Division of Mental Health & Addiction Services
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Mental Health Fee for Service Transition Update

The Department of Human Services and the Division of Mental Health and Addiction Services staff, in collaboration with a mental health stakeholder group, continues to advance communications regarding the transition to fee for service as guidelines and procedures are being developed. This newsletter is an extension of the regular dialogue occurring in various forums with providers and consumers throughout the state. It is intended to share the highlights of our activities and progress.

Fee For Service Provider Eligibility

The Fee-For-Service (FFS) program is available to providers that currently receive state funds to deliver mental health services within a DMHAS cost reimbursement contract. The FFS initiative applies to state funded services already approved and authorized within the scope of their current contract. An agency is considered to be enrolled in the FFS program if they are a DMHAS contracted provider who is also designated and enrolled for participation in the Medicaid program and has a Medicaid identification number assigned to their agency.

Consumer Eligibility for State Fund Reimbursement

The consumer must meet program eligibility criteria as outlined in regulation and/or policy. In addition, the consumer must also be without insurance coverage for the service he/she is seeking. For example, a consumer may have private health insurance which does not cover PACT services AND the consumer meets programmatic criteria for PACT; the provider then could bill for state reimbursement, provided that the required two hours of service are delivered to the consumer or on behalf of the consumer in a one month time period.

State Rates for non-Medicaid Services

For most Medicaid eligible services, the state rates are 90% of the Medicaid rate, except for PACT and Medication Monitoring, which are the same rate for both. The previous FFS Transition Newsletter outlined state rates for services and items that are not reimbursed by Medicaid, like Bed Holds in residential programs and PACT and ICMS in-reach service.

In addition to these state rates, a rate of $6.30 for Partial Care transportation has been added. Two (2) units of partial care transportation can be billed each day with a concurrent partial care billing. Room and Board for residential services is another non-Medicaid reimbursable item for which the state established a rate. Room and Board can be accessed for eligible consumers in A+, A, B group homes and apartments and Level D Family Care Homes.

IMPORTANT DATES

Information Sessions
CENTRAL REGION
November 28, 2016
10:00am to 1:00pm
Mercer County

SOUTHERN REGION
November 30, 2016
9:30 am to 12:30pm
Burlington County

NORTHERN REGION
December 1, 2016
10:00am to 1:00pm
Morris County

Due to limited space and the targeted nature of this presentation, please limit your agency representation to two staff. Please register at the following link: https://njsams.rutgers.edu/training/ffsls/register.aspx

NJ DMHAS of Mental Health and Addiction Services
222 South Warren Street, Trenton, New Jersey 08625

Email questions or comments to FFS.Transition@dhs.state.nj.us

NJ DMHAS Fee For Service Transition Webpage

Presumptive Eligibility (PE) Basics & Training Info

What is Presumptive Eligibility?

Presumptive Eligibility (PE) is temporary health coverage for NJ residents who may be eligible for NJ Family Care (which includes CHIP, Medicaid, and Medicaid expansion populations), but have not yet applied or their application still is being processed. An individual or family in need of medical services can be enrolled temporarily in PE immediately if eligible, and the PE application can then seamlessly result in full eligibility for NJ Family Care. Potential clients need to provide information such as their name, citizenship/immigration status, household size, monthly income, etc., and a PE determination can be made. During the PE period, services are covered through Fee-for-Service Medicaid; there is no managed care option available.

Who can do Presumptive Eligibility and how long does it take?

Only a mental health or substance abuse agency that is a Medicaid provider and a certified PE Provider can do PE. This requires having at least one certified PE staff member that can be available to submit applications for individuals who come in for services. It can take roughly 15-20 minutes per application depending upon how many family members are in the household as their information will also be collected.

What does a provider have to do to become certified in Presumptive Eligibility?

The provider agency will need to become a Medicaid provider, send at least one staff person to take the PE training and pass the certification test, and once approved, become certified as a PE provider. If an agency has multiple sites, each site will need to have a trained, certified PE staff person designated as their PE coordinator. PE coordinators can “oversee” up to two sites and be on-site to answer any questions or to contact the State PE Unit if necessary. The PE Coordinator does not have to complete any additional training; the agency just has to advise the State PE Unit who the PE coordinator is for each of their sites.

When and where is the next Presumptive Eligibility certification training?

The PE certification training is offered by DMHAS through the Civil Service Commission. The initial block of training has just concluded, however DMHAS is working to coordinate additional PE certification trainings for provider agencies transitioning to FFS on January 1, 2017 & July 1, 2017. DMHAS will be sending out a communication regarding the date, time and location of each training session within the next few weeks.

Provider Monthly Limits

Initially, the DMHAS will be establishing a “monthly limit” for DMHAS funded Mental Health Services transitioning to FFS as a tool to assure that expenditures for non-Medicaid services and non-Medicaid covered individuals do not exceed available resources, and to assure reasonable continued geographic availability of such services. Moreover using limits can afford providers additional assurance regarding this revenue stream as long as sufficient quantities of qualifying services are delivered consistent with the underlying regulations.

The monthly limits related to the DMHAS funded Mental Health FFS were developed with the objective of preserving the current allocation/distribution (not current dollar amount) of DMHAS resources supporting services to non-Medicaid individuals and non-Medicaid services across the Mental Health system.

FEE FOR SERVICE

Fee-for-service (FFS) is a payment model in which services are unbundled and paid for separately. Unlike a fixed contract model, FFS allows providers to bill for each service and the flexibility to budget their billing income in a way that suits their business model.

The DMHAS used QCMR data, where available, for each provider and the new state rates to project an annual amount of compensation that each provider would earn based on historical volume experience and the new rates. The dollar amount was aggregated and each individual provider's relative percentage of the total dollar amount was calculated. Each provider's relative percentage was then multiplied by the total resources available for Mental Health FFS to calculate a limit for the January 1, 2017 to June 30, 2017 period.

Mental Health Programs Transitioning to FFS

January 2017	July 2017	Programs under consideration
Programs in Assertive Community Treatment (PACT)	Community Support Services (CSS	Training and Technical Assistance
Integrated Case Management (ICMS)		Specialized Services (i.e., EISS, Justice Involved Services
Outpatient		Involuntary Outpatient Commitment (IOC)
Mental Health Residential Level A+, A, B, & D Family Care		Intensive Family Support Services (IFSS)
Supported Employment		
Supported Education		
Partial Care		
Partial Hospitalization		

The Billing of State Funds

It is the expectation of the DMHAS that every provider participating in FFS reimbursement for state dollars be Medicaid enrolled and submit claims for all Medicaid eligible consumers and Medicaid eligible services prior to seeking state funds. Additionally, providers are encouraged to become certified to perform Presumptive Eligibility (PE).

On September 21, 2016, the DMHAS held an updated FFS information session and overview of the NJ Mental Health Application for Payment Processing (NJMHAPP) for agencies transitioning to FFS on January 1, 2017 and the leadership of the Mental Health Fee-for-Service Stakeholder Workgroup.

On October 3 to 5, 2016, the DMHAS began User Acceptance Testing (UAT) training sessions to test and familiarize FFS providers transitioning in January with the NJMHAPP billing system. The UAT trainings were well attended with approximately 3 to 4 representatives from each eligible FFS agency. There was participation from the Mental Health Fee-for-Service Stakeholders Workgroup, as well. The overall feedback about the NJMHAPP billing system was very positive and the DMHAS's IT staff have worked closely with all participating FFS providers to correct any systems problems through ongoing weekly NJMHAPP webinars.

Launch of the NJMHAPP

The web-based IT solution, NJMHAPP, will launch on Tuesday, January 24, 2017. Providers will be able to enter data into the system to seek payment for non-Medicaid eligible consumers and non-Medicaid reimbursable services. This application is the payment vehicle for state reimbursement.

Cash advances for up to three (3) months can be requested by qualifying providers transitioning in January 2017.

When to use NJMHAPP

Service	Medicaid Member	Uninsured
OP		√
PACT		√
ICMS		√
Residential		√
Residential Room/Board	√	√
Partial Care/Hospital		√
Partial Care Transportation		√
Supported Employment	√	√
Supported Education	√	√
PACT In-Reach	√	√
ICMS In-Reach	√	√
*Bed Holds	√	√
*Bed Hold Extensions	√	√

*In a future version of NJMHAPP. Bed Holds and Bed Hold Extensions are described in this FFS Transition Newsletter.