

***Presentation:***  
**Comprehensive Medicaid Waiver  
Renewal**

**STRENGTHENING MEDICAID:  
ALIGNMENT & REDESIGN  
THROUGH CARE INTEGRATION**

# WHAT IS AN 1115 WAIVER AND WHY DOES NEW JERSEY NEED TO SUBMIT A RENEWAL

- The New Jersey 1115 Comprehensive Medicaid Waiver Demonstration is a “Research and Demonstration” waiver granted by the Centers for Medicare and Medicaid Services (CMS) under Section 1115(a) of the Social Security Act (SSA).
- Demonstrations under Section 1115 of the SSA give states flexibility to design and improve their programs using innovative ideas that are typically not allowed under Medicaid and CHIP rules.
- The Comprehensive Waiver gives NJ the authority to operate most of the NJ FamilyCare program, including:
  - Mandatory Managed Care
  - Managed Long Term Services and Supports (MLTSS)
  - Supports Program
  - Children’s Home and Community Based Services (HCBS) Programs
  - Delivery System Reform Incentive Payment (DSRIP)
- **The Comprehensive Waiver expires on June 30, 2017.**

# OUR VISION

*A fully integrated continuum of care that seamlessly addresses individuals' physical, behavioral health and long-term care needs.*

# 1115 COMPREHENSIVE WAIVER DEMONSTRATION: KEY ACCOMPLISHMENTS

- Implemented a comprehensive integrated community-based MLTSS benefit.
- Consolidated and streamlined reporting of the NJ FamilyCare program under a single waiver authority.
- Improved the Medicaid eligibility system by reducing the backlog of new applications and redeterminations.
- Implemented three Behavioral Health Homes serving individuals with chronic conditions.

# 1115 COMPREHENSIVE WAIVER DEMONSTRATION: KEY ACCOMPLISHMENTS

- Rebalanced the inequalities of primary and preventative services through targeted increases to reimbursement rates.
- Implemented targeted home and community-based programs for beneficiaries with serious emotional disturbance, autism spectrum disorder; and intellectual and developmental disabilities.
- Provided DSRIP funding for hospitals to make significant structural improvements in the health care delivery system.

# KEY CONCEPTS FOR RENEWAL

- Maintain the Managed Long-Term Services and Supports (MLTSS) program.
- Move to an integrated, managed and organized behavioral health delivery system for that includes a flexible and comprehensive substance use disorder (SUD) benefit.
- Increase access to services and supports for individuals with intellectual and developmental disabilities.
- Further streamline NJ FamilyCare eligibility and enrollment.

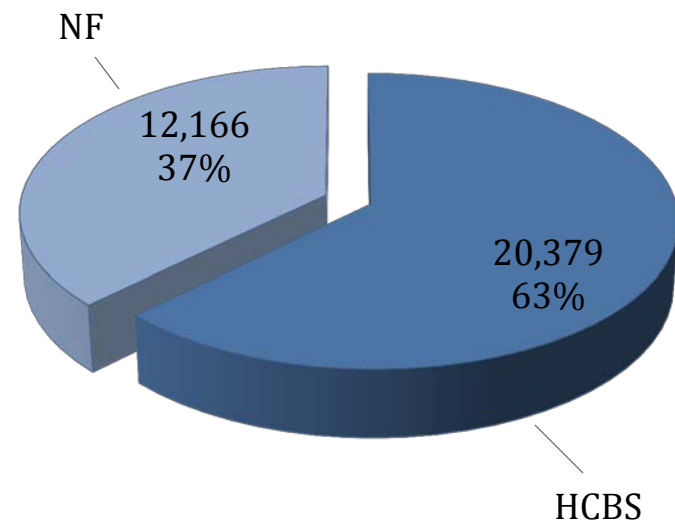
# KEY CONCEPTS FOR RENEWAL

- Explore the expansion of the High-Fidelity Housing First (HFHF) model as well as to invest in a permanent supportive housing benefit which offers pre-tenancy, tenancy and tenancy sustaining services.
- Develop an uninterrupted reentry system for individuals incarcerated.
- Enhance access to critical providers and underserved areas through alternative provider development initiatives.
- Continue DSRIP funding to promote and foster health care delivery system innovations.

# MANAGED LONG TERM SERVICES AND SUPPORTS

- As of December 2016: 32,545 beneficiaries were enrolled in MLTSS.
  - Approximately 2/3 in Home and Community-Based Settings
- Since implementation, the Nursing Facility population has decreased by approximately 1,000 individuals.
- With the renewal, New Jersey plans on continuing the current MLTSS structure and building upon its successes by driving quality and integration.

MLTSS Population by Setting as of December 2016





# BEHAVIORAL HEALTH INTEGRATION

Adults with SMI die on average 25 years earlier than other Americans, largely due to untreated medical conditions

81% of NJ Medicaid high utilization inpatients have a BH diagnosis, including 44% with SMI

Sources: *Journal of Psychopharmacology*. 2010 Nov; 24(4\_supplement): 61–68; Rutgers Center for State Health Policy.

# BEHAVIORAL HEALTH INTEGRATION: A PHASED IN APPROACH

## Phase I: MLTSS and Health Homes

- MLTSS plans integrate PH, BH and LTSS for individuals with long-term care needs
- Health Homes enable integrated care management for individuals with SMI and SED

## Phase II: Building System Capacity

- Interim Management Entity (IME) provides prior authorization and referral to treatment for SUD services
- Governor authorizes \$120M to improve BH system capacity
- Extend presumptive eligibility to BH providers
- BH provider payments move from deficit funding to FFS
- SUD benefit “true-up” for individuals in Plan A

## Phase III: Fully Integrated Care

- Create a comprehensive continuum of SUD care
- Integrate BH benefits into an integrated, coordinated health delivery system
- Implement quality incentives to reward integrated care delivery
- Address regulation barriers

# BEHAVIORAL HEALTH INTEGRATION: SUCSESSES TO DATE

- MCOs have built capacity to manage BH benefits for MLTSS members.
- Through behavioral health homes, five counties now are offering integrated care management and co-located or coordinated primary and behavioral health care.
- IME received 85,902 calls from July 2015 through December 2016.
  - In May 2016, the IME began utilization management (UM) for Medicaid and State funded initiatives as well as established a provider hotline to provide technical assistance during the implementation of UM activities.

# BEHAVIORAL HEALTH INTEGRATION: LESSONS FROM OTHER STATES

- Prioritize access and continuity of care for consumers.
- Invest in BH provider capacity to thrive in the new environment.
- Ensure capacity to effectively manage BH benefits.
- Engage stakeholders in aspects of system design and implementation.
- Employ a timely and thoughtful approach.

# BEHAVIORAL HEALTH INTEGRATION: THREE LEVELS

## Payer

- MLTSS
- IME
- BH Integration into a coordinated Health Delivery System

## Provider

- Health Homes
- Co-Location/  
Integrated Care  
Delivery

## Regulatory

- Streamlining licensure requirements
- Clarifying billing procedures

# SERVING ADULTS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

- The Supports Program, administered under the Division of Developmental Disabilities (DDD), launched in July 2015 as part of the Comprehensive Waiver.
- DDD also administers the Community Care Waiver (CCW), the last remaining active 1915(c) waiver in New Jersey.
- Under the renewal, New Jersey requests to move the authority for CCW under the Comprehensive Waiver.
  - Creates an easier way to navigate between Supports Program and CCW.
  - Does not move the CCW services into managed care.
- A pilot program for adults that will address the distinct needs of individuals with co-occurring developmental disabilities and acute behavioral health needs is being explored.

# SERVING CHILDREN AND FAMILIES WITH COMPREHENSIVE SUPPORTS

- The Children's Home and Community-Based programs under the Comprehensive Waiver are administered by the Department of Children and Families (DCF), Division of Children's System of Care (CSOC). These programs include:
  - Autism Spectrum Disorder (ASD) pilot
  - Children with Intellectual and Developmental Disabilities with Co-occurring Mental Illness (ID/DD-MI) pilot
  - Serious Emotional Disturbance (SED) program
- Under the renewal, a new Children's Support Services program will be initiated to expand access to services currently under the ID/DD-MI and ASD pilots.

# TREATING CHILDREN WITH AUTISM SPECTRUM DISORDER

- In New Jersey, 1 out of every 41 children is diagnosed with Autism Spectrum Disorder.
- NJ FamilyCare began to cover services for youth with Autism as a pilot under the Comprehensive Waiver.
- CMS provided guidance to states regarding coverage of Autism services under EPSDT.
- Staff from DMAHS, CSOC, the Department of Banking and Insurance (DOBI), and the Department of Health (DOH) are collaborating to build a comprehensive package of services to provide to youth with Autism as part of the Medicaid State Plan.



# ELIGIBILITY & ENROLLMENT FLEXIBILITIES

New Jersey will be requesting the following flexibilities in the renewal:

- Authority for individuals who are applying for long term care and home and community-based services to self-attest to the transfer of assets.
  - Continued authority for individuals under 100% of Federal Poverty Level (FPL).
  - Expanded authority for individuals up to 300% of the Federal Benefit Rate (FBR).
- Requirement for new managed care enrollees to choose a Medicaid MCO upon eligibility application or be auto-assigned.

# TRANSITIONING INCARCERATED INDIVIDUALS BACK INTO THE COMMUNITY

To support other state agencies' efforts to reduce the recidivism rate, New Jersey is requesting authority to allow incarcerated individuals who are re-entering the community:

- Continued Medicaid eligibility for 18 to 24 months before redetermination to promote continuity of services.
- Auto-assignment into an MCO to ensure their care is managed at the earliest point possible.
- Individuals will be eligible for enrollment into the SUD program, which includes recovery based supports.
- MCOs will be required to have a dedicated Care Manager working with the jails, prisons and re-entry programs to coordinate both health and social services upon release.
- A designated Behavioral Health Home is also being explored.
- Expanding Presumptive Eligibility to Behavioral Health providers.

# MEDICAID HOUSING AND TENANCY SUPPORTS

- Under the waiver, New Jersey requests to explore the use of the High-Fidelity Housing First (HFHF) model to meet the needs of individuals who are at-risk for homelessness or who are considered to be chronically homeless.
- New Jersey proposes to provide housing-related services to all Medicaid recipients. Broadly defined, these services are a range of flexible services that support individuals and families.
  - Housing Screening Services
  - Housing Transition Services
  - Housing Tenancy Sustaining Services

## ENHANCE ACCESS TO CARE THROUGH ALTERNATIVE PROVIDER DEVELOPMENT INITIATIVES

- Access demands require that New Jersey think beyond the traditional health care workforce model.
- Under the renewal, New Jersey will seek to increase the use of evidence-based telehealth options.
- Value-based purchasing efforts create an opportunity to align performance metrics with NJ FamilyCare beneficiaries' experience accessing care, particularly in areas with documented need.

## Continuing Efforts through the Delivery System Reform Incentive Payment (DSRIP) Program

- Current value-based purchasing strategies (VBP) include MCO Pay-for-Performance and the Delivery System Reform Incentive Payment (DSRIP) Program.
- New Jersey is seeking authority to continue the DSRIP program for two years, with an option to extend for three additional years, if certain performance benchmarks are met by participating hospitals.

# POPULATION HEALTH

- In August 2016, the Department of Health (DOH) convened a Population Health Action Team (PHAT) to advance population health initiatives statewide.
  - The overarching goals of the PHAT are: to remove policy barriers across agencies and enhance coordination in the provision of public services that foster healthy outcomes; focus on vital, health-related priorities using combined resources and expertise; close geographic, racial/ethnic, gender or other differences in health outcomes across the state; and develop innovative solutions to address health in transportation, education, access to healthy food, economic opportunities, and areas where health is not typically a primary consideration.
- In collaboration with the PHAT, DOH will host a series of population health conferences over the next several years to build an understanding and support for population health improvement.
- As part of the Population Health Initiatives, DOH is also promoting the development of seven (7) regional collaborative organizations over the next several years.

# WAIVER RENEWAL PROCESS

- As part of the waiver renewal, in accordance with 42 CFR 431.408, New Jersey is providing a 30 day public comment period for stakeholders and other interested parties. After the comment period has ended, the state will review the comments, make any changes to the application based on those comments and submit the application to CMS.
- Once the renewal application package is received by CMS, in accordance with 42 CFR 431.416(a), CMS has 15 days to determine if the application package is complete. The 30 day Federal public comment period will begin upon response to the state that the package is complete.
- After completion of the 30 day Federal public comment period, CMS will review comments and begin negotiations with the state regarding the renewal. Should it be necessary, under 42 CFR 431.412(c)(4), CMS may grant a temporary extension of the existing waiver demonstration while the successor demonstration is under review.

# STAKEHOLDER PROCESS TO DATE

- The draft renewal application was published on June 10, 2016 for 60 days of public stakeholder comment.
- The Department engaged in an extensive public stakeholder process that included presentations at twelve (12) public forums over the 60 days with interested stakeholders from DMAHS, DMHAS, DoAS, DCF, and DDD.
- DMAHS received over 150 written comments on the renewal application from interested stakeholders and detailed how it addressed the comments in Attachment E of the renewal application.



# SUMMARY OF RENEWAL COMMENTS

- **Majority of the Comments**

- Pertained to the concept of integrating care for dual eligible individuals concept
- Supportive of the housing first and supportive housing concept
- Applauded the work done with autism, and emphasized the need for ABA as a service provided through the State Plan.
- Supported an integrated, organized and managed behavioral health delivery system
- Called for continued stakeholder opportunities.

- **Based on Stakeholder Comment, Key Changes Include**

- Removing Medicare as a condition of Medicaid eligibility.
- Removing the Integrating Care Options for Dual Eligible Individuals concept, including both the seamless enrollment and integrated enrollment option.
- Adding specifics around the types of models Medicaid is considering under the increased access / telehealth option.
- A detailed population health description.

## NEXT STEPS: DMAHS & CMS

- The amended application was submitted to CMS on Friday, September 16, 2016.
- CMS has fifteen (15) days to review the application for completeness and will then post the application to its website for a thirty (30) day federal public comment period.
- CMS completed its review of the application and forwarded clarifying questions to DMAHS on October 4, 2016. DMAHS revised the application to address these questions and resubmitted to CMS on November 22, 2016.
- DMAHS has incorporated feedback from CMS in the amended draft application, and post for an additional 30 days of public comment in January 2017.

## NEXT STEPS: STAKEHOLDERS

- Review the amended application
- Participate in the federal public stakeholder process
- Waiver updates will be posted on the Division's website:  
<http://www.state.nj.us/humanservices/dmahs/home/waiver.html>
  - Updates and ways of participating in workgroups will be announced through stakeholder forums like the MLTSS Steering Committee and the MAAC.

**Waiver comments can  
*always* be sent to  
[dmahs.cmwcomments@dhs.state.nj.us](mailto:dmahs.cmwcomments@dhs.state.nj.us)**

# COMMENTS

- The Renewal application can be found on the Division's website at:  
<http://www.state.nj.us/humanservices/dmahs/home/waiver.html>
- The comment period ends February 10, 2017.
- Comments can be sent via email to  
[dmahs.cmwcomments@dhs.state.nj.us](mailto:dmahs.cmwcomments@dhs.state.nj.us) (preferred method)
  - Or by mail or fax to:
    - Margaret Rose  
Division of Medical Assistance and Health Services  
Office of Legal and Regulatory Affairs  
P.O. Box 712  
Trenton, NJ 08625-0712  
FAX: 609-588-7343

# ***Presentation:***

**AARP NJ Report Highlights:  
*Family Caregivers and Managed  
Long-Term Services and Supports***

# Family Caregivers and Managed Long-Term Services and Supports

## Report Highlights

Presented by Evelyn Liebman, AARP NJ

for the

NJ Medical Assistance Advisory Council Meeting

January 23, 2017

Susan C. Reinhard, Wendy Fox-Grage, and Lynn Friss Feinberg



**Public Policy  
Institute**

Go to: <http://www.aarp.org/ppi/info-2016/family-caregivers-and-managed-ltss.html>

The screenshot shows a web browser window displaying the AARP Public Policy Institute website. The page title is "Family Caregivers & Managed Long-Term Services and Supports" by Susan C. Reinhard, Wendy Fox Grage, and Lynn Fiss Feinberg. The page features a navigation menu with categories like PUBLICATIONS, ISSUES, INITIATIVES, EXPERTS, EVENTS, DATA, and ABOUT PPI. A search bar is visible on the right side. The main content area includes a "Full Report" section with a bullet point: "Family Caregivers & Managed LTSS". Below this, there is a "FINDINGS" section and a list of four promising practices: TennCare, South Carolina Healthy Connections Prime, United Healthcare, and Cal MediConnect Dementia Project. A sidebar on the right contains a "Search Public Policy" box, a "SUSAN'S BLOG" section with a photo of Susan Reinhard, and a "GET PPI NEWS ALERTS" section with a "SUBSCRIBE" button. The Windows taskbar at the bottom shows the date as 11/29/2016 and the time as 3:29 PM.

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# Why this Study

- The family – broadly defined – is the main source of help for older people and adults with chronic care needs and functional limitations.
- Recognition of and support for family caregivers matters because chronic illness and disability often affect the family as well as the individual.
- Today, understanding and addressing family caregivers' needs is viewed as a key component of a high-performing LTSS system



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# **Family caregivers are inseparable members of the care circle.**

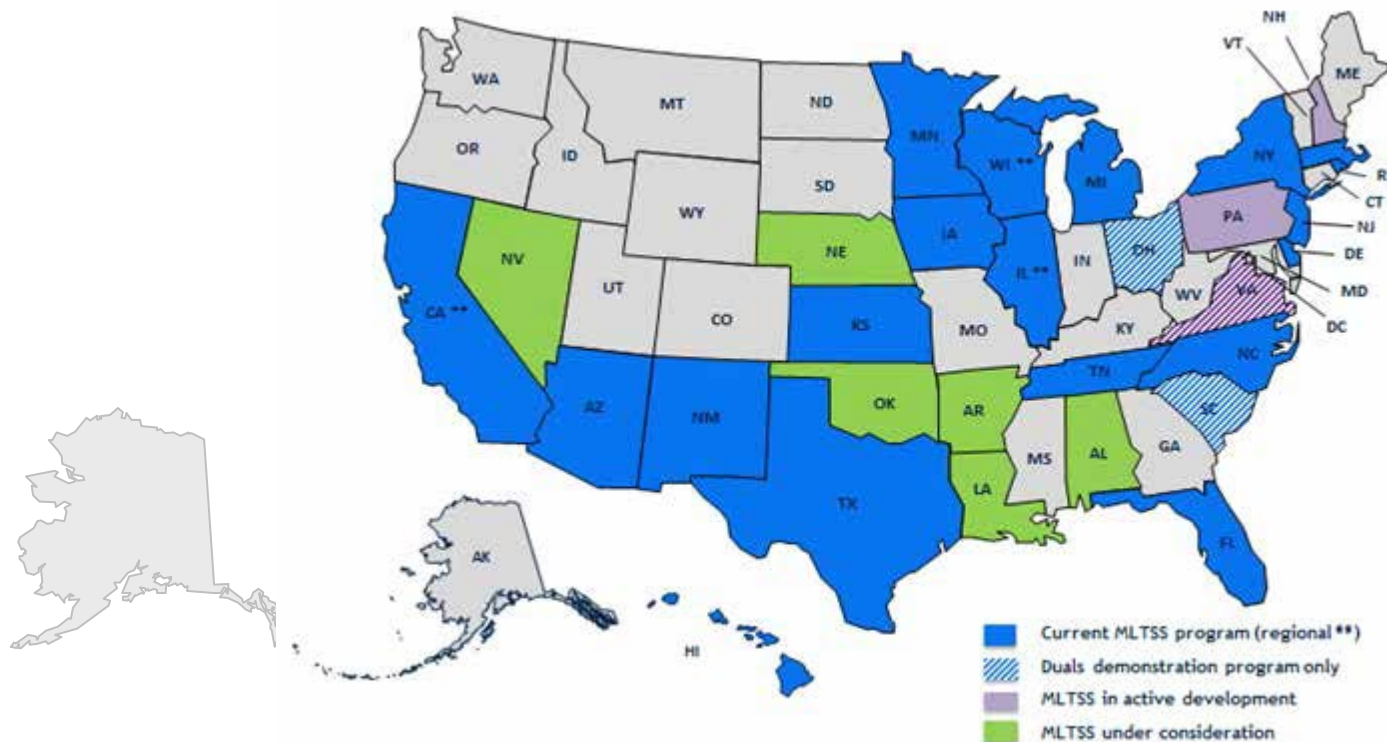
1. The caregiver-as-provider places them in a critical position to affect outcomes that matter to the managed care organization.
2. The caregiver-as-client acknowledges the risk of family caregivers becoming secondary patients.

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# Managed Long-Term Services and Supports are Changing the Field

- The field of LTSS is rapidly changing.
- Approximately half the states moving to Medicaid Managed LTSS
- The bottom line: family involvement does impact the quality of health care and LTSS. It does make a difference in getting better care.

# States with Medicaid Managed LTSS Programs August 2016



Source: Camille Dobson, NASUAD, emailed to authors with permission on 8/26/16

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# About the Report

- 1<sup>st</sup> major research report in the emerging field of managed LTSS that addresses family caregivers' needs.
- Year and half of research and networking.
- 2015 commissioned Truven Health Analytics research state Medicaid contracts for requirements about care coordination & family caregiving
- Established a nationwide learning collaborative.
- Identifies best practices.

# KEY FINDINGS

- **Care Coordination and Services.** Most Medicaid managed care contracts provide little specificity about family caregivers' role in the care coordination process, or about what specific supportive services (such as family meetings or respite care) are available to members' family caregivers.
- **Conversation Starters.** Family caregivers sometimes make important care decisions without understanding what their relatives value in daily living.
- **New Landmark Federal Rule.** A recent federal rule on community living addresses the need for Medicaid home- and community-based service programs to conduct an assessment of caregivers' needs when their care is part of a service plan for the person with a disability. While this rule applies to only one of the Medicaid home- and community-based service programs, the 1915(i) state plan option, it is a landmark rule for the way it acknowledges caregivers and recognizes the need for providers to better understand the caregiving situation.

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# Promising Practices: TennCare



- Requires the caregiver's role to be determined, health and well-being assessed, and training and other needs identified.
- Requires that care coordinators give their contact information to the family caregivers.
- Family caregiver needs assessments are typically performed as part of the member's face-to-face assessment.

# Promising Practices: TennCare

## TennCare Family Caregivers' Needs Assessment Protocol

“[A]t each face to face visit..., the Care Coordinator shall, as part of the ongoing needs assessment, inquire about the primary caregiver’s overall well-being and ability to continue providing the level of supports outlined in the plan of care. If a caregiver expresses concern about his or her overall well-being and/or ability to continue providing their current level of care for the member, the Care Coordinator shall complete a full caregiver assessment and update the member’s plan of care and/or risk agreement, as necessary.”

*Source: TennCare Needs Assessment Protocol, cited by Patti Killingsworth, “State of Tennessee: Family Caregivers in MLTSS” (Presentation at the Home and Community-Based Services Conference, Washington, DC, September 1, 2015).*

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# Promising Practices: South Carolina's Healthy Connections Prime

- Medicare-Medicaid duals demonstration that is recognized for its promising practices in caregiver assessment, services, care coordinator training, and quality measurement of family caregiver supports.
- Each health plan is required to have a caregiver quality improvement project.





# Promising Practices: United Healthcare

- Offers family caregiver supports in some of its Medicare Advantage Plans and Medicaid plans, as well as to some large employers with self-funded health plans.
- Solutions for Caregivers program, available in some Medicare Advantage Plans, offers covered services for the family caregiver, including coaching and support over the phone and geriatric case manager services to conduct an in-person assessment and provide family consultation.
- Solutions for Caregivers Portal for large employers features in-person, phone, and online resources to help working caregivers.
- In some Medicaid programs, UnitedHealthcare refers caregivers to its Caring for Caregivers program, which provides a community education workshop series that focuses on the needs and health of the caregiver.



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# Promising Practices: Cal MediConnect Dementia Project



- Provides assessment, services, and supports to the family caregivers of people with dementia who are participating in California's Medicare-Medicaid duals demonstration.
- Working with Alzheimer's Greater Los Angeles and other Alzheimer's groups, provides care manager training and support, caregiver education and respite care, support services through referrals, and technical assistance to create systems change.

# Conclusions

**Plans have a strong financial incentive to support family caregivers since they can make it possible for a member to stay at home. Helping to prevent caregiver burnout can prevent or delay more costly nursing home placements.**

- Managed LTSS programs should offer appropriate services that address the needs of family caregivers.
- A key component of managed LTSS should be the identification and provision of supports to meet family caregivers' needs and preferences.
- Services and supports should include family caregiver assessments for their own needs; supportive services such as training, support groups, family meetings, counseling, and respite care that are identified in the assessment; home modifications and assistive technologies; and other supportive services and transportation.

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# Conclusions

**Health plans should recognize and involve family caregivers, especially when the care plan depends on them.**

- Family caregivers should be part of the care planning process upon consent of the member and agreement from the family caregiver.
- Care coordinators and family caregivers also should have each other's contact information.

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# Conclusions

## **Family caregivers' feedback and involvement can help ensure better quality of care.**

- Input from family caregivers should be included in the evaluations of health plans, and health plan advisory councils should include family caregivers to inform them of the care experience.
- Evaluations of the quality and access of LTSS should also include surveys of family caregivers, especially when the member depends on their care.

**By implementing the report recommendations into new provisions, protocols, or amendments to existing managed LTSS contracts, managed care plans can lead the way to better care for members and their family caregivers**



Real Possibilities

**Public Policy  
Institute**

**AARP's Public Policy Institute informs and stimulates public debate on the issues we face as we age. Through research, analysis, and dialogue with the nation's leading experts, PPI promotes development of sound, creative policies to address our common need for economic security, health care, and quality of life.**

**The views expressed herein are for information, debate, and discussion, and do not necessarily represent official policies of AARP.**

***Informational Update:***

**NJ FamilyCare Update**

# December 2016 Enrollment Headlines

**Highest Enrollment on Record (1,771,672)**

**487,191 (37.9%) Net Increase Since Dec. 2013**

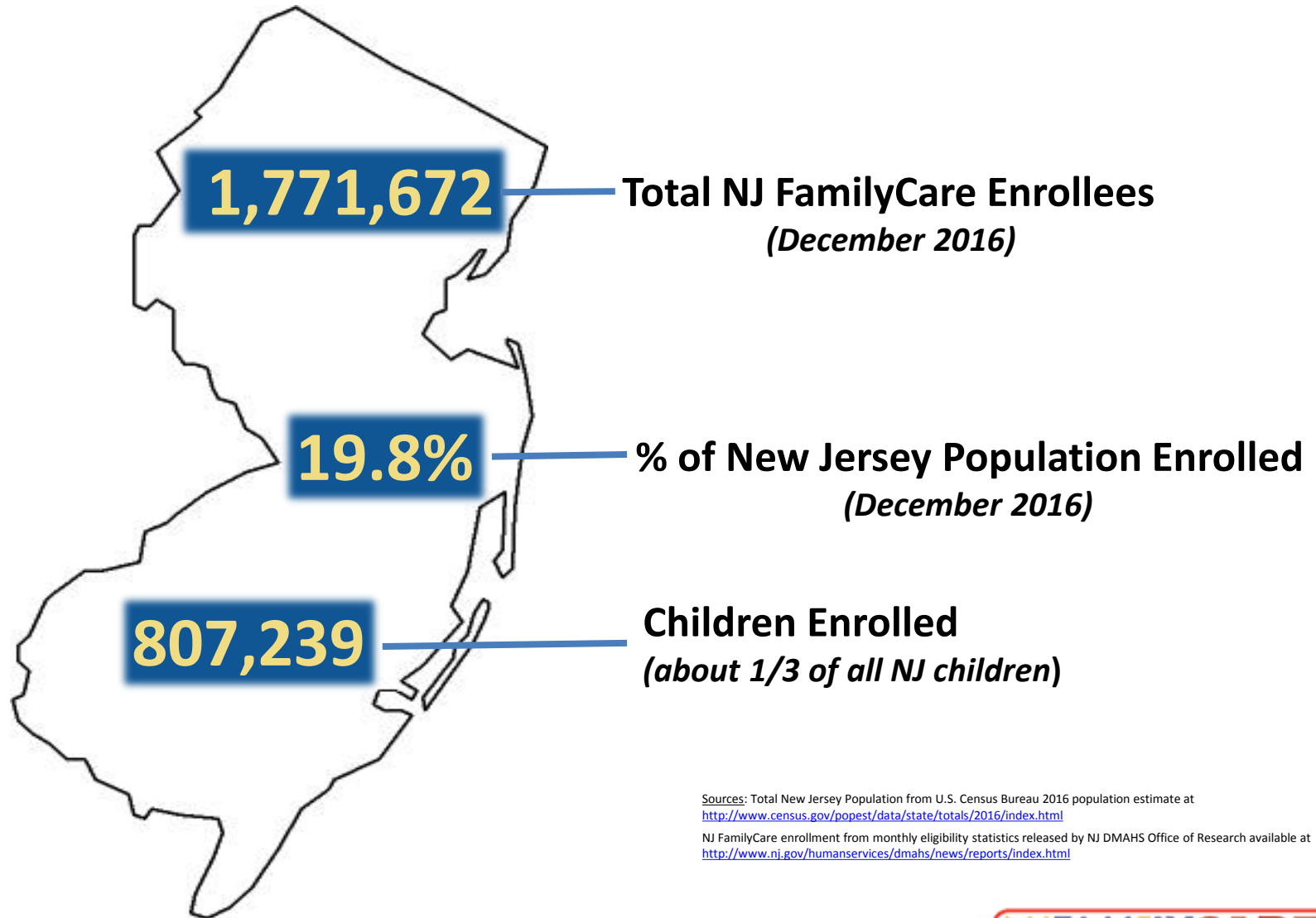
**94.8% of All Recipients are Enrolled in Managed Care  
2nd Highest Managed Care Penetration Rate**

Source: Monthly eligibility statistics released by NJ DMAHS Office of Research available at <http://www.nj.gov/humanservices/dmahs/news/reports/index.html>;  
Dec. eligibility recast to reflect new public statistical report categories established in January 2014

Notes: Net change since Dec. 2013; includes individuals enrolling and leaving NJFamilyCare.



# NJ Total Population: 8,935,421



Sources: Total New Jersey Population from U.S. Census Bureau 2016 population estimate at <http://www.census.gov/popest/data/state/totals/2016/index.html>

NJ FamilyCare enrollment from monthly eligibility statistics released by NJ DMAHS Office of Research available at <http://www.nj.gov/humanservices/dmahs/news/reports/index.html>

# December 2016 Eligibility Summary

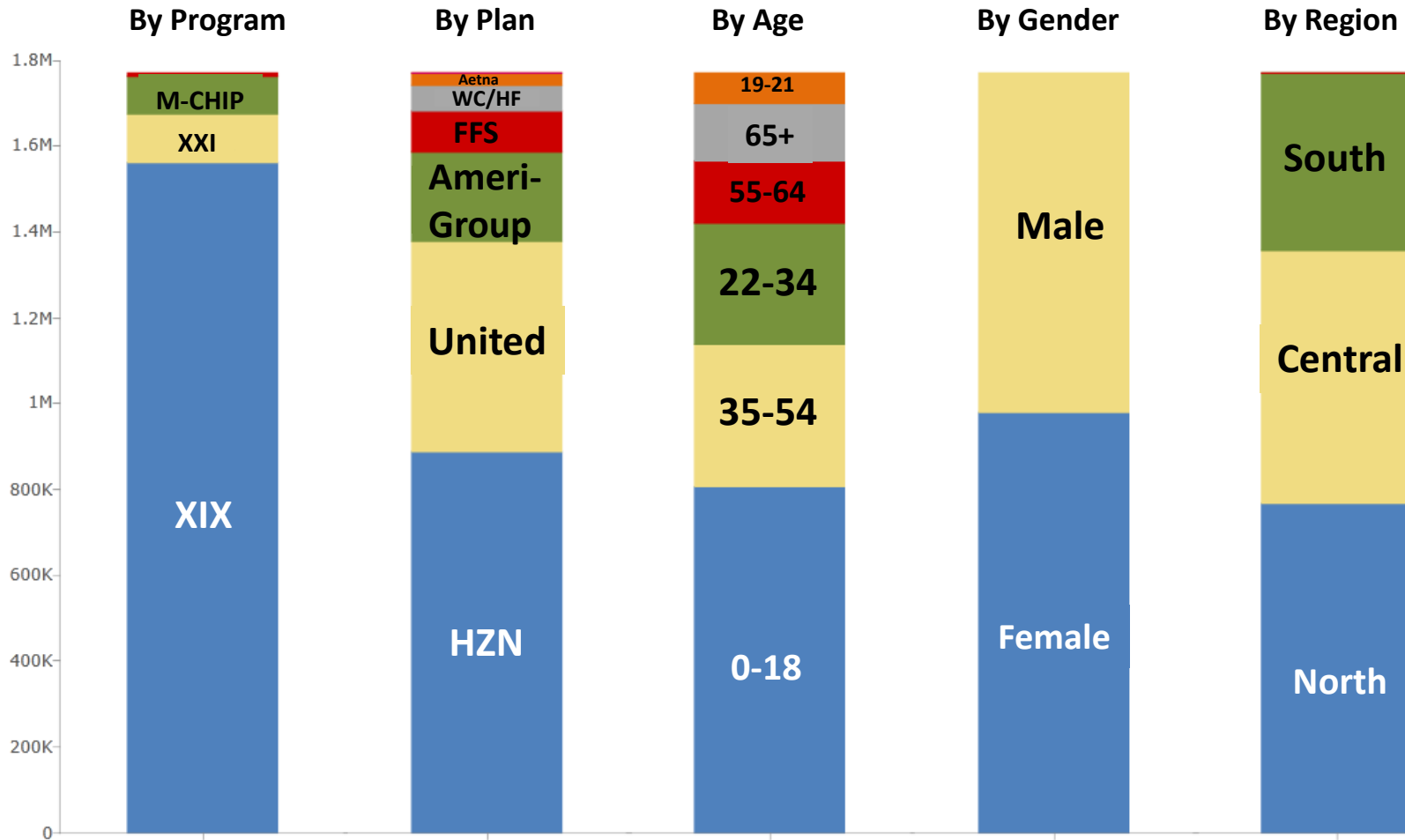
|                            |                |              |
|----------------------------|----------------|--------------|
| <b>Expansion Adults</b>    | <b>546,897</b> | <b>30.9%</b> |
| <b>Other Adults</b>        | <b>112,220</b> | <b>6.3%</b>  |
| <b>Medicaid Children</b>   | <b>701,685</b> | <b>39.6%</b> |
| <b>CHIP Children</b>       | <b>111,695</b> | <b>6.3%</b>  |
| <b>Aged/Blind/Disabled</b> | <b>299,175</b> | <b>16.9%</b> |

Source: Monthly eligibility statistics released by NJ DMAHS Office of Research available at <http://www.nj.gov/humanservices/dmahs/news/reports/index.html>;

Notes: Expansion Adults consists of 'ABP Parents' and 'ABP Other Adults'; Other Adults consists of 'Medicaid Adults'; Medicaid Children consists of 'Medicaid Children', 'M-CHIP' and 'Childrens Services'; CHIP Children consists of all CHIP eligibility categories; ABD consists of 'Aged', 'Blind' and 'Disabled'.

# NJ FamilyCare Enrollment “Breakdowns”

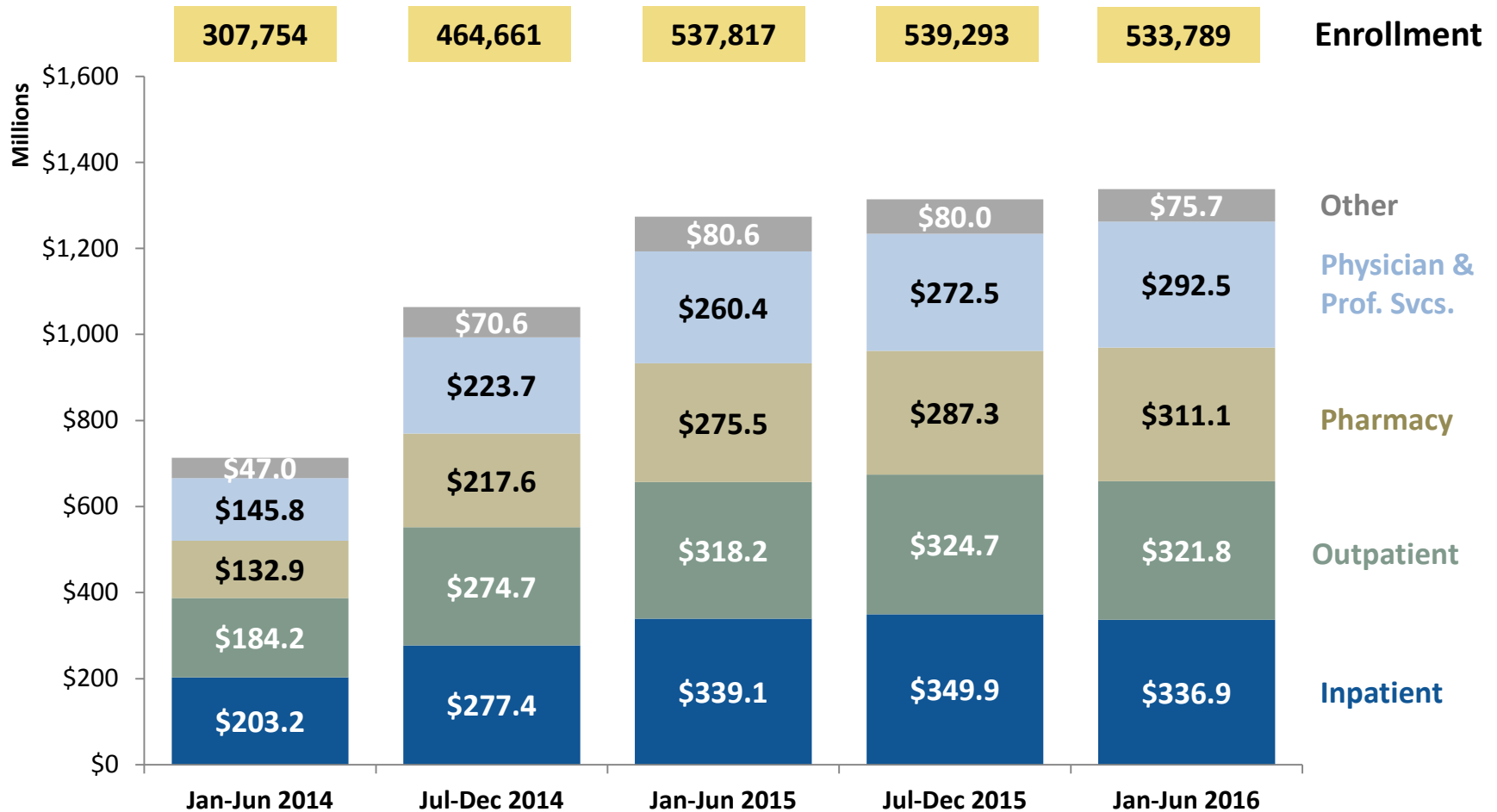
**Total Enrollment: 1,771,672**



Source: NJ DMAHS Shared Data Warehouse Snapshot Eligibility Summary Universe, run for December 2016.

Notes: By Region: North= Bergen, Essex, Hudson, Morris, Passaic, Sussex & Warren. Central= Hunterdon, Mercer, Middlesex, Monmouth, Ocean, Somerset & Union. South= Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester & Salem. Region does not add up to total enrollment due to small “unknown” category that is not displayed. \*M-CHIP: Individuals eligible under Title XIX, but paid with CHIP (Title XXI) federal funds.

# Expansion Population Service Cost Detail



Source: NJ DMAHS Share Data Warehouse fee-for-service claim and managed care encounter information accessed 1/10/2017

Notes: Amounts shown are dollars paid by NJ FamilyCare MCOs to providers for services supplied to NJ FamilyCare members – capitation payments made by NJ FamilyCare to its managed care organizations are not included. Amounts shown include all claims paid through 12/28/15 for services provided in the time period shown. Additional service claims may have been received after this date. Subcapitations are not included in this data. In addition to traditional “physician services” claims, “Professional Services” includes orthotics, prosthetics, independent clinics, supplies, durable medical equipment, hearing aids and EPSDT, laboratory, chiropractor, podiatry, optometry, psychology, nurse practitioner, and nurse midwifery services. “Other” includes dental, transportation, home health, long term care, vision and crossover claims for duals.

# Credentialing Update

# Unified Credentialing Program

**Alignment with Larger R-MMIS Implementation**

**CMS Certification Requirements**

**Projected go-live July 2018**

# Advantages to R-MMIS Alignment

- ✓ **Eliminates Need to Design Two Separate Programs**
  - Reduces overall cost
  - Allows for NJ-specific programming
  - Improved provider user-friendliness
  - Providers only need to learn one process
- ✓ **Incorporation of DDD, DCF, Aging, DDS Workflows**
- ✓ **Streamlining to reduce provider dissatisfaction**
- ✓ **Enhanced ability to monitor provider networks**
- ✓ **Improved accuracy of provider data**

# The Future of Medicaid



# Health and Human Services Nominees



## Secretary of HHS: Tom Price, M.D.

Duties of the Secretary of Health and Human Services include advising the President on issues of health and human welfare

Congressman from Georgia; currently serves as the Chairman of the House Budget Committee

Physician for 25 years

Strongly favors repealing the Affordable Care Act and reforming Medicaid and Medicare

# Health and Human Services Nominees



## CMS Administrator: Seema Verma

Duties of CMS Administrator include overseeing Medicare, Medicaid, CHIP and ACA Health Insurance Marketplaces.

President and Founder of SVC Consulting

Worked for many years as a consultant to the State of Indiana both under Governor Mitch Daniels and Governor Mike Pence, including creating the Healthy Indiana Plan and Healthy Indiana Plan 2.0.

Has also consulted for other State Medicaid programs including Iowa, Ohio, Kentucky, Tennessee, Michigan and Maine.

# What We Know

- No clear, concrete plans have been announced
- Campaign promise to repeal the Affordable Care Act
  - Priority is shared by other Congressional conservatives , as well as reforming the Medicare and Medicaid programs.
  - Recurring themes: health savings accounts, personal responsibility and more flexibility to administer the Medicaid program
- DMAHS is engaged with CMS regarding the Waiver and other initiatives; CMS has expressed a “business as usual” attitude.
- Various speculation around changes to the way Medicaid is financed at the federal level.

# Current Medicaid Financing Structure

**Federal money is guaranteed as a match to State Spending**

- **50% match for New Jersey**
- **State's must follow federal rules, or waiver special terms and conditions to receive this funding**

**Medicaid is the largest source of federal revenue to states**

**Federal Medicaid funding accounts for more than \$9.4 billion, or 17% of New Jersey's general revenue.**

# Alternative Medicaid Financing Structure: Block Grant

States would receive a predetermined, set amount of funding for the Medicaid program and would be required to administer the program within that dollar amount.

The set amount would be predicated on a certain base year and increases would only be permitted using a predetermined trend factor (ex. CPI)

Depending on the design of the block grant, states may be required to have a set spending requirement.

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Medicaid  
Block Grant



# Alternative Medicaid Financing Structure: Block Grant, cont.

## Social Services

- Guaranteed set amount; no state spending required

## TANF

- Guaranteed set amount, with a set state spending amount

## CHIP

- Guaranteed funding up to a set amount, with federal payments up to that cap

**Opportunities:** Provides funding/spending certainty to the federal government and increased flexibility to States who want to try new ways of administering their Medicaid program

**Challenges:** Shifts the risks for enrollment growth and program costs over the set amount of funding to the States. Could mean less federal regulation or oversight from the government

# Increased Choice and Flexibility for States

There is also conversation around increased choice and flexibility around the Medicaid program through a “per capita allocation” plan.

---

A “per-member-per-month” (PMPM) payment model

Federal allotment calculated for aged, blind and disabled, children and adults

Based on NJ’s average Medicaid and non-benefit expenditures per enrollee, adjusted for inflation



# Increased Choice and Flexibility for States, cont.

## National policy discussions regarding:

- ➔ Work requirements for Medicaid recipients
- ➔ Cost-sharing and premiums for non-disabled adults
- ➔ Expanding premium support options to encourage individuals to purchase health insurance on the exchange
- ➔ The use of wait-lists for certain services
- ➔ Enrollment caps

# Who is DMAHS Engaged With and What is the National Conversation?

**DMAHS is engaged in conversations on the national front and is actively participating in webinars and calls with the following entities:**

- **The National Governors Association (NGA)**
- **National Association of Medicaid Directors (NAMD)**



# Resources

- **Tom Price's HR 2300 Empowering Patients First**  
<http://tomprice.house.gov/sites/tomprice.house.gov/files/Section%20by%20Section%20of%20HR%202300%20Empowering%20Patients%20First%20Act%202015.pdf>
- **Paul Ryan's "A Better Way"**  
<http://abetterway.speaker.gov/?page=health-care>
- **State Health Reform Assistance Network (SHRAN)**  
<http://statenetwork.org/resource/?tag=shran,shvs&topic=&type=>  
<http://statenetwork.org/medicaid-expansions-economic-impact/>
- **National Governor's Association Recommendations for President-elect Trump:**  
<https://resources.nga.org/cms/westates/healthcare.html>

***Informational Update:***

**Managed Long Term Services  
and Supports**

# December 2016 LTC Headlines

**43.2% of the NJ FamilyCare LTC Population is in Home and Community Based Services\***

*Prior Month = 42.4%; Start of Program = 28.9%*

**Nursing Facility Population\*\* Down by Almost 1,000 Since the July 2014 Implementation of MLTSS**

\* Methodology used to calculate completion factor for claims lag in the 'NF FFS Other' category (which primarily consists of medically needy and rehab recipients) has been recalculated as of December 2015 to account for changes in claims lag; this population was being under-estimated.

\*\* Nursing Facility Population includes all MLTSS recipients and all FFS recipients (grandfathered, medically needy, etc.) physically residing in a nursing facility during the reporting month.

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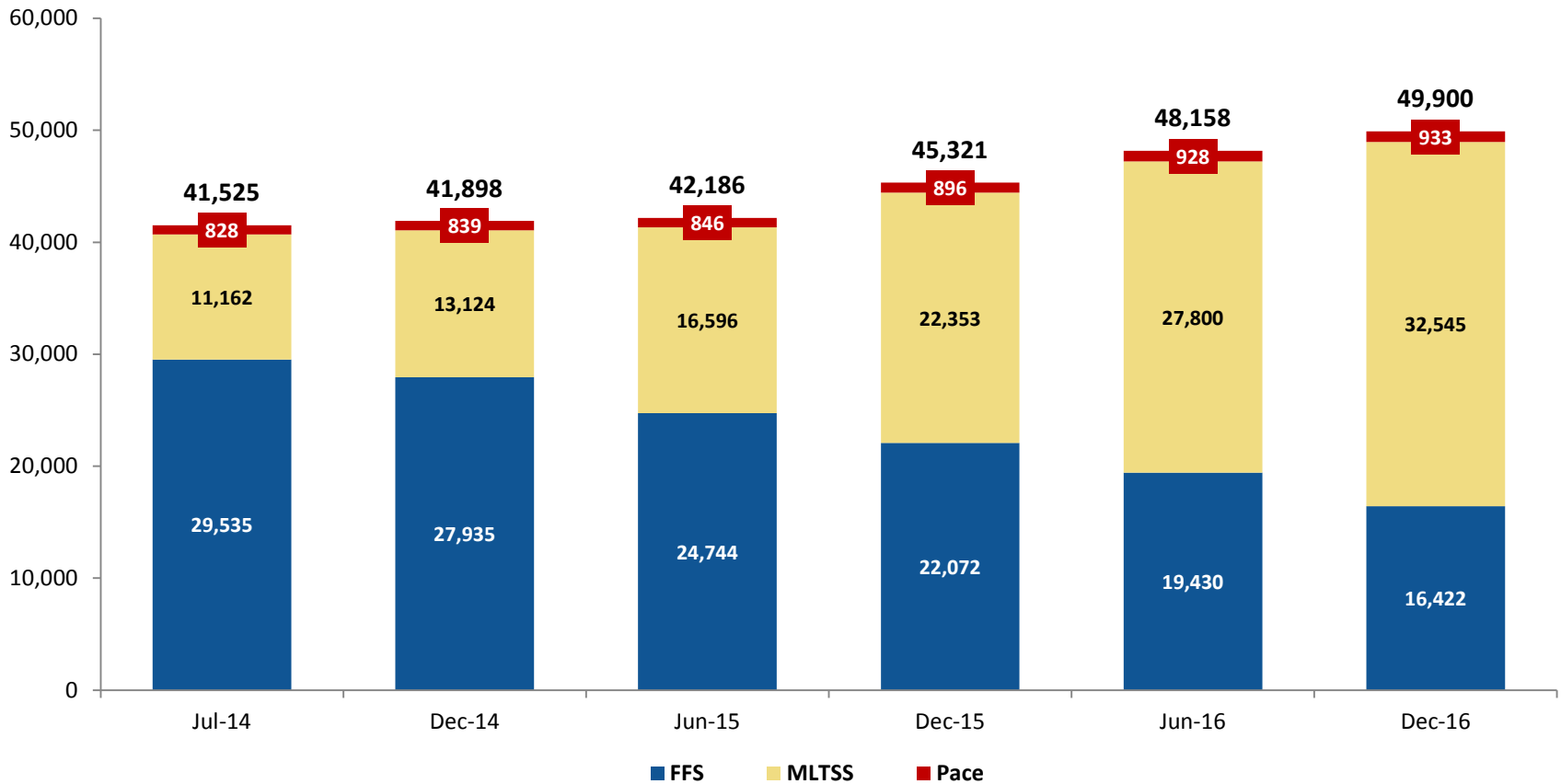
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# Long Term Care Population: FFS-MLTSS Breakdown

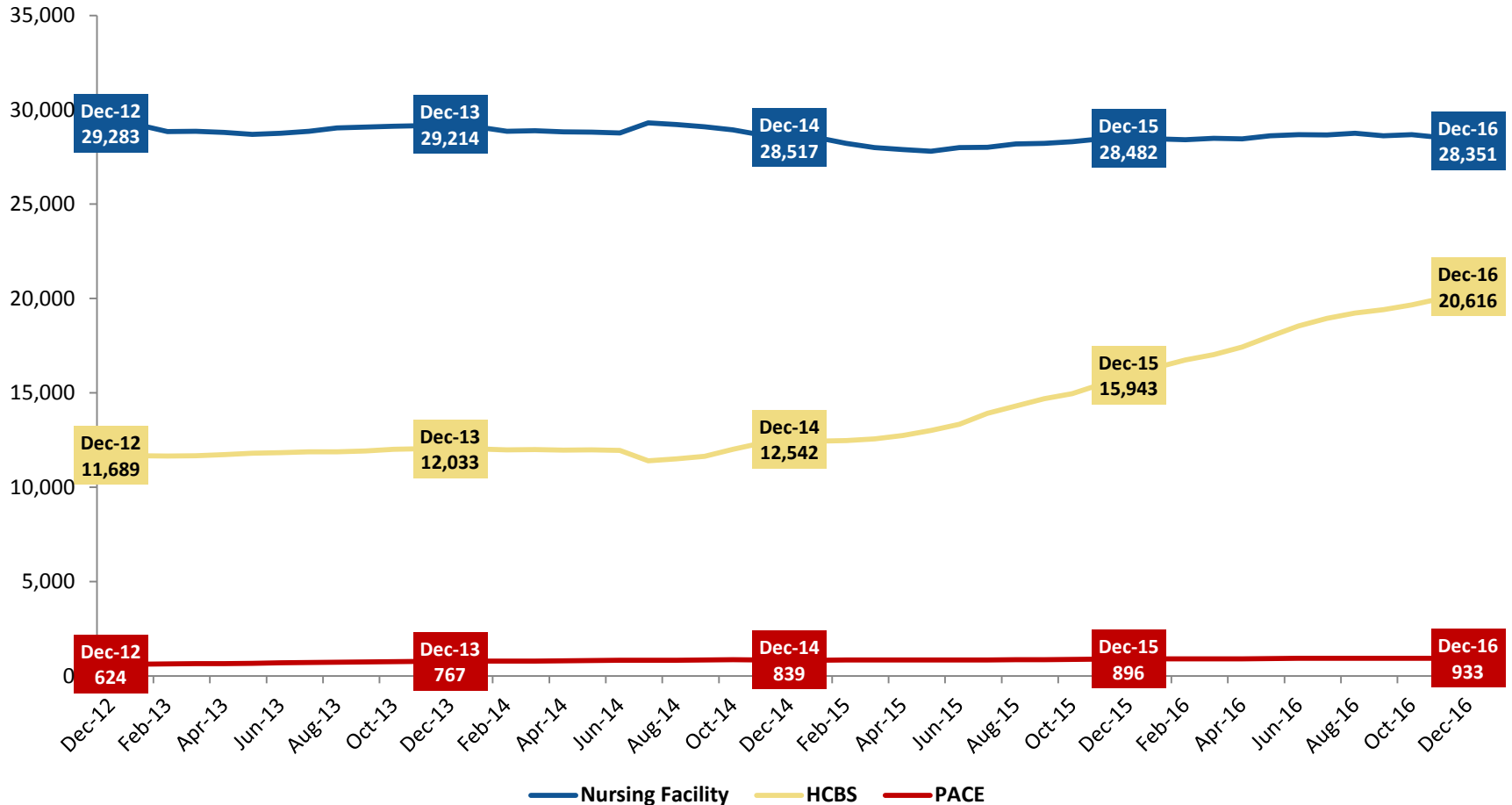
## 6-Month Intervals



Source: Monthly Eligibility Universe (MMX) in Shared Data Warehouse (SDW), accessed on 1/5/2017.

Notes: Information shown includes any person who was considered LTC at any point in a given month based on: Capitation Codes 79399, 89399, 78199, 88199, 78399, 88399, 78499 & 88499, Special Program Codes 03, 05, 06, 17, 32, 60-67, Category of Service Code 07, or MC Plan Codes 220-223 (PACE). All recipients with PACE plan codes (220-229) are categorized as PACE regardless of SPC, Capitation Code, or COS. MLTSS includes all recipients with the cap codes listed above. FFS includes SPC 65-67 and all other COS 07, which is derived using the prior month's COS 07 population with a completion factor (CF) included to estimate the impact of nursing facility claims not yet received. Historically, 90.76% of long term care nursing facility claims and encounters are received one month after the end of a given service month.

# Long Term Care Population by Setting



Source: Monthly Eligibility Universe (MMX) in Shared Data Warehouse (SDW), accessed on 1/5/2017.

Notes: All recipients with PACE plan codes (220-229) are categorized as PACE regardless of SPC, Capitation Code, or COS.

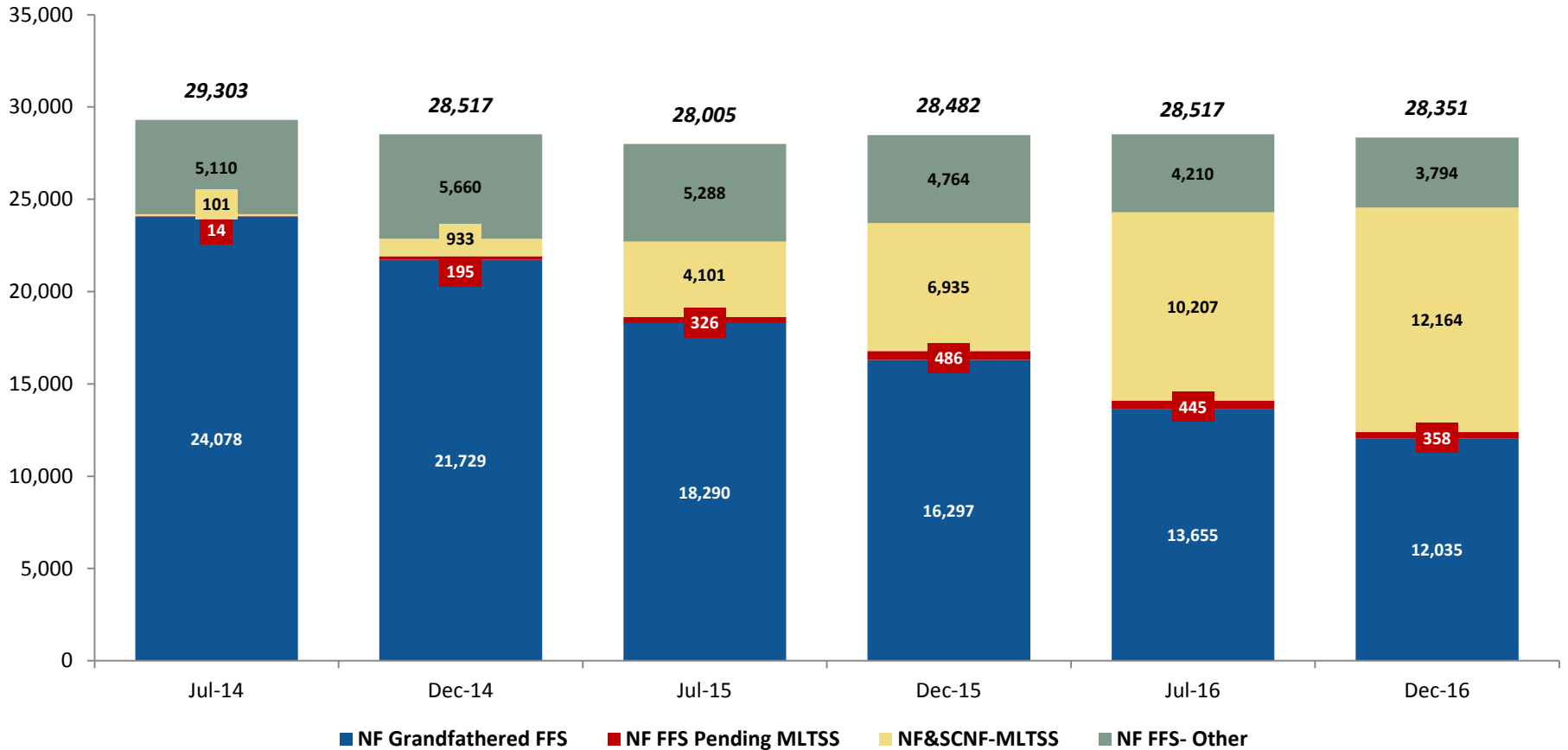
Home & Community Based Services (HCBS) Population is defined as recipients with a special program code (SPC) of 60 (HCBS) or 62 (HCBS – Assisted Living) OR Capitation Code 79399,89399 (MLTSS HCBS) with no fee-for-service nursing facility claims in the measured month.

Nursing Facility (NF) Population is defined as recipients with a SPC 61,63,64,65,66,67 OR CAP Code 78199,88199,78399,88399,78499,88499 OR a SPC 60,62 with a COS code 07 OR a Cap Code 79399,89399 with a COS code 07 OR a COS 07 without a SPC 60-67 (Medically Needy). COS 07 count w/out a SPC 6x or one of the specified cap codes uses count for the prior month and applies a completion factor (CF) due to claims lag (majority are medically needy recipients).



# Nursing Facility Population

## 6-Month Intervals

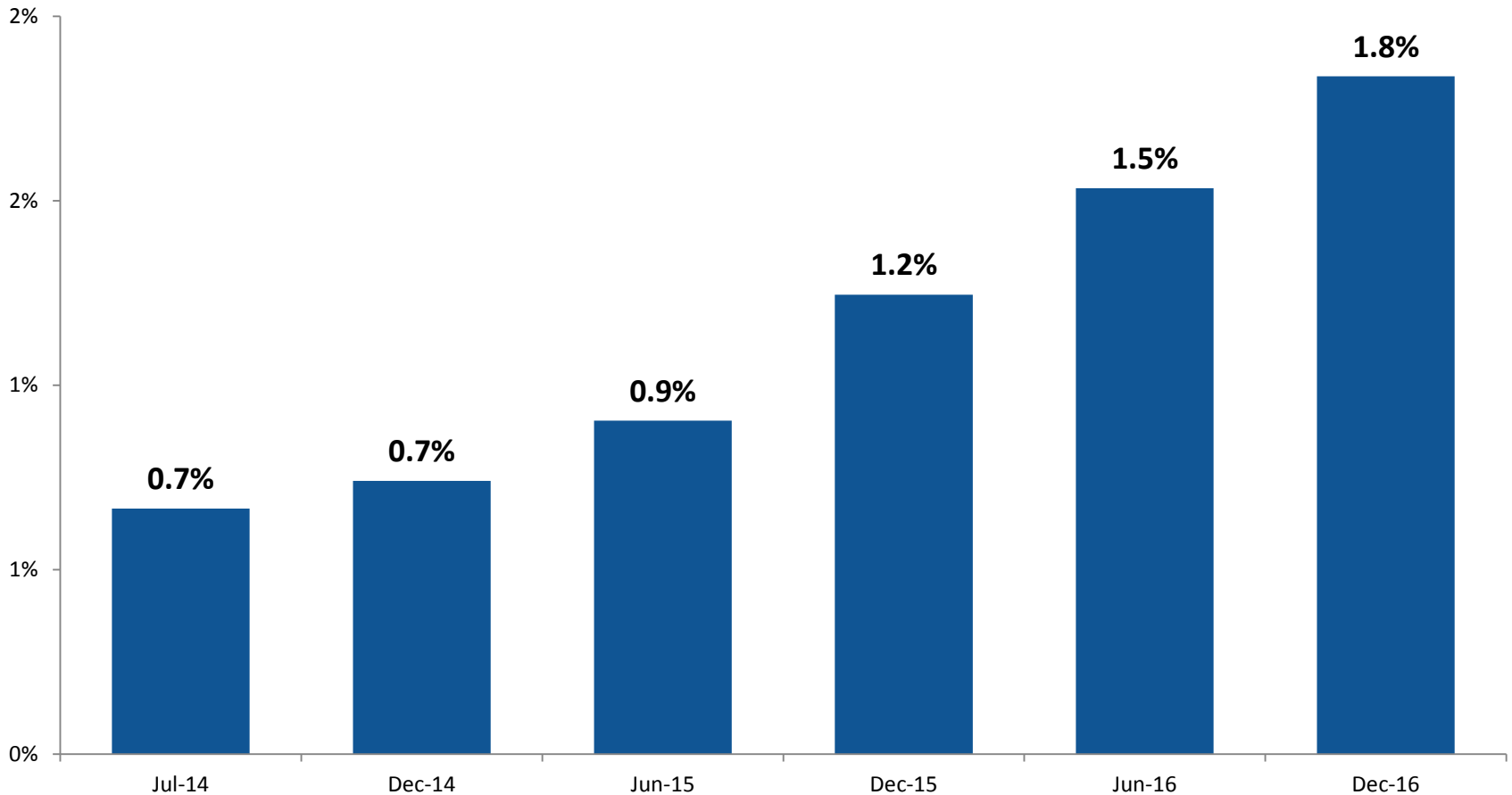


Source: Monthly Eligibility Universe (MMX) in Shared Data Warehouse (SDW), accessed on 1/5/2017.

Notes: "NF (Nursing Facility) Grandfathered FFS" population is defined as recipients with Special Program Code (SPC) 65-67. "NF - MLTSS" population is defined as recipients with Capitation Code 78199, 88199, 78399, 88399, 78499 or 88499. "NF FFS Pending MLTSS" population is defined as recipients with a SPC 61,63, or 64 but not in Capitation Codes 78199, 88199, 78399, 88399, 78499 or 88499 OR recipients with SPC 60 or 62 and COS 07 but not in Capitation Codes 79399 or 89399. "NF FFS- Other" population is defined as all other recipients with COS code 07 that do not meet any of the previous criteria (most are medically needy recipients); most recent month: since claims have not been received yet, this category uses counts from the prior month with the same completion factor applied as in the prior month. "NF-PACE" is defined as recipients with a Plan Code 220-229.

# MLTSS Percent of the Overall NJ FamilyCare Population

## 6 Month Intervals

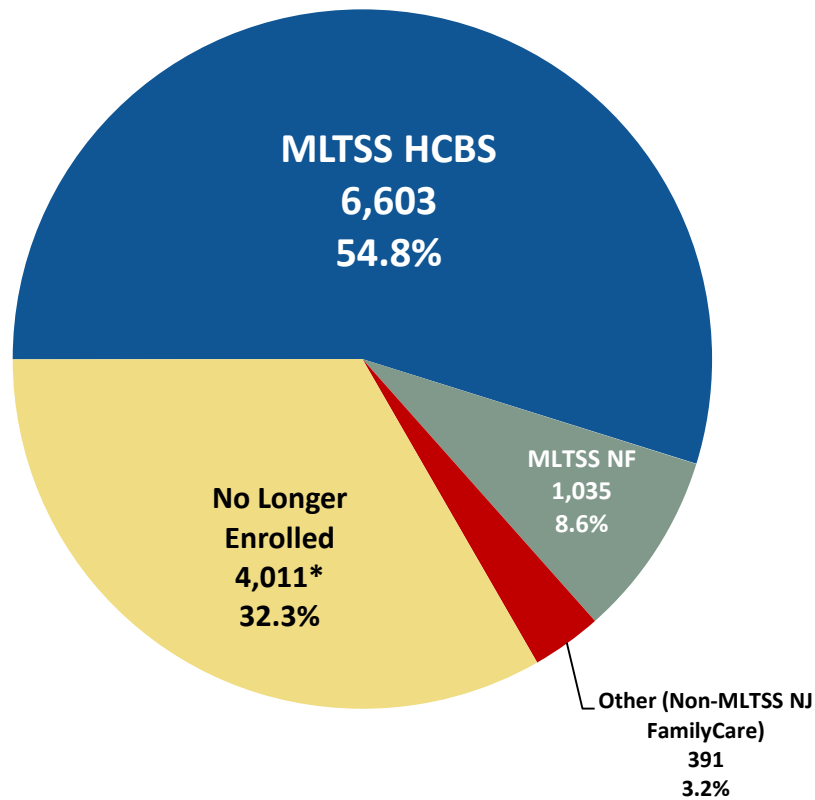


Source: DMAHS Shared Data Warehouse Monthly Eligibility Universe, accessed 1/11/2017.

Notes: Includes all recipients in Capitation Codes 79399, 89399, 78199, 88199, 78399, 88399, 78499, 88499 at any point in the given month and categorizes them considering both their cap code and their SPC.

# A Look at the June 30, 2014 Waiver Population Today

**All Waivers**  
(6/30/14 = 12,040)

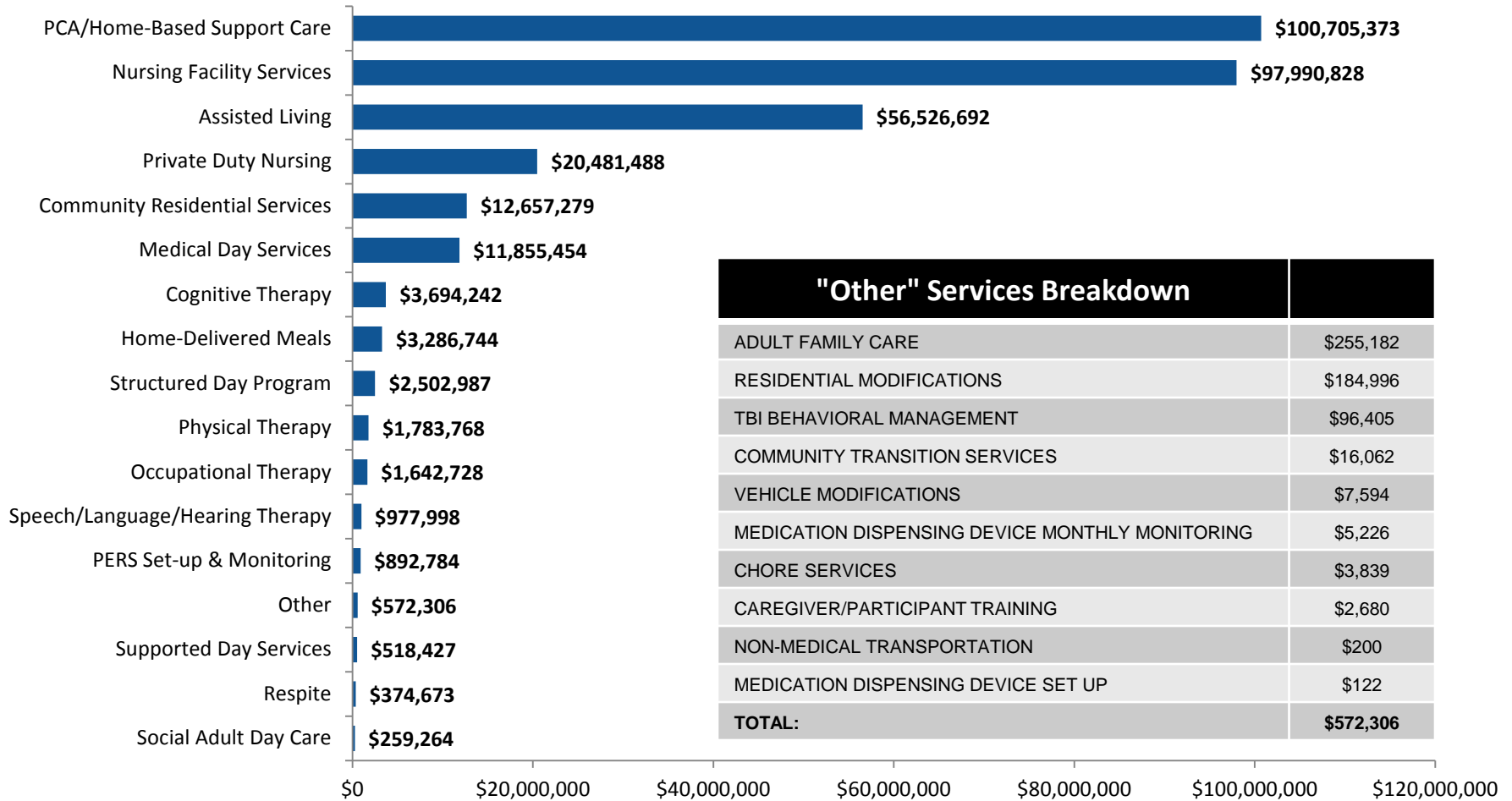


Source: DMAHS Shared Data Warehouse Monthly Eligibility Universe, accessed 1/11/17.

Notes: Includes all recipients who were in a waiver SPC (03, 05, 06, 17 or 32) on 6/30/14. Where they are now is based on capitation code or PSC. Those without a current capitation code or PSC are determined to be "No Longer Enrolled". Of the total number no longer enrolled, 93.8% (3,102) have a date of death in the system (current through 7-11-16).

# MLTSS Population's LTC Services Cost: SFY15

SFY15

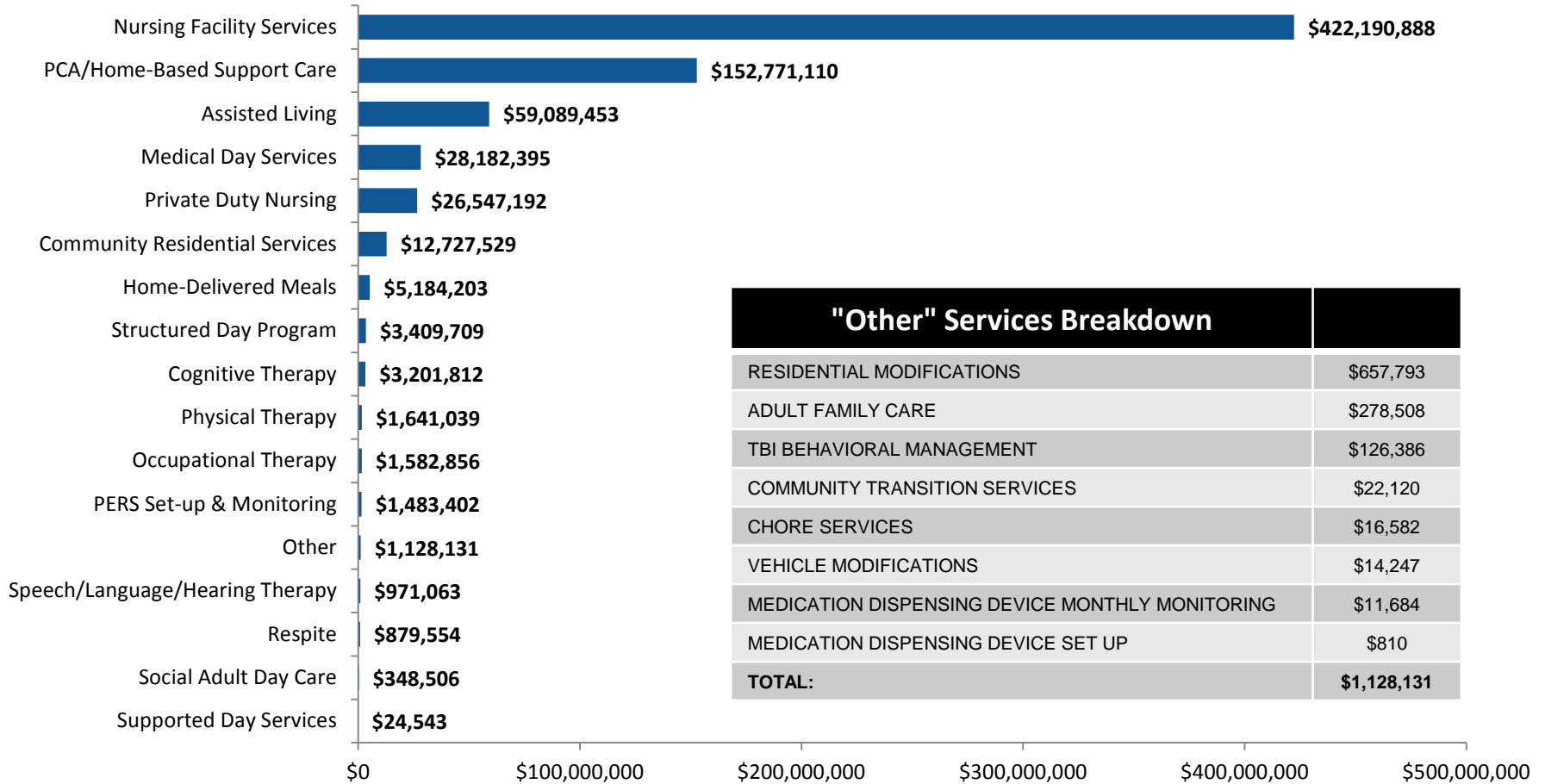


Source: NJ DMAHS Share Data Warehouse MLTSS Services Dictionary, accessed on 1/13/17.

Notes: Dollars represent encounters paid through the date that the SDW was accessed. Subcapitations are not included in this data. Other Includes: Adult Family Care, Caregiver Training, Chore Services, Community Transition Services, Medication Dispensing Device (Monitoring), Medication Dispensing Device (Setup), Residential Modifications, TBI Behavioral Management, Non-Medical Transportation, and Vehicle Modifications.

# MLTSS Population's LTC Services Cost: SFY16

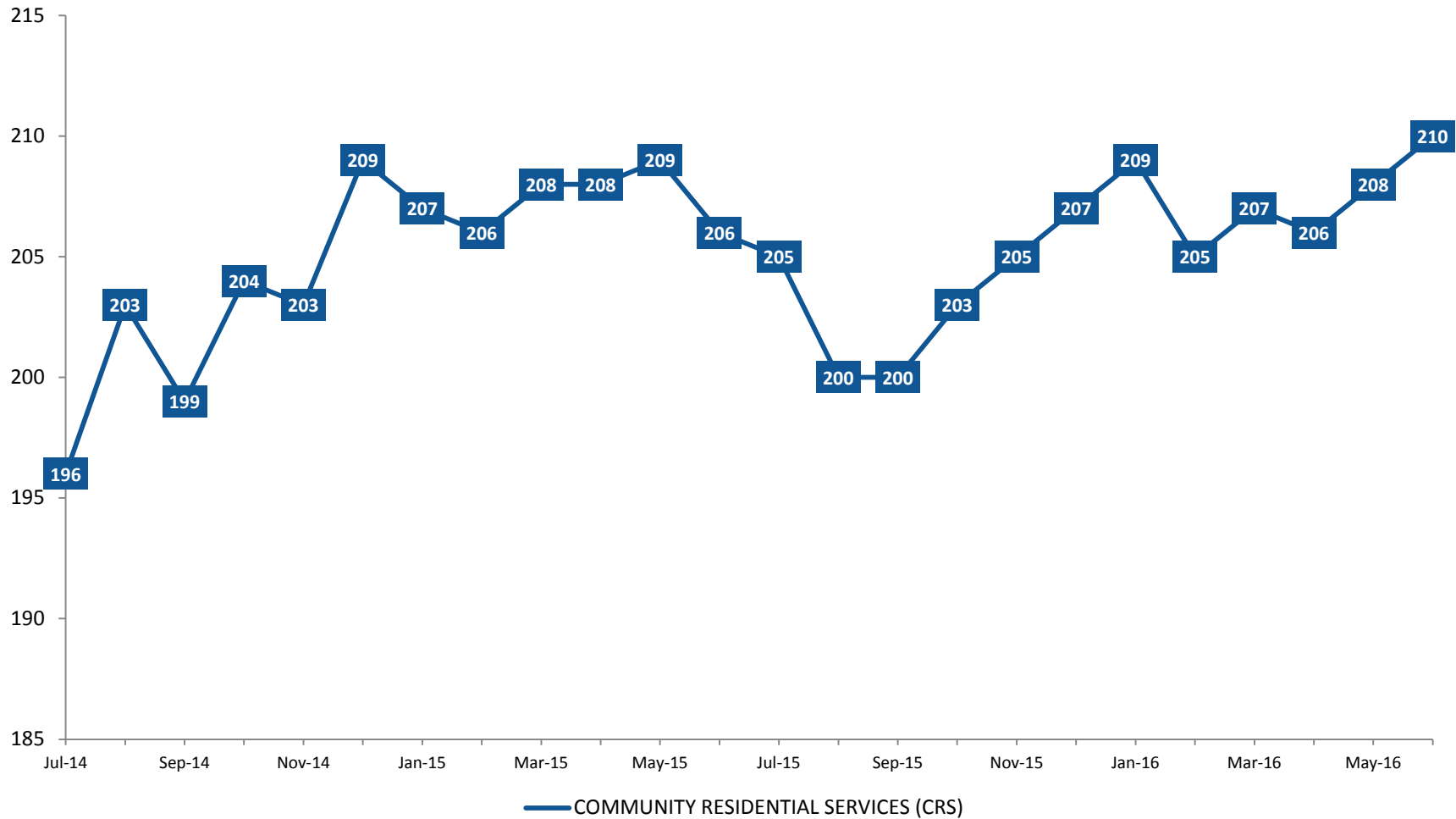
SFY16



Source: NJ DMAHS Share Data Warehouse MLTSS Services Dictionary, accessed on 1/13/17.

Notes: Dollars represent encounters paid through the date that the SDW was accessed. Subcapitations are not included in this data. Other Includes: Adult Family Care, Caregiver Training, Chore Services, Community Transition Services, Medication Dispensing Device (Monitoring), Medication Dispensing Device (Setup), Residential Modifications, TBI Behavioral Management, Non-Medical Transportation, and Vehicle Modifications.

# MLTSS Recipients Using Community Residential Services

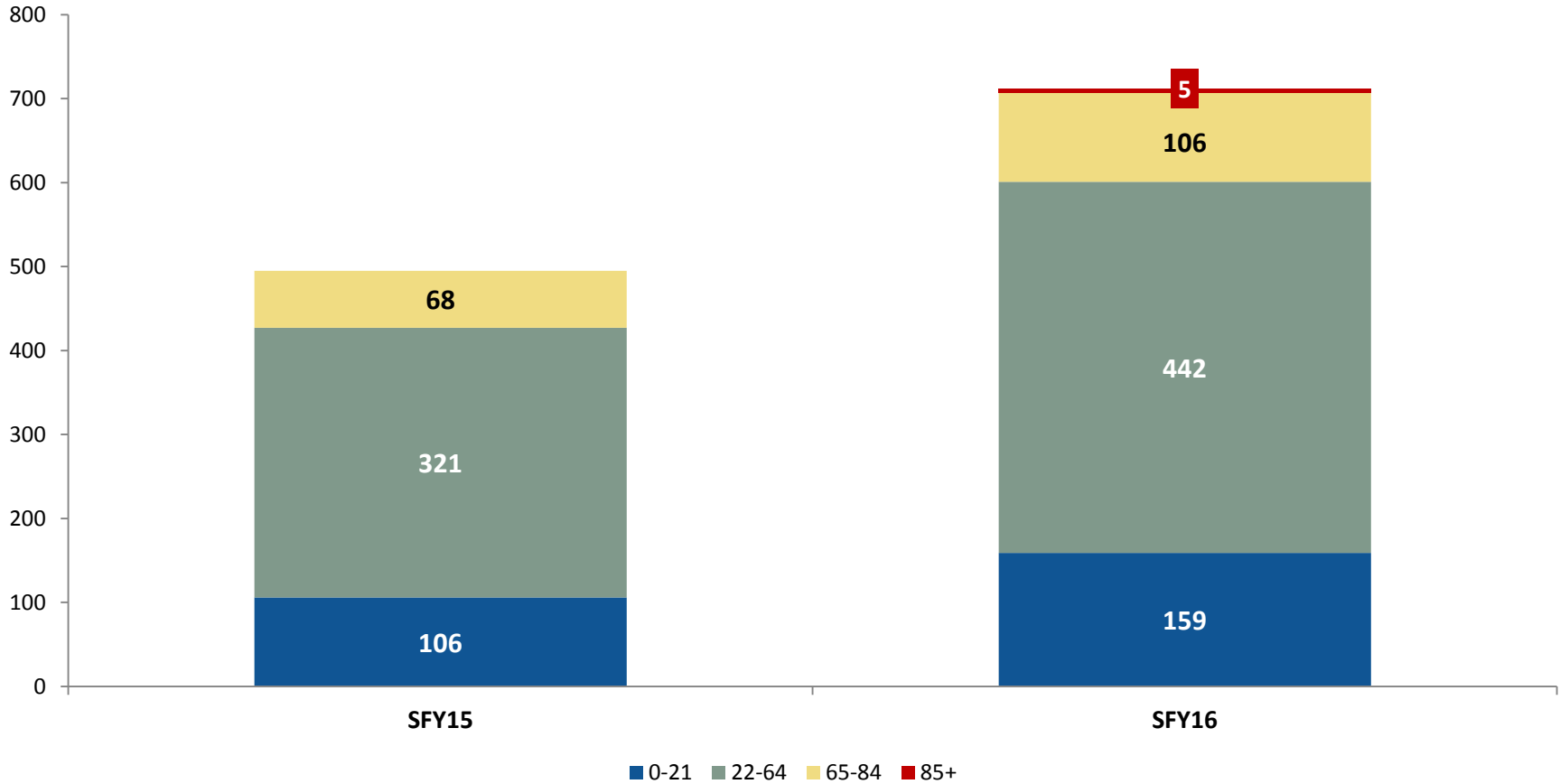


Source: NJ DMAHS Share Data Warehouse MLTSS Services Dictionary, accessed on 1/13/17.

Notes: Recipients had a MLTSS capitation code as well as a CRS claim (procedure codes T2033, T2033\_TF or T2033\_TG) in the given month. Note that recipients may be counted in more than one month.

# MLTSS DDD Claims

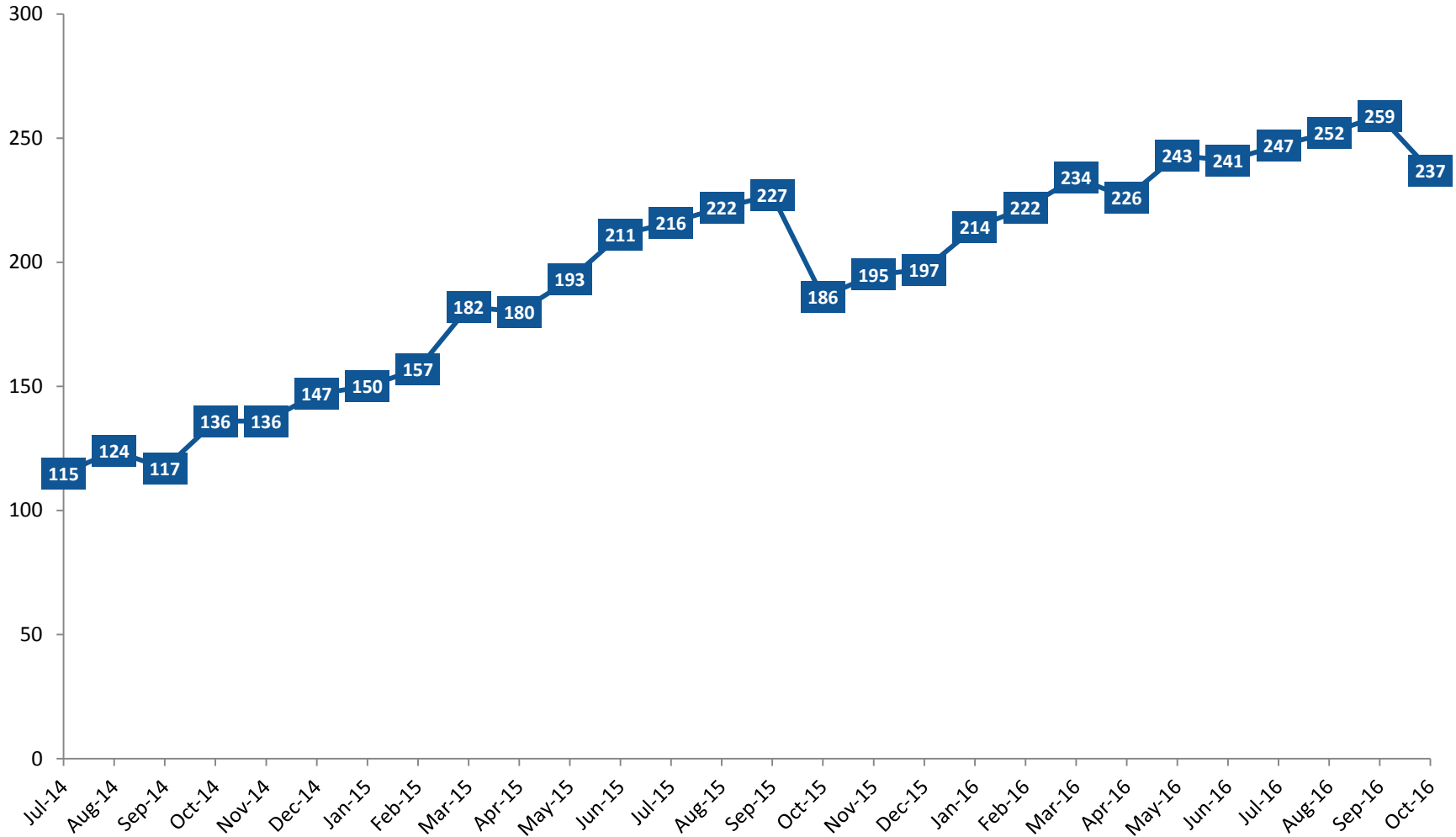
## MLTSS Recipients (by Age Group) with a DDD Claim



Source: NJ DMAHS Share Data Warehouse MLTSS Table and Claims Universe, accessed 11/15/16.

Notes: Includes DDD claims for all MLTSS recipients, as defined by capitation codes 79399;89399;78199;88199;78399;88399;78499;88499. DDD Claims are defined as having one of the following paycodes: 4, 6, B, C, D, S (respectively: High Cost Drugs & DDD; Cystic Fibrosis & DDD; AIDS & DDD; HIV+ & DDD; DDD; DYFS and ABD and DDD). Note that the same recipient may appear in multiple month's counts.

# MLTSS Recipients with a TBI Claim

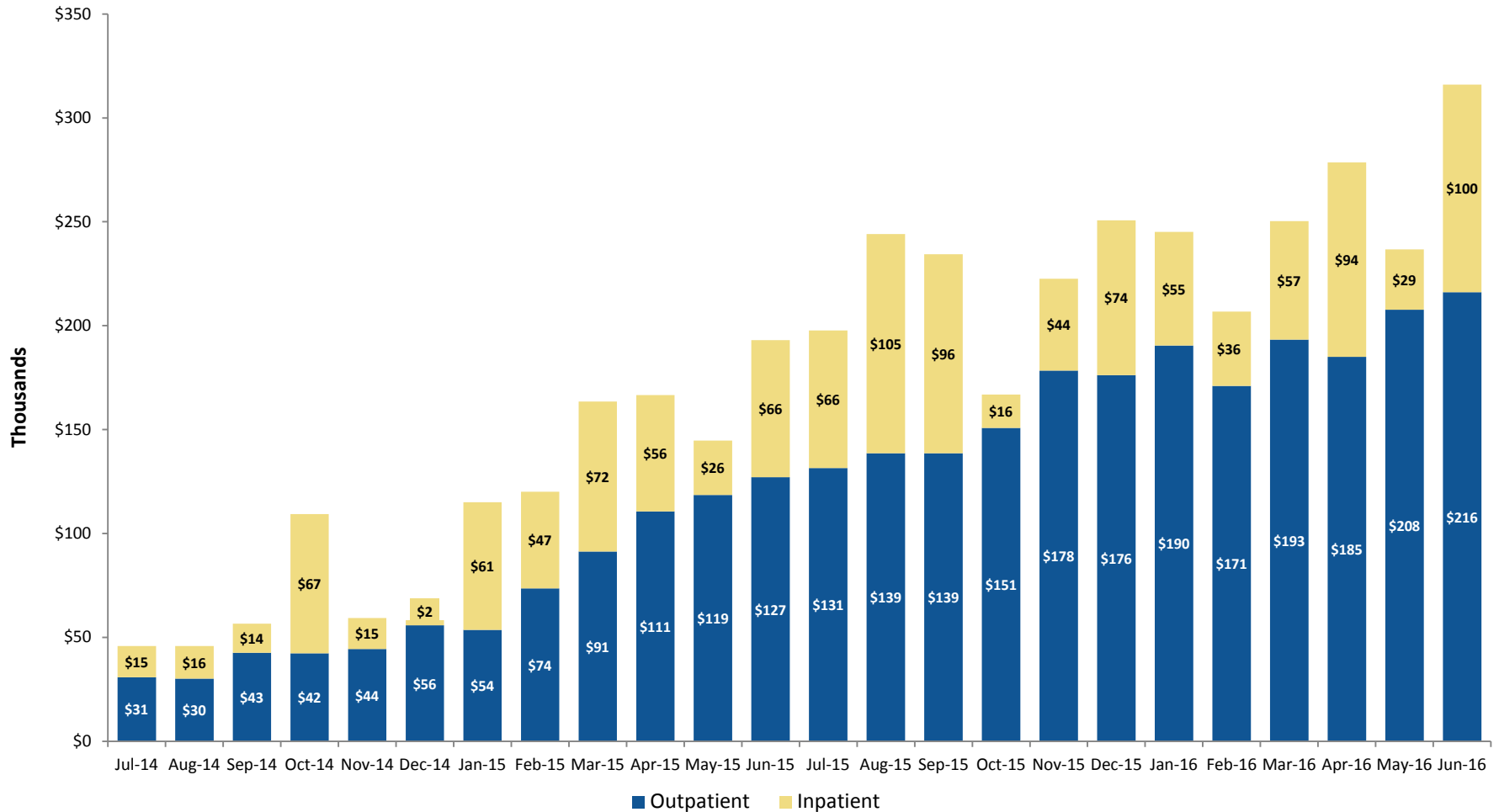


Source: NJ DMAHS Share Data Warehouse MLTSS Services Dictionary, accessed on 1/18/17.

Notes: Recipients had a MLTSS capitation code as well as a TBI diagnosis code (ICD9 through 9/30/15 and ICD10 starting 10/1/15) in the given month. Note that the same recipient may appear in multiple month's counts.



# MLTSS Behavioral Health Services Utilization



Source: NJ DMAHS Share Data Warehouse MLTSS Services Dictionary, accessed on 12/20/16.

Notes: Amounts shown by service dates. Services are classified as BH based on DRG code, diagnosis code (ICD9 through 9/30/15; ICD10 10/1/15 & forward), procedure code or revenue code. Does not include services meeting the definition of MLTSS Waiver, Medical Day Care or PCA as defined in the MLTSS Services Dictionary. Amounts shown are dollars paid by NJ FamilyCare MCOs to providers for services supplied to NJ FamilyCare members – capitation payments made by NJ FamilyCare to its managed care organizations are not included. Amounts shown include all claims paid through 12/20/16 for services provided in the time period shown. Additional service claims may have been received after this date. Subcapitations are not included in this data.

## Any Willing Provider (AWP) Policy

- New Jersey's goal has been to safeguard the NF industry's financial health and minimize disruption to NF residents as the state moves from FFS to managed care under MLTSS.
- AWP provision is in place whereby MCOs and NFs must contract with one another and the MCOs must pay NFs at least at the approved state Medicaid rates.
- AWP contracting policy for NFs has been extended beyond its original two year period until 6/30/17.
- Before eliminating AWP, NJ has a goal to develop updated NF provider network requirements and quality indicators to be used in the contracting process between providers and the MCOs.

# AWP Policy Revision

1. AWP provisions for NFs will continue through June 2017 providing an opportunity for the NFs to improve performance during this time.
2. DHS will modify MCO contracts effective July 2017, providing authority to narrow networks based on NF performance.

# NF Quality Indicators Initiative

1. Create incentives for NFs to improve quality of care delivered in key areas
2. Develop a mechanism for assessing NF quality that the MCOs can use in making contracting decisions after the AWP period ends
3. Establish standards to move from strictly state-based rates for NFs to negotiated rates between the MCOs and NFs

# MLTSS Quality Workgroup Results

- MLTSS Steering Committee Workgroup through meetings over a three-month period have:
  - Confirmed seven quality NF measures (outlined on the next two slides) for Year One as the threshold for the MCOs to narrow their nursing facility (NF) provider network
  - Committed to use CoreQ as the survey tool to measure NF resident and family satisfaction across all NFs in New Jersey
    - National CoreQ expert Dr. Nick Castle of the University of Pittsburgh will be able to administer survey for DHS
    - DHS is entering into a MOU since state regulations allow New Jersey to contract directly with another state government entity without any advertising

# Quality Measures and Data Source

| Measures   | Data Source   |
|--|---------------|
| 1. Usage of CoreQ, a standardized and validated tool to capture the resident/family experience in the NF.  | Dr. Castle    |
| 2. Is the facility using INTERACT, Advancing Excellence tools, TrendTracker or another validated tool to measure 30-day hospitalizations and hospital utilization so that it can share data with the MCOs? | Self-reported |
| 3. Is the facility at or below the statewide average for antipsychotic medication use in the long-stay population? ( <i>Statewide average is currently 12.89%</i> )  | MDS           |
| 4. Is the percent of long-stay residents who are immunized against influenza annually at or above the statewide average? ( <i>Statewide average is currently 95.96%</i> )                                  | MDS           |

*Note: MDS statewide averages as of August 2016*

**Continued...**

# Quality Measures and Data Source

| Measures   | Data Source |
|--|-------------|
| 5. Is the percent of long-stay, high-risk residents with a pressure ulcer at or below the statewide average on a quarterly basis for 4 of the last 6 quarters for which data is available? ( <i>Statewide average is currently 6.6%</i> )                  | MDS         |
| 6. Is the percent of long-stay residents who are physically restrained at or below the statewide average on a quarterly basis for 4 of the last 6 quarters for which data is available? ( <i>Statewide average is currently 1.1%</i> )                     | MDS         |
| 7. Is the percent of long-stay residents experiencing one or more falls with major injury at or below the statewide average on a quarterly basis for 4 of the last 6 quarters for which data is available? ( <i>Statewide average is currently 2.43%</i> ) | MDS         |

Note: MDS statewide averages as of August 2016

# Policy Decisions

1. Begin with seven measures, but retire measures and add others as the initiative evolves.
  - I. CoreQ becomes mandatory in Year Two.
2. Begin July 1, 2017 with a phase-in of NF performance metrics: Allow NFs to meet 4/7 measures in Year One as the performance threshold.
3. MCOs will focus their NF care management on working with the NFs to improve their quality measures.



## Policy Decisions continued...

4. MCOs may not contract with a NF for new admissions that does not meet 4/7 measures.
5. A NF will be able to enter into a corrective action plan with the State if it doesn't meet 4/7 measures.
6. NFs will be able to appeal to the State for reconsideration of network exclusion. Exceptions may be for NFs that have a population with disproportionate needs, etc.