

Department of Human Services
Division of Mental Health and Addiction Services

**Q & A: Frequently Asked Questions Regarding the DMHAS
Mental Health Fee-For-Service (FFS) Program**

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General Mental Health FFS Questions

1. Q: What is the Mental Health FFS Program?

A: The Mental Health FFS Program is the Division of Mental Health and Addiction Services' State-funded program that pays provider agencies to deliver community-based mental health services on a fee-for-service basis. It is the payer of last resort and, as such, payment through the program is prohibited if there is another available source of payment for the service, for example Medicaid, Medicare or private insurance.

2. Q: Which mental health agencies are eligible to participate in the DMHAS Mental Health FFS Program?

A: At this time, participation in the MH FFS Program is limited to provider agencies under contract with DMHAS as of December 31, 2016. Those provider agencies have been offered the choice of transitioning from their current cost-related contracts with installment payments (also known as cost-reimbursement contracts) to a non-cost related contract with fee-for-service payment on either

January 1, 2017 (Phase I) or July 1, 2017 (Phase II). In addition, all providers participating in the Mental Health FFS Program must be an approved NJ FamilyCare provider.

3. Q: Does my agency need to be enrolled as a NJ Family Care Provider to participate in FFS?

A: Yes. As noted above, all providers transitioning to the MH FFS Program are required to be an approved NJ Family Care (Medicaid) provider and have an assigned NJ Family Care provider number. In addition, a provider must maintain its status as an approved Medicaid/NJ Family Care provider as a condition of continuing participation in the MH FFS Program. For mental health agencies that do not provide Medicaid covered services, DMHAS will work with Medicaid and the provider to get a number assigned in order to receive payment.

4. Q: How do we go about becoming an approved NJ FamilyCare provider?

A: A NJ FamilyCare enrollment application can be obtained by contacting Molina, the fiscal agent for the Division of Medical Assistance and Health Services, which is the single state Medicaid agency in New Jersey. The application may be requested on Molina's website at <https://www.njmmis.com/onlineEnrollment.aspx> or by telephone at 1-800-776-6334.

5. Q: Which mental health programs are eligible to transition to FFS?

A: DMHAS contracted mental health agencies that provide the following programs have been given the option of transitioning from cost-related contracts to fee-for-service contracts as of January 1, 2017 (Phase 1) : Outpatient, Partial Care/Partial Hospital, Integrated Case Management (ICMS), Programs of Assertive Community Treatment (PACT), Residential, Supported Employment (SE) & Supported Education (Sed).

For July 1, 2017 (Phase II), all DMHAS agencies that provide the above listed programs and Community Support Services (CSS) and Acute Partial Hospitalization services must transition to FFS.

6. Q: Which mental health programs will remain in cost reimbursement contracts?

A: The following services are not scheduled to move to FFS on 1/1/17 and will remain within cost reimbursement contracts: Training and Technical Assistance Services; Specialized Services; Intensive Outpatient Support Services (IOTSS); Involuntary Outpatient Commitment (IOC); Early Intervention Support Services (EISS); Psychiatric Emergency Screening Services/Affiliated Emergency Services; Systems 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 specialized services.

7. Q: Are all DMHAS contracted Community Support Services (CSS) programs scheduled to transition to FFS on July 1, 2017?

A: Yes. Community Support Services (CSS) will be transitioning to FFS on July 1, 2017.

8. Q: Can a mental health provider that is not contracted with DMHAS participate in FFS?

A: No. Only DMHAS contracted providers are eligible to participate in FFS.

9. Q: Can all of the mental health consumers my agency serves participate in the MH FFS Program?

A: As noted in the response to the first question, the MH FFS Program is the payer of last resort. As such, providers cannot seek reimbursement for services through the MH FFS Program that are provided to consumers who have another source of payment for the service, such as Medicaid, private insurance or charity care. If the agency is providing a service that is not covered by another payment source, then the agency can seek funding through NJMHAPP for that service not covered by another payment source.

10. Q: Will training be made available to assist mental health providers in the transition to the Mental Health FFS Program?

A: Yes. For all mental health providers transitioning to FFS on January 1, 2017 (Phase I), DMHAS held FFS information sessions which included an overview of the New Jersey Mental Health Application for Payment Processing (NJMHAPP), the secure web-based application that provider agencies will use to submit information required to process payment for services funded by the Mental Health FFS Program. In addition, DMHAS began "hands on" User Acceptance Testing (UAT) training sessions on the NJMHAPP system for all eligible providers in the Department of Human Services Computer Training lab. Following the UAT training sessions, the DMHAS held weekly FFS webinars to obtain direct provider feedback and correct any systems glitches. The DMHAS will continue to provide ongoing FFS trainings to all eligible mental health providers for Phase II.

11. Q: I understand DMHAS is working on a Mental Health FFS Program Provider Manual and a New Jersey Mental Health Application for Payment Processing (NJMHAPP) User Guide that will be available soon?

A: The Mental Health FFS Program Provider Manual was sent to all providers transitioning to the Mental Health FFS Program in Phase I in early November and also is available through a link on the NJMHAPP login page. The Provider Manual includes information on the Mental Health FFS Program including provider eligibility, services covered under the MH FFS Program, the MH FFS Program as the payer of last resort, rates for services under the MH FFS Program, monthly billing limits, billing procedures, and documentation requirement and the use of monthly limit., The NJMHAPP User Guide also is available through a link on the [NJMHAPP login page](#) and provides an overview of the NJMHAPP and instructions on its use.

12. Q: Will there be a cap on reimbursement through the Mental Health FFS Program

A: Yes, each provider agency has a monthly limit for reimbursement through the Mental Health FFS Program that is set forth in its FFS contract with the DMHAS. More information about the monthly limit, including modification of the limit, is available in the provider's contract and in the Mental Health FFS Program Provider Manual, Section 4E. As a State-funded program, the amount of available

funds for the Mental Health FFS Program is fixed by the annual Appropriations Act. The monthly limits will help to assure that funding through the Mental Health FFS Program is available throughout the year.

DMHAS Contract Specific FFS Questions

1. Q: Will providers still have a contract with DMHAS when we transition to the Mental Health FFS Program?

A: Yes. DMHAS will initiate FFS contracts with all providers participating in the Mental Health FFS Program.

2. Q: If my agency has elected to transition eligible programs to FFS on January 1, 2017, how will this transition date affect our DMHAS contract?

A: Please review the CY 2017 DMHAS Contract Review & Award Process memorandum at the following link: [CY 2017 DMHAS Contract Review & Award Process Letter](#) for complete details regarding contract renewals and FFS. For those agencies transitioning eligible programs to FFS on January 1, 2017, the FFS contract covers the period January 1, 2017 through June 30, 2017. There is no “award summary” for FFS contracts but rather a monthly dollar limitation has been provided. If these providers have any services remaining in cost related contracts, the cost related contract and associated award summary will cover the period January 1, 2017 through December 31, 2017 for all services except Community Support Services (CSS).

3. Q: If my agency has elected to transition eligible programs to FFS on July 1, 2017, how will this transition date affect our DMHAS contract?

A: Please review the CY 2017 DMHAS Contract Review & Award Process memorandum at the following link: [CY 2017 DMHAS Contract Review & Award Process Letter](#) for complete details regarding contract renewals and FFS. For those agencies transitioning eligible programs to FFS on July 1, 2017, the cost related contract components relating to services that will convert to FFS on July 1, 2017 will be for six months, including CSS, and the components for services that remain in cost related contracts will be for twelve months. There are two separate award summaries reflecting these parameters and two separate budgets and contract and contract packages will be required.

4. Q: How will the transition to FFS change the reporting requirements for my current DMHAS contract?

A: Providers transitioning all DMHAS contracted programs to FFS on January 1, 2017 will no longer need to submit contract budgets and reports of expenditure (ROE's). Providers that have DMHAS contracted programs in FFS and in cost related contracts will need to reflect the FFS program on the budget/ROE documents if the programs share any direct or indirect costs with the cost-related programs. Sufficient detail will be required on the budget/ROE to assure the appropriateness of indirect and shared cost allocations.

- Q: Does my agency still need to complete Annex As, QCMRs & USTFs for programs that move to FFS?

A: Yes. All provider agencies with programs moving to FFS still will need to complete Annex As, QCMRs and USTFs for all eligible FFS programs and submit them to DMHAS.

Questions Regarding the New Jersey Mental Health Application for Payment Processing (NJMHAPP)

- Q: What is NJMHAPP?

A: The New Jersey Mental Health Application for Payment Processing (NJMHAPP) is a secure web-based application developed by DMHAS to collect information from providers participating in the MH FFS Program that is needed for DMHAS to pay providers for covered services provided to qualifying consumers. Thus, payment under the MH FFS Program requires the provider to enter all required information into the NJMHAPP.

- Q: I have been informed by DMHAS that the official start date for FFS is actually January 10, 2017, so when can we start entering our data into the NJMHAPP system?

A: Providers can start entering data on January 10, 2017.

- Q: I understand we can enter the billing data daily, but how often can we bill? Can we bill weekly or do we have to bill monthly on the 15th of each month?

A: Agencies will be paid every two weeks based on the encounter/billing data entered into the NJMHAPP by the end date of the billing cycle. The proposed billing schedule is:

Billing Cycle Number	Billing Start Date	Billing End Date
1	1/1/2017	1/14/2017
2	1/15/2017	1/28/2017
3	1/29/2017	2/11/2017
4	2/12/2017	2/25/2017
5	2/26/2017	3/11/2017
6	3/12/2017	3/25/2017
7	3/26/2017	4/8/2017
8	4/9/2017	4/22/2017

Billing Cycle Number	Billing Start Date	Billing End Date
9	4/23/2017	5/6/2017
10	5/7/2017	5/20/2017
11	5/21/2017	6/3/2017
12	6/4/2017	6/17/2017
13	6/18/2017	6/30/2017

4. Q: I understand our agency must enter claims into NJMHAPP for the previous month's service by the 15th of the following month in order to receive payment. What is the DMHAS policy if we fail to meet the billing deadline?

A: DMHAS expects all providers seeking payment through the Mental Health FFS Program to enter encounter data for a service by the 15th of the month after the service was provided. In order to meet that requirement, the DMHAS suggests that providers enter encounter data on a daily or weekly basis to avoid a last minute rush to meet the deadline. If there is an extenuating circumstance that does not allow the provider to submit claims by the 15th of the following month, the agency would need to follow off line payment procedures documented in the FFS Provider Manual to explain circumstances and request consideration for payment.

5. Q: Once our agency enters the encounter data into NJMHAPP, do we have to upload an Electronic Data Interchange (EDI) file like we have to do for Medicaid billing?

A: No, once a provider enters the encounter data into NJMHAPP, the information will be automatically processed for payment. NJMHAPP does not have the capacity to accept EDI format at this time.

6. Q: Our agency operates a lot of level A+ residential sites and a PACT program where consumers can often stay for multiple years. How far in advance can my agency encumber funds in NJMHAPP for eligible consumers?

A: There is no time limit for encumbering funds in NJMHAPP, but the provider agency must monitor and manage its budget limits accordingly on a month to month basis. Please note, a provider agency cannot encounter (bill) for services to be provided in the future, only for services the agency has provided.

7. Q: Our agency has many consumers who have received services for years at a time, why do we have to enter an end date in NJMHAPP to receive reimbursement?

A: An end date must be captured so the NJMHAPP system can encumber funds for each month. Providers can change the end date at any time by reducing or extending it. This offers more flexibility to providers to encumber funds based on their need.

8. Q: Can a Provider bill NJMHAPP for consumers already receiving a sliding scale rate from our agency?

A: If the consumer meets all participation criteria for state reimbursement the provider should bill through NJMHAPP and report revenue received in accordance with forthcoming instructions from DMHAS.

9. Q: Can a consumer be served at two different agencies and still receive state reimbursement through NJMHAPP?

A: Yes, as long as the consumer is not receiving the same service from both agencies and all rules regarding service conflicts and limitations are observed. The Mental Health FFS Program Provider Manual includes a summary of the business rules, including services that cannot be provided during the same time period, in Appendix D.

10. Q: Can we register and admit consumers for state reimbursement through NJMHAPP if they do not have a Social Security number?

A: Yes, the NJMHAPP system allows provider agencies to enter all nines (999-99-9999) in order to proceed in the application and admit the consumer for service if no Social Security is available.

11. Q: What if our agency admits a consumer into NJMHAPP who does not have a Social Security number and we later obtain the consumers actual Social Security number?

A: If the agency later obtains the consumer's actual Social Security number, the agency must submit a work "ticket" in the NJMHAPP system to change the Social Security number for that consumer. DMHAS IT staff will process this ticket accordingly.

Question Regarding Medicaid Status Changes

1. Q: What should my agency do if a consumer becomes Medicaid eligible, but is only receiving a Medicaid reimbursable service?

A: The provider must discharge the consumer from the NJMHAPP service and then pursue Medicaid reimbursement.

2. Q: What should my agency do if the consumer becomes Medicaid eligible but is receiving a non-Medicaid covered service?

A: The provider must discharge and re-admit the consumer into NJMHAPP. The discharge is NJMHAPP enables the client record to accurately reflect the consumer's Medicaid status and allows the provider to bill only for non-Medicaid reimbursable services.

3. What should my agency do if a consumer becomes ineligible for Medicaid?

A: The provider must discharge and re-admit the consumer into NJMHAPP for that service so the provider can access payment for eligible services.

Questions Regarding Third Party Liability, Charity Care & Medicare

1. Q: Will DMHAS funds be able to supplement or wrap around insurance payments up to the State rate for Mental Health covered insurance?

A: No. Insurance payments are considered payment in full.

2. Q: Will DMHAS funds be able to supplement or wrap around charity care up to the State rate for Mental Health services eligible for reimbursement through charity care at FFS eligible hospital based programs?

A: 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 mental health services they receive at the hospital should be billed against charity care by the hospital.

3. Q: Are all consumers who have Third Party Liability (TPL) coverage ineligible for state reimbursement through NJMHAPP?

A: If a TPL plan covers a state funded service, then state funds cannot be accessed for reimbursement. If the TPL plan does not cover a state funded service, then NJMHAPP can be used for reimbursement through state funds.

4. Q: If a consumer has insurance coverage for Mental Health and the provider is not in network, can DMHAS funds be accessed in lieu of insurance coverage?

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

5. Q: Can our agency bill NJMHAPP for consumers who have Medicare coverage?

A: Medicare is a TPL, so if it covers a state funded service, then state funds cannot be accessed for reimbursement. If Medicare does not cover a state funded service, then NJMHAPP can be used for reimbursement through state funds.

6. Q: Can a Partial Care provider bill NJMHAPP for state reimbursement when a Medicaid enrolled consumer reaches the Medicaid prior-authorized maximum billable units within a 6 month time frame?

A: No. Medicaid is payment in full. The provider should seek another prior-authorization for that consumer from the local Medical Assistance Customer Centers (MACC) offices. If the consumer does

not meet medical necessity criteria for Medicaid covered services, then the provider would not seek NJMHAPP for payment.

7. Q: If a consumer has Medicare as their primary insurance and has no secondary insurance, can our agency bill NJMHAPP for the amount Medicare does not cover?

A: No, payment received from Medicare and other insurances including charity care, is considered payment in full.

8. Q: If a consumer with Medicare coverage is seen by a non-credentialed therapist, can we bill NJMHAPP for the service?

A: No, if the provider agency has not met the Medicare credentialing requirements for that Medicare covered consumer, they cannot bill NJMHAPP for state reimbursement. Consumers should be assigned to appropriate TPL paneled clinicians. If a clinician is not available at the provider, a referral to an in-network provider should be facilitated.

9. Q: What is the NJMHAPP billing policy for instances when a provider agency is receiving state reimbursement for a non-Medicaid enrolled consumer and that consumer later obtains Medicaid coverage without informing the provider?

A: The provider agency is expected to check the consumer's Medicaid status through the EMEVS before entering encounter data for a Medicaid covered service and NJMHAPP will not allow the provider to enter encounter data for a Medicaid-covered service unless the provider checks a box indicating that EMEVS has been checked. In the situation where Medicaid eligibility is retroactive, the provider agency will need to bill Medicaid for payment and reimburse the state for the dollars received through NJMHAPP during the consumer's Medicaid eligibility.

10. Q: What is the NJMHAPP billing policy for instances when a Medicaid enrolled consumer receiving services at the provider agency loses Medicaid coverage?

A: The provider agency can start billing NJMHAPP on the date of service after Medicaid is terminated.

11. Q: Will our agency be able to receive a "client level" report from MOLINA, Medicaid fiscal agent, so we know exactly how much was paid for an individual consumer?

A: No, Molina will not provide client level claims data at this time. However, client level data can be generated through reports in NJMHAPP.

12. Q: Our current MOLINA generated Medicaid payment report can be 500 pages of codes and numbers for one week of billing, how will we know what is state reimbursement through NJMHAPP and what is Medicaid reimbursement?

A: There will be a separate control number for state paid claims. This will differentiate state payments from Medicaid payments. DMHAS Fiscal will provide you with the control number for your reference.

13. Q: Can our agency bill NJMHAPP for residential “Bed Holds” starting in January, 2017?

A: No, it cannot be billed in NJMHAPP. However Bed Hold reimbursement will be available for providers in January, 2017 but not in the NJMHAPP system. Bed Hold reimbursement will be available via a manual process through the DMHAS fiscal office which has been outlined in detail in the Provider Program Manual.

14. Q: Can our agency bill for children’s services in our Outpatient program?

A: Yes, at this time and as long as the child is not receiving services through the Children’s System of Care in the Department of Children and Families. The DMHAS anticipates the ability to bill in NJMHAPP for services provided to individuals under the age of 18 will change in the near future.

Questions Regarding Presumptive Eligibility (PE)

1. Q: What is Presumptive Eligibility?

A: Presumptive Eligibility (PE) is temporary health coverage for NJ residents who may be eligible for NJ Family Care (which include CHIP, Medicaid, and Medicaid expansion populations), but have not yet applied or their application is still being processed. An individual or family in need of medical services can be temporarily enrolled in Medicaid immediately if it appears they are eligible, and the PE application then can seamlessly result in full enrollment for NJ FamilyCare. 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.

2. Q: Who is qualified to submit a PE application and how long does it take?

A: Only a mental health or substance abuse agency that is a Medicaid provider and employs certified PE staff 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 approximately 15-20 minutes to complete and submit an application depending upon how many family members are in the household. Once the application is submitted, approval or denial of the application will be issued within three business days.

3. Q: What does a provider have to do to become Presumptive Eligibility certified?

A: The provider agency must be a Fee-for Service 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 only “oversee” up to two sites and be on-site to answer questions or 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. For more information about PE and PE trainings, please submit your questions to the following email address: PE-Trainingrequests@dhs.state.nj.us

4. Q: When and where is the next Presumptive Eligibility certification training going to take place?

A: 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 communication regarding the date, time and location of each training session moving forward.