NJ Division of Medical Assistance and Health Services

BH Integration Achieving Success with Managed Care 10/16

Frequently Asked Questions (FAQs)

Last updated: October 31, 2024

General BH Integration Questions

Will there be additional provider trainings after go-live?

- The State is committed to supporting providers as they transition from FFS to managed care
- As a reminder, the full training schedule can be found on DMAHS BH Integration Stakeholder Website, with two more trainings in 2024: Prior Authorization and Office Hours
- After go-live, DMAHS will host a provider training on Care Management on January 28 (register here), along with additional trainings on using NJSAMS (Date TBD)
- DMAHS is constantly assessing provider readiness and will continue to add trainings on key topics based on the needs of providers
- If you have suggestions for future topic trainings or ideas for how the State can better support you (and other providers), please send us an email: dmahs.behavioralhealth@dhs.nj.gov

How is the State promoting the diverse cultural and language needs of Medicaid providers and members?

- Supporting the diverse needs of NJ behavioral health providers and the members they serve is of upmost important to the Department of Human Services (DHS)
- To better support our providers and members, the State is working closely with MCOs to ensure they have the tools, training, and resources needed to enhance cultural sensitivity and provide more inclusive, equitable care that meets the diverse needs of NJ Medicaid / NJ FamilyCare members
- State standards now require MCOs to submit an annual written plan on how to address cultural sensitivity needs of providers through training and resources, managed by each MCO's designated Health Equity administrator

Member Eligibility

Should I bill Phase 1 services FFS for members who are not yet enrolled in an MCO but are approved for Medicaid FFS?

- Yes. If a member is enrolled in Medicaid FFS and not in a managed care organization, providers shall bill Medicaid FFS for services rendered

- If members are part of an MCO, providers must bill MCOs for Phase 1 services starting January 1, 2025
- Providers cannot balance bill Medicaid members for services rendered

Services Covered

Are Phase 1 services for adults and children?

- All Phase 1 services are for the general population, both adults and children

Are laboratory services included in this transition, and if so, what Phase?

- At this stage, SUD laboratory services are tentatively planned for integration in phase 2, alongside Opioid Treatment Programs (OTP)
- Laboratory services will not be integrated during Phase 1, and as such, providers will need to continue to bill FFS directly for any lab services

When are intensive in-community (IIC) services being integrated?

- IIC services are one of the services that are being considered for Phase 3
- IIC services will not be integrated in Phase 1

Are care management services covered in Phase 1? Do I need to add care management services to my contract with the MCO to be reimbursed?

- SUD Care Management is covered for SUD independent clinics as part of Phase 1
- However, targeted case management is not part of Phase 1 and is being considered for integration in Phase 3
- Providers should review contracts with their MCO to confirm all applicable services are included

Network

How is the State promoting network adequacy?

- The State contract requires MCOs to meet network adequacy standards
- MCOs must:
- Accept any willing qualified behavioral health provider for first 24 months of Phase 1 (until December 31, 2026)
- Set up single case agreements for any active non-contracted FFS providers

Enrollment and Credentialing

Can individuals licensed under supervision (e.g., LSW, LACs, CADCs) enroll to provide outpatient counselling services?

- Individuals must be fully licensed (e.g., LCSWs, LPCs, LMFTs and LCADCs) to enroll in NJ FamilyCare
- Individuals who do not hold a full license cannot enroll in NJ FamilyCare as an individual practitioner
- Individuals whose license requires supervision (i.e. LSW) can only provide services within the scope of their license

Can non-licensed individuals (e.g., interns, Master's in Counselling) provide or bill outpatient counselling services?

- No, individuals who are not licensed to provide services cannot provide or bill for services.

Do I have to join all five managed care organizations?

- No but providers should join all MCOs with which their existing FFS members are enrolled
- Providers encourage you to contract and credential with all five MCOs to ensure continuity of care for your members – as members often change health plans

Can I use the Council of Affordable Quality Healthcare (CAQH) platform to streamline the credentialing process?

- All 5 MCOs are required to accept CAQH for credentialing individual practitioners
- Individual providers are encouraged to create a CAQH profile, storing information about provider education, work history, training, licenses, insurances, etc.
- Individual providers only need to enter this information once into CAQH and can grant access for it to flow to all five MCOs
- CAQH is used to store individual practitioner information and is not available for agencies

What can I do if I cannot join an MCO by January 1, 2025?

- MCOs are required to attempt to contract and credential with all active FFS providers providing Phase 1 services ahead of go-live on January 1, 2025
- If you are unable to contract and credential for whatever reason, you can reach out to each MCO to discuss the possibility of setting up an out-of-network (OON) or single-case agreement

Rates & Claims

What will I be paid by MCOs?

- As of January 1, 2025, MCOs are required to pay providers at or above the amount outlined in the fee-for-service (FFS) payment schedule
- Providers shall work independently with each MCO regarding contracted rates

Will MCOs be required to raise contract rates to match floor if Medicaid FFS rates are adjusted in middle of contract period?

- Yes, contract rates, at all times, must be at or exceed the FFS floor effective on the date indicated by DMAHS.

How long will it take to process my clean claim?

- All MCO BH claims processing timelines must comply with the following requirements:
- 15 days for 90% of electronic clean claims
- 30 days for 90% of manual clean claims
- 45 days for 99.5% of all claims
- Specific MCO processing timelines may be shorter than the State minimum

Once my claim is approved, how long will it take to be paid?

- Processed claims are required to be paid weekly

Prior Authorization (PA)

Which services will require PA?

- Behavioral Health Phase 1 services that may require PA include:
- Mental Health (MH) Partial Care
- MH Partial Hospital
- MH Partial Hospital
- Substance Use Disorder (SUD) Partial Care
- SUD Intensive Outpatient
- Ambulatory Withdrawal Management
- PA is prohibited for Outpatient MH/SUD Counseling

What will happen to my active FFS authorization come January 1, 2025?

- All active FFS authorizations as of December 31, 2024 will be automatically transferred to MCOs and remain active for the remaining duration of the original authorization period

Can we submit PA requests before January 1, 2025?

- If providers need to submit PAs from now through to December 31, 2024, please submit as FFS and the authorization will be auto-transferred

Who do I submit PA requests to after January 1, 2025?

- Providers must submit requests to MCO for continued coverage prior to the end date of the original PA

Will MCOs utilize ASAM-3 or ASAM-4?

- SUD level of care determinations will be made using ASAM-3 standards to align with NJ Substance Abuse Monitoring System (NJSAMS)

Do MCOs provide retroactive authorizations?

- Yes, MCOs accept retro authorizations for a minimum of 5 days. The length of retroactive authorization beyond 5 days would is determined on a case-by-case basis by your MCO
- If you have any specific questions, please reach out to your MCO

What happens when clients choose to switch MCO mid treatment/mid authorization?

- When a member changes MCOs mid treatment or mid authorization, the provider must first call the new MCO and submit a new authorization request. To prioritize continuity of care, the MCO is required to allow providers to continue providing the service until a new plan of care is identified by the new MCO

MCO Care Management (CM)

How will MCO care managers affect services provided by agency care/case management programs?

- MCO care managers are a resource provided by MCOs, and are designed to compliment / support care/case management provided by agencies
- If a member meets criteria, MCOs must offer that member a care manager in addition to any care / case manager provided by an agency
- MCO are well versed in working with a variety of agency providers and will collaborate with agency care/case managers on developing care plan
- The State will provide more detail on roles and responsibilities, and tips for working with MCO care managers in DMAH's BH Integration Care Management Training in January