SECTION 7 - Medicaid Rate Review Process for Residential Treatment Centers Participating in the Medicaid Program

State of New Jersey
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SECTION 7

MEDICAID RATE REVIEW PROCESS FOR RESIDENTIAL TREATMENT CENTERS PARTICIPATING IN THE MEDICAID PROGRAM

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7.1 Introduction

This section of the manual contains additional guidelines to be used to establish per diem rates for public-operated and private provider agencies furnishing residential treatment services under the State's Medicaid Program. These guidelines have been developed in consultation with the Division of Medical Assistance and Health Services (DMA&HS) and are in accordance with applicable federal regulations as set forth in the Code of Federal Regulations. The Division of Youth and Family Services in conjunction with the DMA&HS is responsible for ensuring that only allowable costs and/or payment rates are paid to providers participating in the Medicaid Program.

The Department believes that the application of these guidelines will generally produce equitable rates for reimbursement to agencies for providing routine resident care. The Department recognizes, however, that no set of guidelines can be developed which might not result in some inequities if applied rigidly and indiscriminately in all situations. Inequities can be in the form of rates that are unduly high or low.

Accordingly, in a case where a residential treatment provider believes that, due to an unusual situation, the application of these guidelines results in an inequity, the Department is prepared to review the particular circumstances with the provider through the appeal process described below. Appeals on the grounds of inequities should be limited to circumstances peculiar to the provider affected. They should not address the broader aspect of the guidelines themselves.

Reimbursement rates for contracted services may be established using a cost analysis or price analysis method as described in Section 3, Types of Contracts. Per diem rates for inpatient psychiatric services for individuals under age 21 provided in State-operated residential treatment centers are based on reasonable costs reported on quarterly cost reports. These cost reports are based on a Cost Allocation Plan for administrative costs of the New Jersey Department of Human Services, Division of Youth and Family Services and are used in lieu of the contract budget/expenditure forms applicable to contract service provider agencies. This Cost Allocation Plan is in accordance with federal rules and regulations contained in 45 CFR, Part 95 and is approved by the federal Department of Health and Human Services.

Reimbursement rates established by the Department will be subject to on-going verification of all applicable provider agency records. It should be noted that the Department reserves the right to question and exclude from rates any unreasonable costs. The formula for calculating Medicaid reimbursement rates has been developed to meet the following overall goals:

1. to provide sufficient reimbursement to ensure adequate levels of resident care; and

2. to comply with federal requirements for a reasonable rate.

7.2 Guidelines

Provider Agreement

The Department will not make payments to a provider for residential treatment services without a formal provider agreement as set forth in the Code of Federal Regulations, Title 42, Subpart B, 442.10 through 442.30. This provider agreement is in addition to the regular contract execute between the provider and DMA&HS.

Upper Limits on Payment Rates

The Department will not pay a rate higher than the lower of (1) the customary charges of the provider for the same service or (2) the prevailing charges in the locality for comparable services under comparable circumstances.

Late Submission of Cost Reports

To ensure the timely receipt of cost reports, the Department will send a reminder letter to the provider 30 days prior to the date on which the cost report is due.

If the provider has not filed its cost report by the first day after the due date (allowing for any approved extensions), the Department will send a first demand letter to the provider. The letter will inform the provider that if the report is not received within 30 days of the date of the demand letter, the Department may reduce the per diem rate by 20 percent.

If the Department does not receive the cost report or a response to the first demand letter within 30 days, a recommendation may be made to reduce the per diem rate, and a second demand letter will be sent. This letter will inform the provider of the recommended rate reduction. The letter will also inform the provider that if the cost report or a response is not received within 30 days from the date of the letter, the Department may suspend payments.

If the Department does not receive the cost report or a response to the second demand letter within 30 days, payments may be suspended, and all prior payments to the provider may be declared overpayments.

In the case of a terminated provider agreement, the Department will inform the provider in writing that the final cost report is due within 45 days of the termination date. If the provider does not respond or submit a cost report within 45 days, the Department may declare that an overpayment has been made to the provider.

The provider may submit a written request to the Department for a 30-day extension to any of the reporting requirements listed above. The provider must give adequate justification for the requested extension. The request must be received by the Department prior to the due date for the report in question. The Department may accept or reject the requested extension based on the written justification furnished by the provider.

Suspension of Payments

When the Department determines that a provider does not maintain adequate records for the determination of reasonable costs or charges under the residential treatment program, payments to the provider shall be suspended until the Department is assured that adequate records are maintained. Before suspending payments, the

Department shall send written notice to the provider of its intent to recommend suspension. The notice shall explain the basis for the Department's determination with respect to the provider's records and shall identify the specific recordkeeping deficiencies. The provider will be given the opportunity to submit a statement (including any pertinent evidence) as to why the suspension should not be effected.

As indicated in the previous section, Late Submission of Cost Reports, the Department may also suspend payment to a provider for failure to submit required reports.

Appeal Process

When a residential treatment provider believes that, due to an unusual situation, the application of these guidelines results in an inequity, the provider may appeal the rate component(s) affected by the situation. All appeals must be submitted in writing to the Director, Division of Medical Assistance and Health Services, Department of Human Services, within 30 days of notification of the rate. Two levels of appeal are available to providers.

Level I

The first level of appeal represents an informal administrative process and can include two stages. The first stage appeal will be heard by an Assistant Commissioner of the Department of Human Services. The provider should be prepared to present such substantiating material as may be required for an informal discussion of the subject matter. This level of appeal will attempt to reach equitable resolutions of matters peculiar to individual providers. It will not be expected to resolve issues which have policy implications or broader applicability. The Assistant Commissioner's recommendation will then be forwarded to the DMA&HS Director for approval.

If the provider is not satisfied with the results of the first stage of the Level I appeal, a second stage may be requested. The second stage may be requested. The second stage appeal will be heard by a panel of designated representatives from the Assistant Commissioner's Office and DMA&HS. This panel will be chaired by a senior member from DMA&HS. The DMA&HS Director will schedule an appropriate time and place for the panel to hear the appeal. The panel will record and submit its recommendations to the Director for final resolution.

Level II

If the provider is not satisfied with the results of the Level I appeal, the contested rate issues will be referred to the Office of Administrative Law for a formal hearing pursuant to the Administrative Procedures Act.

It should be noted that professional fees related to legal actions against the State are unallowable costs.

Any adjustment resulting from an appeal will be effective:

1. from the beginning of the reimbursement period if an error in computation was made by the Department or if the appeal was submitted within the specified period; or

2. from the first of the month following the date of appeal for non-computational matters if the appeal is submitted after the specified period.

The date of submission is defined as the date received by the Department.

Audit Requirements

Private provider agency's records are subject to audit as described in Section 2.4, Audit and Department Policy DCF.P7.06-2007, Audit Requirements. State-operated residential treatment facilities are also subject to audit. The scope of the audit for Medicaid purposes depends on the type of rate established for the provider agency. Audits must be performed in accordance with generally accepted auditing standards.