

Department of Human Services  
Division of Mental Health and Addiction Services

Frequently Asked Questions

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Transition to Fee For Service Questions

**1. Will training be made available to assist providers in the transition to FFS?**

Yes, BH Business Plus, funded by SAMHSA, offers customized, virtual technical assistance and training to behavioral health executives at no cost to help identify and implement change projects that expand service capacity, harness new payer sources and thrive in the changing health care environment. You can find more information here: <http://bhbusiness.org/>.

In addition, DMHAS will make training and information available to providers in preparation for and post transition.

**2. What can providers expect in terms of cash flow for services billed fee-for-service?**

Medicaid payments to providers are made on a weekly basis. Depending upon the timing of the claims submission and assuming all required information is included, providers can expect to be paid within one to two weeks.

It is anticipated that mental health fee-for-service billing for State dollars will be done every other week.

**3. Will there be a cap on State-only (non-Medicaid) utilization?**

Non-Medicaid clients will be paid for through State appropriations, which are fixed by the Appropriations Act. Over the course of the fiscal year, DHS/DMHAS will monitor spending to ensure budget compliance.

**4. Is there any action or process that providers need to take to access the new Medicaid rates?**

No. Beginning July 1, 2016, Medicaid will have the new rates associated with the appropriate billing code. Providers will bill normally and services provided on or after July 1, 2016 will be reimbursed, accordingly.

However for the weekly bundled rates in Opioid Treatment Programs, new codes are being established that will replace current codes for OTP services. These codes and the services included in these codes will be included in a Newsletter published by Molina in the near future.

**5. Will DMHAS funds be able to supplement or wrap around insurance payments up to the State (DMHAS) rate for MH or SUD services covered by insurance?**

No. Insurance payments are considered payment in full.

**6. If a consumer has insurance covering needed MH or SUD services and the provider is not in the insurance provider's network can DMHAS funds be accessed in lieu of insurance coverage?**

No. Consumers must receive services from a provider participating in their insurer's network. Out of network providers can/should refer the consumer, accordingly.

**7. Will DMHAS funds be able to supplement or wrap around charity care up to the State rate for MH/SUD services eligible for reimbursement through charity care at hospitals eligible to participate in the charity care program?**

No. Charity care payments may not be supplemented by DMHAS payments. Consumers must be evaluated for participation in charity care and if they are found to be eligible, the MH or SUD services they receive at the hospital should be billed by the hospital accordingly.

**8. If consumers fail to pay any required co-payments based on the sliding fee schedule will the Division provide reimbursement?**

No. Since the consumer will have been determined to have the ability to pay, the Division cannot provide reimbursement. The Division is however evaluating whether extenuating circumstances should be considered when making the co-pay determination which might lower or eliminate what otherwise would be the required co-pay. When a final determination is made it will be incorporated into the co-pay policy.

This sliding fee scale co-pay issue is separate from the issue of potential Division reimbursement for consumer insurance deductibles and co-payments discussed earlier.

**9. Some consumers' insurance has high deductibles and/or co-payment requirements. Will DMHAS payments be allowed to be used to satisfy the deductibles and/or co-pays subject to the financial eligibility criteria ultimately established by the Division?**

This issue is under consideration.

**10. In the past for MH services, individual providers established sliding fee schedules and charged consumers co-payments to varying degrees. The income was reported as a reduction to gross cost in arriving at the DMHAS contract ceiling. In the FFS system how will consumer resources be considered in relation to the amount that DMHAS will pay?**

The Division is developing a uniform sliding fee scale that will be applied by all providers to evaluate consumer income and calculate potential co-pays for all services. With regard to services supported by Medicaid, no consumer co-pay may be charged as Medicaid must be accepted as payment in full. With regard to services not supported by Medicaid, the sum of the

DMHAS payment and any required co-pay must be accepted as payment in full. As soon as the sliding fee schedule is complete, it will be distributed to providers.

**11. Will the sliding fee schedule developed for MH services be used for SUD services?**

Yes, the Division is developing an integrated MH/SUD schedule. The same instruction designating the sum of the Division payment and any required co-pay as payment in full will apply.

## Contract Questions

**1. How will mental health contract renewals for SFY'17 occur?**

For providers on a fiscal year contract, services transitioning to FFS beginning January 1, 2017 will be contracted for six months (July 2016 – December 2016).

Services that do not transition to fee-for-service January 2017 will continue as deficit funded contracts. As a result, some providers will have two contracts during the July – December time-frame.

**2. Will we still have a contract with DMHAS?**

The DMHAS will initiate fee-for-service contracts with all providers in the fee-for-service network. For services that remain in a slot-based or deficit-funded they will continue using a similar contract mechanism that currently exists.

**3. What funds does the State expect to recoup from providers during the time period for which the mental health contracts remain deficit-funded and the Medicaid reimbursement increases?**

Since the new rates are “gross cost” basis rates, the Division expects to reduce the contract ceiling based on any funds received from 3<sup>rd</sup> party payers (Medicare, Insurance, Client Fees) specific to those clients. This is consistent with current deficit-funded contract policy.

**4. Can providers charge a co-pay?**

Providers may not charge a co-pay for Medicaid-reimbursed services. For services reimbursed with State appropriations – client co-pays will be based on a DMHAS approved sliding fee schedule, which currently is in development. The state rate will be reduced by the co-pay amount collected.

## Mental Health Program Specific Questions

**1. Will there be any Mental Health Services that remain in contract?**

Yes. The following list of services are not scheduled to move to Fee for Service at this time: Training and Technical Assistance Services; Specialized Services; Intensive Outpatient Support Services; Involuntary Outpatient Commitment\*; Early Intervention Support Services\*; Psychiatric Emergency Screening Services/Affiliated Emergency Services; System’s Advocacy/Legal Services\*; PATH\* (Homeless Outreach); Intensive Family Support Services(IFSS)\*; Self-Help Recovery Centers; Justice Involved Services\*; Peer Respite Housing\*; Technical Assistance Services; Cultural Competency Contracts; Information

Technology Services; Warmlines and Hotlines; and other unique, specialized services to be determined on a case by case basis.

\*These services are anticipated to move to Fee for Service in Phase 2 of the transition for which a date has not yet been determined.

**2. Why is the Partial Hospitalization Medicaid rate decreasing?**

DMHAS set the rate based on current regulations and business practices. Since Partial Care and Partial Hospitalization are both licensed as partial care but delivered in different settings, the new rate for both services will be the same. There are additional requirements for Partial Hospitalization programs beyond the Partial Care Regulations. The Department of Human Services has proposed budget language (subject to adoption through the 2017 Budget Act) that would give the Commissioner of DHS the authority to relax these additional requirements, which may result in the partial hospitalization programs to be paid the same service as partial care.

**3. Will Acute Partial Hospitalization rate change?**

No. At this time, there is no plan to adjust the Acute Partial Hospitalization rate.

**4. When a client who is receiving mental health services is jailed or hospitalized, can state dollars be accessed since Medicaid cannot be billed?**

Yes. State dollars can be accessed for services provided to an incarcerated client. Additional information related to the covered services will be made available at a later date.

## Substance Use Disorder Program Specific Questions

**1. Will there be any Substance Use Disorder services that remain in contract?**

Yes. The following list of services are not scheduled to move to Fee for Service at this time: Women's Set Aside; all County AEREF Funds; Council on Compulsive Gambling Contracts; Opioid Overdose Recovery Programs; Opioid Overdose Prevention Programs\*; Recovery Centers; All HIV Case Management\*; Medication Assisted Treatment Initiative (MATI) Vans; Transitional Support; Information and Referral Services; Sign Language Interpreter\*; Communication Accessibility Deaf (DEDR); Treatment Disabled Developmental Disabled (DEDR); Medication Assisted Treatment Outreach Program; and other unique, specialized services to be determined on a case by case basis

\*These services are anticipated to move to Fee for Service in Phase 2 of the transition, for which a date has not yet been determined

**2. Are Substance Abuse Initiative (SAI) rates impacted?**

No. The new rates do not have an impact on SAI programs or clients.

**3. Can Halfway Houses bill for co-occurring disorder enhancements?**

For State services, starting July 1, 2016, the residential core package will allow access to the full co-occurring disorder (COD) enhancement package. Ambulatory core packages will not have access to the full COD enhancement package. The ambulatory packages will have access to the psychiatric services enhancement package. Credentialing requirements for the enhancement package will not change.

**4. Will all opioid treatment facilities receive the bundled rate for Medicaid services starting July 2016?**

Yes., Opioid treatment facilities will receive a bundled rate for OTP services for Medicaid members, beginning July 2016.

**5. What do the Methadone/Buprenorphine bundles include and exclude?**

The bundled rate includes: Dispensing and drug costs; Counseling sessions; Case Management session; and Medication monitoring.

The bundled rate excludes the following services, which may be billed separately: Urine analysis; Transportation; Psychiatric Evaluation; and Comprehensive Intake Evaluation.

**6. Does Medicaid currently cover Suboxone (drug and counseling) in an opioid treatment facility for both the expansion and state plan population?**

Medicaid covers the drug Suboxone in an Opioid Treatment Program (OTP) only for the Expansion population at this time. Beginning July 2016, the state is “truing up” the Medicaid state plan benefit to equal the Expansion benefit so that all Substance Use Disorder services available to the Expansion population will also be available to the Title 19 Medicaid members.

## Medicaid Questions

**1. How do we go about becoming a Medicaid provider and able to bill Medicaid for services we currently do not provide?**

Agencies must be licensed to provide the services they want to bill to Medicaid. To do so, the provider must outreach the DHS, Office of Licensing at (609) 633-6932.

Once licensed, the agency must contact Molina, the fiscal agent for the Division of Medical Assistance and Health Services at 609588-6036 for an application to receive a Medicaid provider number.

**2. Will there be a cap on Medicaid clients?**

No. Medicaid is an entitlement program; however, in some Medicaid programs, services must be prior authorized and/or extended care must be approved based on client medical necessity.

## Interim Managing Entity (IME)

**1. When will prior authorization by the Interim Managing Entity (IME) for addiction services begin? Will there be any maximum turnaround time for the IME to provide prior authorization?**

Prior Authorizations for state-only and Medicaid services will begin in May 2016, however, the Prior Authorizations for Medicaid Services will not be required for reimbursement until July 2016.

**2. How quickly can a Prior Authorization number be issued for new consumers accessing SUD treatment services?**

It is expected that new clients will get Prior Authorization numbers from the IME within an hour of the request, assuming that all necessary information is made available and medical necessity is confirmed.

## General Rates Questions

**1. Will rates apply to clients with singular and co-occurring diagnoses?**

Yes. In instances for which rates are defined as “co-occurring capable,” both populations can be served.

**2. Any consideration of geographical differences in setting the rates?**

In general, DMHAS staff took median NJ values for the Fair Market Rent costs and BLS wages. When certain rates were capped at 100% of the Medicare rate, the Division applied the Northern New Jersey Medicare rate.

**3. Why is the State reimbursement rate 90% of the Medicaid rate?**

Medicaid always should be billed for eligible clients prior to seeking state-only funds. When an eligible consumer is enrolled in Medicaid, it allows for a better managed care plan for their primary health needs and improves patient outcomes.

**4. Will rates be increased in the future to account for inflation?**

At this time, there is no planned, automatic adjustment for inflation. However, rates indexed at the Medicare rate, may be modified, accordingly.