intake form) <ul style="list-style-type: none"> • 'Intake date' field should match the 1st day of billing period (i.e. May 26)² • Best practice to fill out intake form after member is authorized (backdating intake date), but permissible to fill out intake form during 1st client interaction <ul style="list-style-type: none"> - If a member is never authorized, provider must discharge the member • Providers cannot complete contact logs until intake form is completed <hr/> Log 2 or 4 touchpoints in HMIS and complete contact logs, depending on member's level of need Please note: touchpoints can occur anytime within the 30-day billing unit (May 26 – June 24)						Complete discharge form
Claims workflow	First day of the 30-day billing period				Last day (Day 30) of the billing period	First day you can submit a claim for the 1 st 30 day billing period ³	

1. This date reflects the MCO turnaround times listed in the guidance and are illustrative, these dates may vary

2. If receiving a referral from an MCO, the MCO will provide dates of authorization and intake form should reflect day 1 as the 'intake date/project start date';

3. Please note: It is best practice to wait until the LON is approved to submit claims; if services do not continue past 30 days (therefore there will be no LON submission), providers should bill using the 'low' LON modifier

Example Billing Timeline for Pre-Tenancy and Tenancy Sustaining Services

Action	Date	Significance
Meet Mr. Smith for the first time	May 20	
Complete and submit the Initial Assessment Tool for the initial 30-day authorization period	May 26	This is the first day of the first 30-day billing period
Receive approval for the first 30-day authorization period	May 28	
Complete and submit the Level of Need and Housing Stabilization Plan for the continuing 31 to 180 day authorization period	June 5	
Receive approval for the 31 to 180 day authorization period	June 11	Note: Submit your first claim AFTER you receive approval for the 31 to 180 day auth period because the approval confirms the Level of Need and amount you can bill for
	June 24	This is the last day of the first 30-day billing period
You can submit a claim for services rendered between May 26 and June 24	June 25	This is <u>FIRST</u> day you can submit a claim for the first 30-day billing period
You can submit a claim for services rendered between May 26 and June 24	Nov. 21	This is the <u>LAST</u> day you can submit a claim for the first 30-day billing period (180 days from 1st day of billing)

#4: Confirm the time is right to bill (con't)

Key Things to Remember

- The date you submit the Initial Assessment Tool starts the clock on the initial 30-day authorization period - which is the same as the initial 30-day billing period
- Best practice is to bill after the MCO approves the member's Level of Need
 - Caveat: If the member does not continue services beyond the first 30 days, then the provider does not submit the Level of Need form, so the provider bills for a low Level of Need (\$320)
- Do not bill until after you have delivered the service i.e. you have completed your touchpoints **and** the 30-day billing period is over
- The deadline to submit a claim is 180 days after the first day of the 30-day billing period

#4: Confirm the time is right to bill (con't)

Move In & Residential Modification and Remediations Services

- **Claim form:** CMS 1500
- **Payment format:** One lump sum
- **When to submit claim:** The start and end date timing is MCO-specific.



Overview of the Billing Process

Four Steps of the Claims Submission Process

- Step 1: Determine how you will submit your claim form
- Step 2: Gather information for the claim form
- Step 3: Submit the claim
- Step 4: Payment *or* work the denial

Step 1: Determine how you will submit your claim form

- Providers will use the CMS 1500 claim form to submit all claims for all four Housing Supports Program services.
- Claims can be submitted electronically or on paper; electronic is preferred.
- Providers may use billing platforms and/or billing services . .



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Blank area for carrier information

CARRIER ↑
↓ PATIENT AND INSURED INFORMATION

PICA PICA

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) <input type="text"/>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <input type="text"/>		3. PATIENT'S BIRTH DATE SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) <input type="text"/>		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY <input type="text"/> STATE <input type="text"/>		7. INSURED'S ADDRESS (No., Street) <input type="text"/>	
ZIP CODE <input type="text"/> TELEPHONE (Include Area Code) <input type="text"/>		8. RESERVED FOR NUCC USE <input type="text"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <input type="text"/>		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="text"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
a. OTHER INSURED'S POLICY OR GROUP NUMBER <input type="text"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER <input type="text"/>	
b. RESERVED FOR NUCC USE <input type="text"/>		a. INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>	
c. RESERVED FOR NUCC USE <input type="text"/>		b. OTHER CLAIM ID (Designated by NUCC) <input type="text"/>	
d. INSURANCE PLAN NAME OR PROGRAM NAME <input type="text"/>		c. INSURANCE PLAN NAME OR PROGRAM NAME <input type="text"/>	
12d. CLAIM CODES (Designated by NUCC) <input type="text"/>		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL			15. OTHER DATE MM DD YY QUAL			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY								
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			17a			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY								
			17b NPI											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO								
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. ICD Ind. B. C. D. E. F. G. H. I. J. K. L.						22. RESUBMISSION CODE ORIGINAL REF. NO.								
23. PRIOR AUTHORIZATION NUMBER														
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #			
1									NPI					
2									NPI					
3									NPI					
4									NPI					
5									NPI					
6									NPI					
25. FEDERAL TAX I.D. NUMBER SSN EIN			26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO			28. TOTAL CHARGE \$ 0.00		29. AMOUNT PAID \$		30. Rsvd. for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)			32. SERVICE FACILITY LOCATION INFORMATION			33. BILLING PROVIDER INFO & PH # ()								
SIGNED			DATE			a. NPI		b.		a. NPI		b.		

PHYSICIAN OR SUPPLIER INFORMATION



Step 2: Gather information for the claim form

There are three categories of information needed to submit a claim:

1. Member Info

- Name, address, DOB, Member ID number, plan name

2. Provider Info

- Name, phone number, NPI, Federal Tax ID number

3. Service Info

- Billing codes, service dates, place of service codes, your charge

Step 3: Submit the claim

- Claims can be submitted electronically or manually (paper) - electronic is recommended
- You will soon receive MCO specific information to submit (e.g. the MCO payer ID, link to their portal, street address)

Step 4: Payment or work the denial

* Once you have submitted the claim, it's not over yet! The process is incomplete until you receive payment or an official denial in writing.

* Making corrections and resubmitting the claim may be necessary.

- **Payment:**

- You can receive payments electronically or by check.
- The payment processing time will vary by MCO – see your MCO contract for details.

- **Denial:**

- If you had any claims that were denied, then now it's time to “work your denials” or research why the claim was denied, and if correctable, correct the error and resubmit.

- **Appeal:**

- Providers have a right to appeal denied or underpaid claims if you believe the decision was incorrect.
- Refer to your MCO contract for the steps in the appeal process.

“Owning” the Billing Process

- Different staff or team members may be involved in the process
 - Communication and documentation are the keys to success!
- Assigning one “owner” of the process is necessary to help ensure accountability
 - This can be an Office Manager, Biller, Director of Accounts Receivable, etc.
 - Even if you outsource your claims submission process to a vendor or hub, having an accountable “owner” who works with that vendor/hub to ensure follow-through and accuracy is helpful
 - The “owner” understands and utilizes a service documentation process, whether an Electronic Health Record (EHR) software system or a paper file system
 - The “owner” maintains a tracking system that monitors each claim from “soup to nuts” to ensure minimum losses or write-offs (could be part of the EHR or even a simple spreadsheet)

Traits the “Owner” Should Have

- Whoever owns the claims submission process in your organization should have the following traits:
 - Attention to detail
 - Follow-through/tenacity
 - Organized / ability to create processes and workflows
- Must utilize resources published by DMAHS, the MCOs, or create needed resources
- Must develop and maintain relationships with the contracted MCOs
- Must be able to navigate differences in policies and procedures of the various plans with which your organization has contracted

Help is Available!

Who to reach out to

Camden Coalition Help Desk

Type of inquiry

- General Housing Supports billing processes (e.g., filling out billing codes, service charge amounts)
 - General Medicaid billing information
 - General assistance with appeal/denial process
-

MCO claims team

- MCO-specific standards/processes (i.e., submission portals, required fields to complete on the claim form)
 - Status of submitted claims
 - Appeal/denial processes/submission requirements
-

HMIS

- Gain access to the Housing Supports Program module(s)
- Documentation clarification



MCO Billing Staff Introductions

PASSWORD:
cchppubli

Who are Camden's High Inpatient Utilizers?

Avg. age: 57

Chronic conditions
1% of population



2011 averages:

Top Diagnoses

Social Media

Follow @camdenhealht

#CCHPTALKS

Facebook.com/camdencoalition

COMPUTER
presentation
projector1

Q & A with the MCOs

Important Announcements

- DMAHS released new versions of the provider and MCO guidance documents and will soon be posted on the Housing Supports webpage.
- The Camden Coalition will soon post fillable pdf versions of the Intake Assessment Tool, the Level of Need form, the Housing Stabilization Plan form and the MCO credentialing application. Updated links to these documents will also be in the new versions of the provider and MCO guidance.
- The Camden Coalition's guidance on MCO contracting is now posted on the Housing Supports webpage [here](#).

Next steps

- Upcoming trainings (every other Wednesday from 1 – 2:30 pm):
 - 7/ 9: Office Hours
- Bookmark the Housing Supports webpage [here](#)
- Sign up for our Housing Supports Program newsletter [here](#)
- Use our Help Desk Inquiry Form to ask your questions and get timely support [here](#)





Appendix

Intake fields in HMIS

- Demographics (Name, DOB, SSN, Gender, Race)
- Translation Assistance Needed
- Veteran Status
- Housing Status
 - Type of residence
 - Length of stay in prior living situation
- Income from any source
- Non-cash benefits from any source
- Covered by health insurance
- Special needs (physical disability; developmental disability; chronic health condition; HIV/AIDS; mental health disorder; substance use disorder; disabling condition)
- Domestic violence
- Household program enrollment (individual/family type)
- Education status for member and children (eg: enrollment; type of education; barriers, etc)
- Services sought
- Housing Supports Medicaid Provider Intake
 - MCO
 - Medicaid ID