

***Informational Update:***

**Transition of Mental Health Services  
to Fee-for-Service**

# MH Contracted Programs transitioning to FFS

January 2017	July 2017	January 2018	Programs under consideration
PACT	6 CSS providers	Remaining CSS providers	Training and TA
ICMS			Specialized Services (i.e. EISS, Justice Involved Services)
OP			IOC
MH Residential-Level A+, A, B & FamilyCare			IFSS
Supported Employment/Education			Legal Services
Partial Care			
Partial Hospitalization			

# FFS Consumer Program Eligibility



- Individual meets program eligibility criteria as outlined in regulation or policy
- Individual does not have private insurance or their private insurance does not cover the service/treatment, i.e. PACT
- $\geq 5$  years of age and not receiving mental health services from CSOC

# FFS & Third Party Insured



- State funds cannot be used to wraparound or subsidize Third Party Liability (TPL) or Charity Care (CC) reimbursements.
- Providers may not seek reimbursement via NJMHAPP for services covered by TPL or CC applicable services.



# Highlights of July 1, 2107 FFS



- 79 Providers have transitioned to MH FFS contracts
- All providers were trained in the New Jersey Mental Health Application for Payment Processing (NJMHAPP)
- FFS Transition Stakeholder Group continued to meet monthly to provide feedback and input

# Highlights of July 1, 2107 FFS



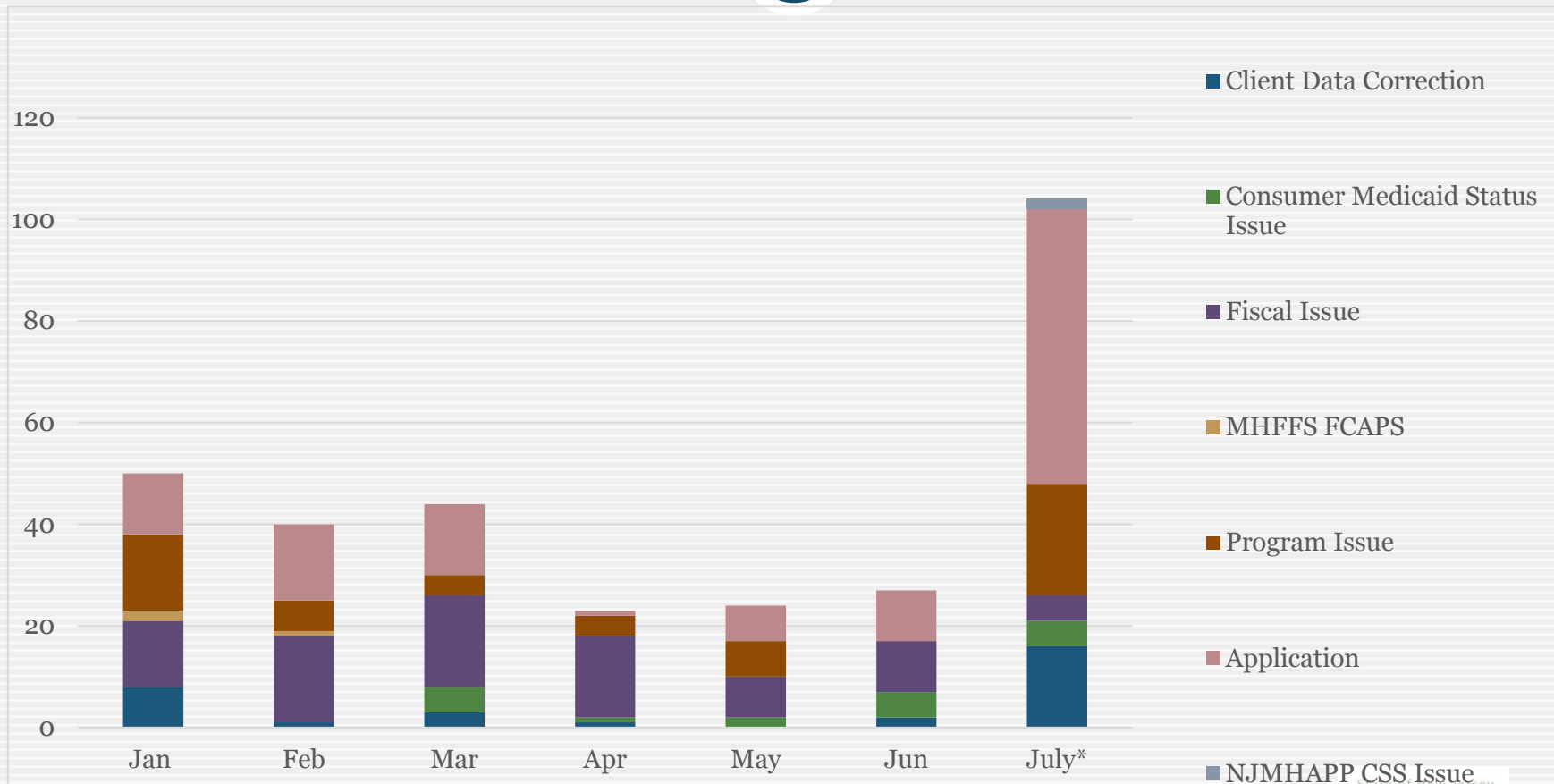
- Enhancements to NJMHAPP based on provider users' feedback
- Developed a FFS Team to be available to providers transitioning to FFS consisting of specialists in :
  - ✦ IT application
  - ✦ Program and Policy
  - ✦ Fiscal
  - ✦ Contracting
  - ✦ Network

# New Jersey Mental Health Application for Payment Processing (NJMHAPP)



- NJ Mental Health Application for Payment Processing (NJMHAPP) is a web based modular system, which provides ability for Providers transitioning to Fee For Service to submit eligible encounters/claims for all fee for service programs/services to DMHAS.

# Number of FFS Tickets





# Policies for Fiscal Operations of FFS

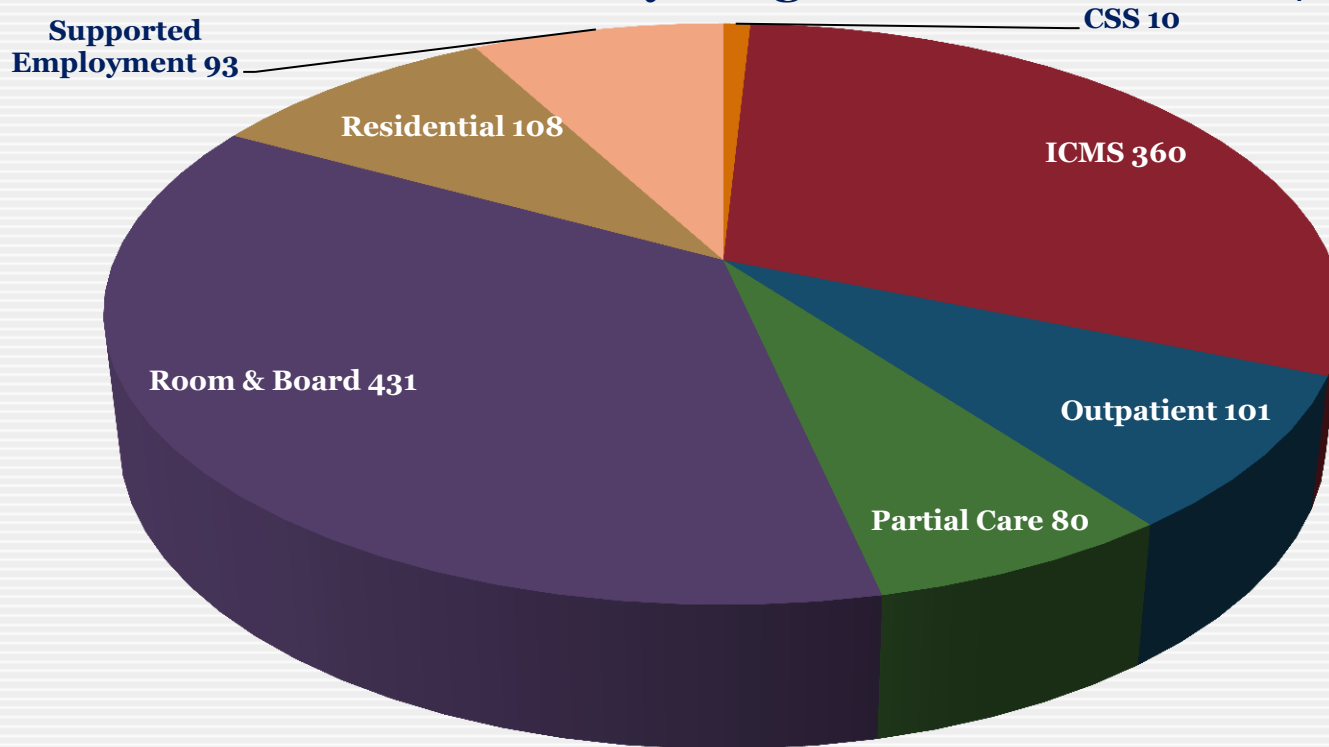


- Monthly limits
- FFS Contracts for Mental Health
- Cash Advance
- FCAPS

# Consumers in FFS by Service



## # of FFS Consumers by Program (Jan - June 2017)



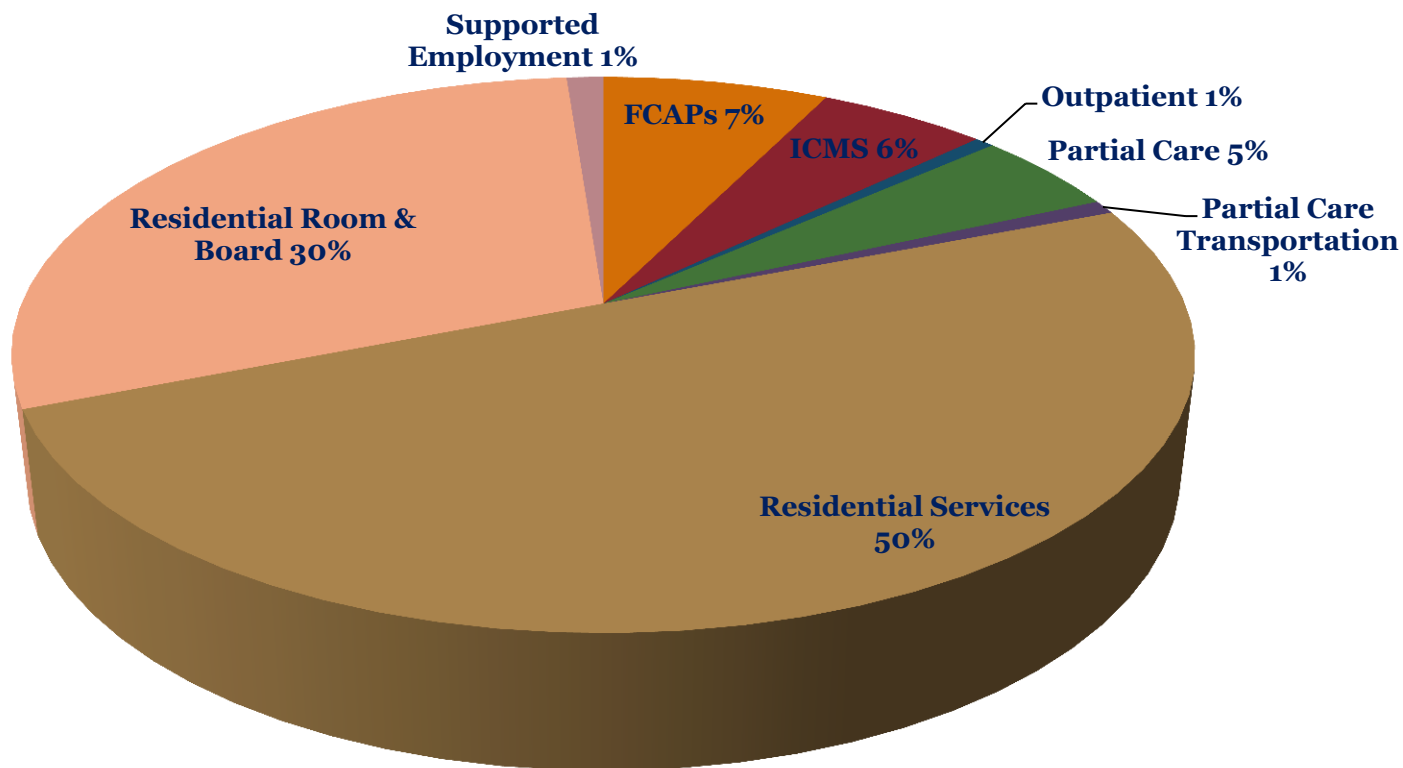
**Total Consumer Count = 1183**



# FFS Claims by Service



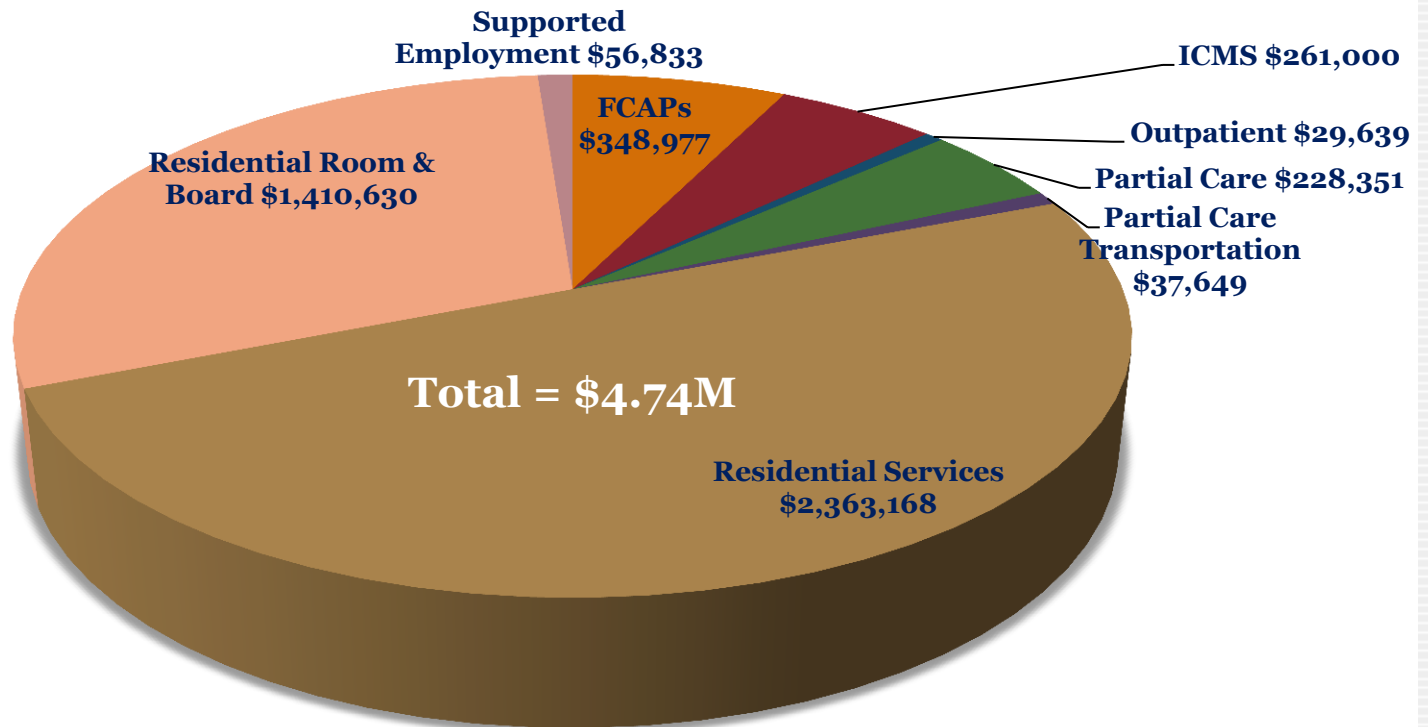
## FFS Program Claims (Jan - June 2017)\*



# FFS Claims Data



## \$ Value of FFS Program Claims (Jan - June 2017)\*



\* June includes only 1 of 2 billing cycles of data

# Next Steps



- Phase 3 planning for January 2018 implementation to include:
  - Moving remaining CSS providers into FFS Contracts
  - NJMHAPP enhancements
  - Evaluation of Year 1 MH FFS implementation

***Informational Update:***

**Division of Developmental  
Disabilities**

# DDD – The Long View

## 2010 – 2018: The Christie Administration

- Children with I/DD separate from DCF services
- Seven developmental centers in operation – no closure since 1998
- One Medicaid waiver
- \$100 M unmatched state funding
- 8000+ individuals on the CCW priority waiting list
- State-based case management only
- Contract-based service reimbursement – limited providers and flexibility

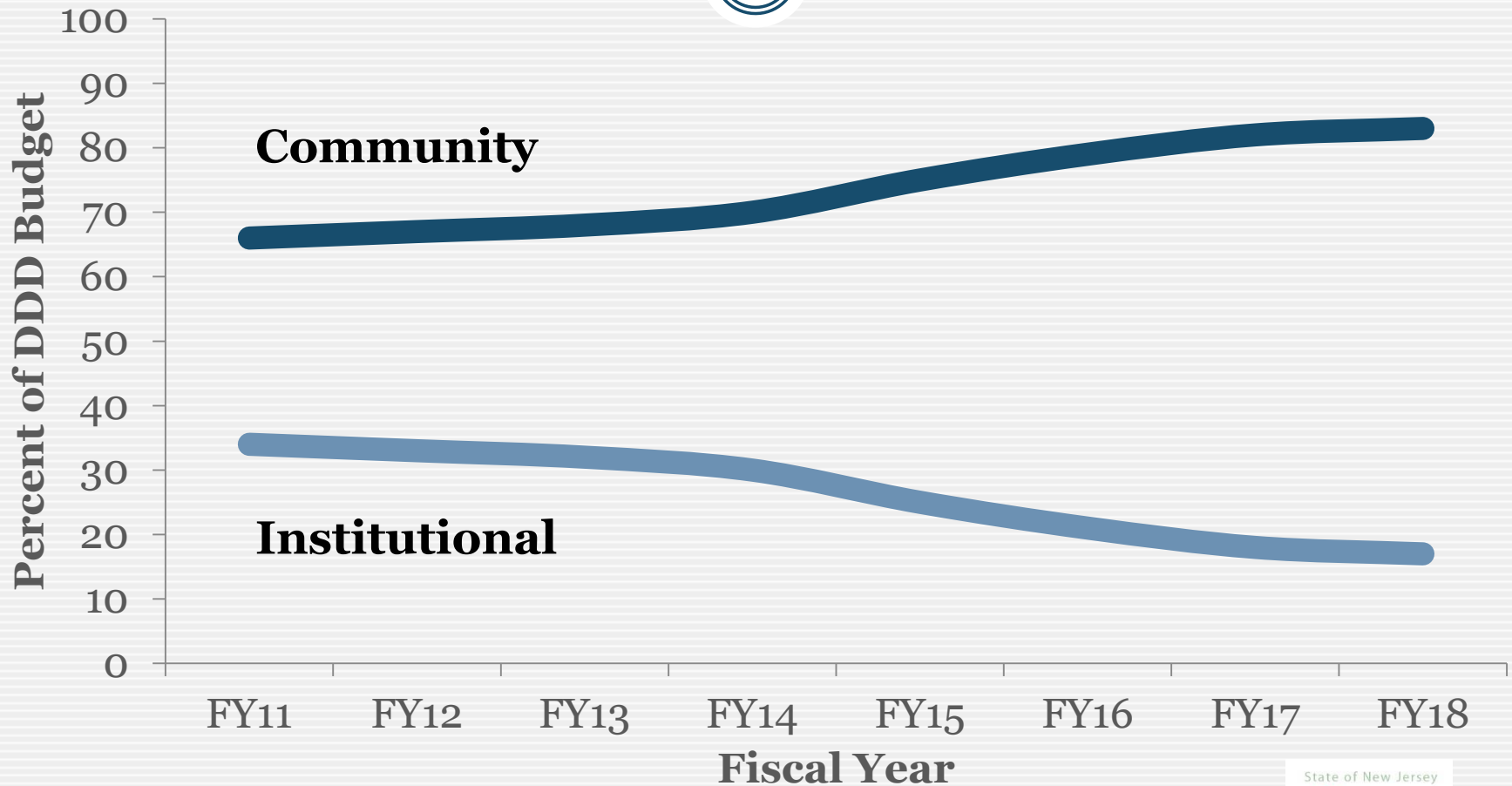
## System Reform

- Children's services transferred to DCF – DDD shifts to services for adults (21+)
- Two Medicaid waivers – Supports Program (in Comprehensive Medicaid Waiver) and Community Care Waiver program
- Mandated Medicaid eligibility allows draw down of federal funding
- Community-based Support Coordination – choice of care management
- Fee-for-Service reimbursement
- Increased provider choice
- Increased flexibility

## Shift to Community-Based

- 5000+ individuals moved off CCW priority waiting list
- Closure of two developmental centers
- Supportive Housing Connection subsidies support community-based housing
- CMS Home and Community Based Services Final Rule

# DDD Budget – The Long View





**Division of  
Developmental  
Disabilities (DDD)**

Disability-related services  
that assist individuals to  
live, work, and socialize  
in their communities

**Division of  
Vocational  
Rehabilitation  
Services (DVRS)**

Vocational services

**Supportive Housing  
Connection and  
local Housing  
Authorities**

Housing/rental  
subsidies

**Medicaid State  
Plan/Managed Care  
Organization (MCO)**

Medical and mental  
health services

**Managed Long  
Term Services and  
Supports (MLTSS)**

Alternative to DDD for  
eligible individuals  
who meet nursing  
home level of care



# DDD System Reform



## Phase One

Transfer of Children's Services to DCF  
Adult Service System  
Medicaid Eligibility  
Transition to NJ CAT  
Implementation of ISP  
Expansion and Training of Support Coordination Agencies  
Engagement of Rate Setter  
Education of Stakeholders  
State Only/CCW  
Development of iRecord  
Employment First Implementation



## Phase Two

SP Policy Manual  
Establishing and Sharing Standardized Rates  
Provider Approval Process (Medicaid & DDD)  
Growth in Provider Capacity  
Launching of the Supports Program (initial enrollment)  
Expanded Services  
Establishing Department-Wide Fiscal Intermediary (FI)  
Operationalizing iRecord  
Day Habilitation Certification  
Begin transfer from Contract Reimbursement to Fee-For-Service



## Phase Three

Supports Program Implementation  
FFS Implementation  
CCW Policy Manual  
Oversight and Liaison to SCA  
Quality Monitoring  
Enhanced focus on best practice in provider services  
Waiting List Reform  
Provider Performance and Monitoring  
Provider Technical Assistance  
Department-Wide FI Implementation  
Self-Direction is the "rule"

# Fee-for-Service Update

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## Supports Program

- Approximately 3,000 individuals enrolled
- 2017 graduates not on the Community Care Waiver (CCW) enrolled directly in the Supports Program
  - ✦ Self-Directed Employee Option
- Approximately 45 individuals enrolled or enrolling on Supports Program + Private Duty Nursing (SP+PDN)
- Projected timeline to complete SP enrollment:
  - ✦ **October 2017 – 4,000**
  - ✦ **December 2017 – 5,500**
  - ✦ **March 2018 – 7,000**
  - ✦ **June 2018 - Full enrollment**



# Fee-for-Service Update

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## Community Care Waiver (CCW)

- March 30, 2017: Renewal approved by federal Centers for Medicare and Medicaid Services (CMS)
- Discussions to incorporate into the 1115(i) ongoing
- Projected timeline to shift CCW individuals into fee-for-service
  - ✦ **July 1, 2017 – June 30, 2018:** convert all in-state CCW program participants except individuals served in Community Care Residences (CCRs)
  - ✦ **July 1, 2018 – June 30, 2019:** convert CCW program participants in CCRs and out of state
  - ✦ **By June 30, 2019:** Full fee-for-service implementation



# Fee-for-Service Update

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## Community Care Waiver (CCW)

- The addition of housing vouchers makes the conversion of the CCW to FFS more complicated
  - ✦ For individuals currently in residential “placement”, there are essentially two simultaneous conversions happening
- The CCW brings with it – according to DDD policy – access to a housing voucher via the Supportive Housing Connection (SHC)
- Individuals (or guardians) need to sign lease/residency agreements and rental subsidy agreements
- There are rules related to rental costs – both in terms of how much the rental unit can cost and an individual contribution to the rental cost based on income

# Fee-for-Service Update

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## Fee-for-Service Implementation

- 200+ individual provider fee-for-service readiness meetings held
- Approximately 90 Support Coordination Agencies approved
- 334 Service Providers approved
- 9,000+ individuals newly enrolled in Medicaid
- 21,000+ individuals with a completed NJ CAT
- 480+ fee-for-service webinars/presentations for self-advocates, families, providers and other stakeholders since 2013.



# The Bottom Line for Individuals & Families



- There has been a lot of talk about changes and “reform” within the Division of Developmental Disabilities
- **People who are currently happy with what they have – with some small exceptions – will be able to continue to receive exactly what they have today.**
  - There will be a change in case management
  - If living in a funded residential “placement”, there will be additional documents to sign



# The Bottom Line for Individuals & Families



- **People who are currently happy with what they have – with some small exceptions – will be able to continue to receive exactly what they have today.**
  - If utilizing self-directed employees (SDEs), there will be a new Fiscal Intermediary and a new model of service provision
  - If previously utilizing Division budget for services that cannot be reimbursed by federal Medicaid (*i.e. personal training, clothing, etc.*), individuals will have to choose alternate services



# The Bottom Line for Individuals & Families



- **People who are not currently happy with what they have will be able to change services and/or service providers.**
  - The new system allows for greater “mixing” of services in a given day/week/month
  - The new system will bring in new providers, allowing individuals greater choice
  - The new system has additional services, so individuals will be able to choose services that were previously not available

# The Bottom Line for Individuals & Families

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- **Individuals/families do not need to become “experts” in any of this – DDD and Support Coordinators will provide guidance throughout the transition process.**
  - Support Coordinators will assist with the development of the new Service Plan, including identifying needed services and service providers
  - Individuals need to ensure these four items: **(1)** Medicaid eligibility, **(2)** DDD eligibility, **(3)** NJ CAT completion, and **(4)** Support Coordination Agency selection.

# Hot Topics

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## **NJ CAT Final Notice**

- NJ CAT Final Notification letters sent first week of June to all DDD eligible individuals
- July 31, 2017 – mandatory deadline for NJ CAT completion
- Services will be discontinued September 1, 2017 for individuals who have not completed NJ CAT by 7/31
- Instructions for requesting to complete NJ CAT:  
[www.nj.gov/humanservices/ddd/resources/njcat.html](http://www.nj.gov/humanservices/ddd/resources/njcat.html)

# Hot Topics

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## New Department-wide Fiscal Intermediary

- December 2016 – PCG Public Partnerships LLC (PPL)
  - Transition from Easter Seals to PPL for DDD Self-Directed Employee (SDE) Option participants
  - Transition from Community Access Unlimited (CAU) to PPL for DDS Personal Preference Program (PPP) participants
- ✦ **July 1, 2017** – limited “cohort” transitioned into PPL to ensure SDE payment goes smoothly
- ✦ **July – October 1, 2017** – anticipated transition of remaining SDE Option participants, including PPP/DDDD dual enrollees with 90-day extension



***Informational Update:***

**NJ FamilyCare Update**

# June 2017 Enrollment Headlines

1,773,206 Overall Enrollment

11,141 (0.6%) Net Decrease Over May 2017

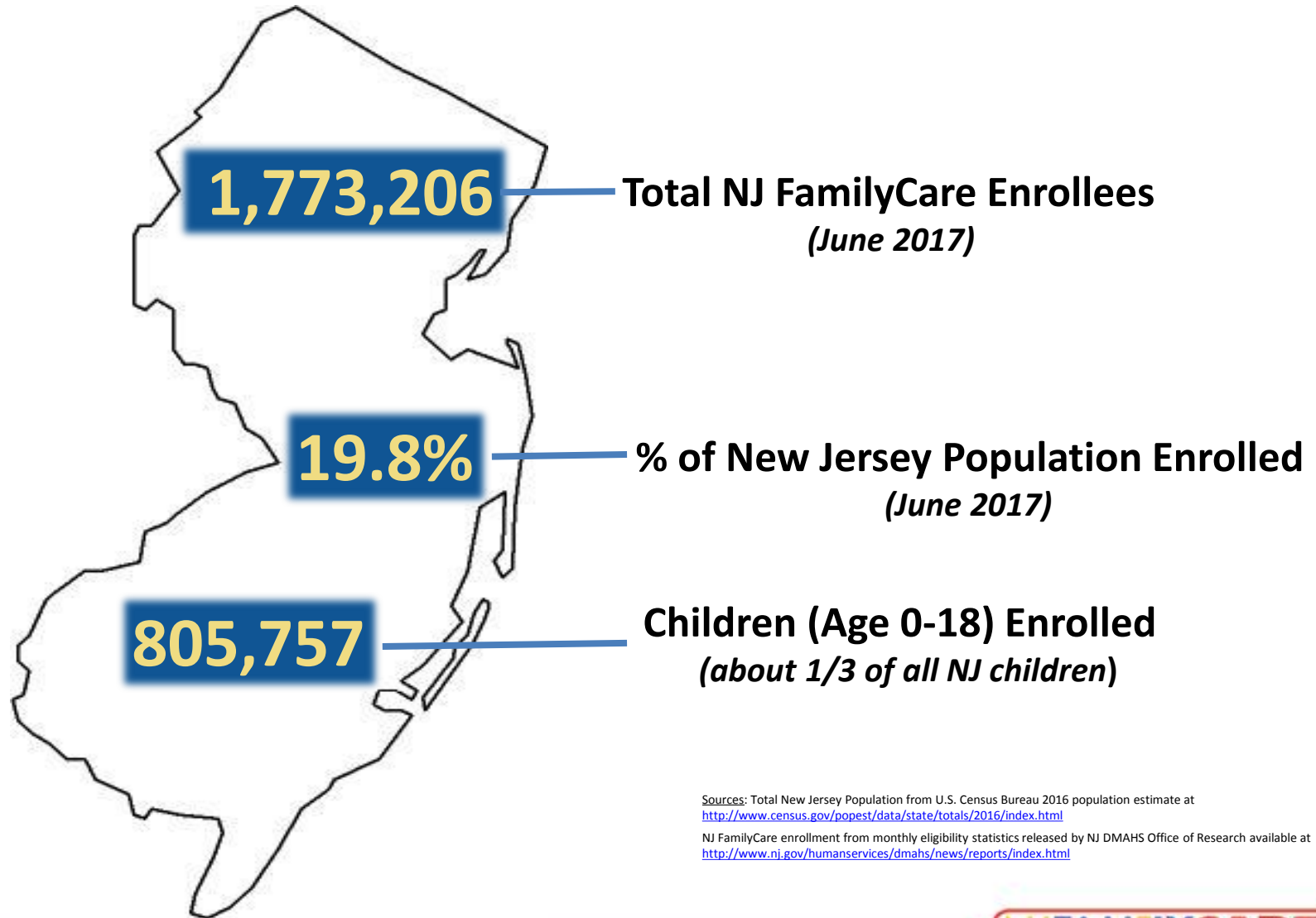
12,719 (0.7%) Net Increase Over June 2016

95.5% are Enrolled in Managed Care

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>

# June 2017 Eligibility Summary

Total Enrollment: 1,786,221

Expansion Adults	555,099	31.3%
Other Adults	107,405	6.1%
Medicaid Children	698,983	39.4%
CHIP Children	112,476	6.3%
Aged/Blind/Disabled	299,243	16.9%

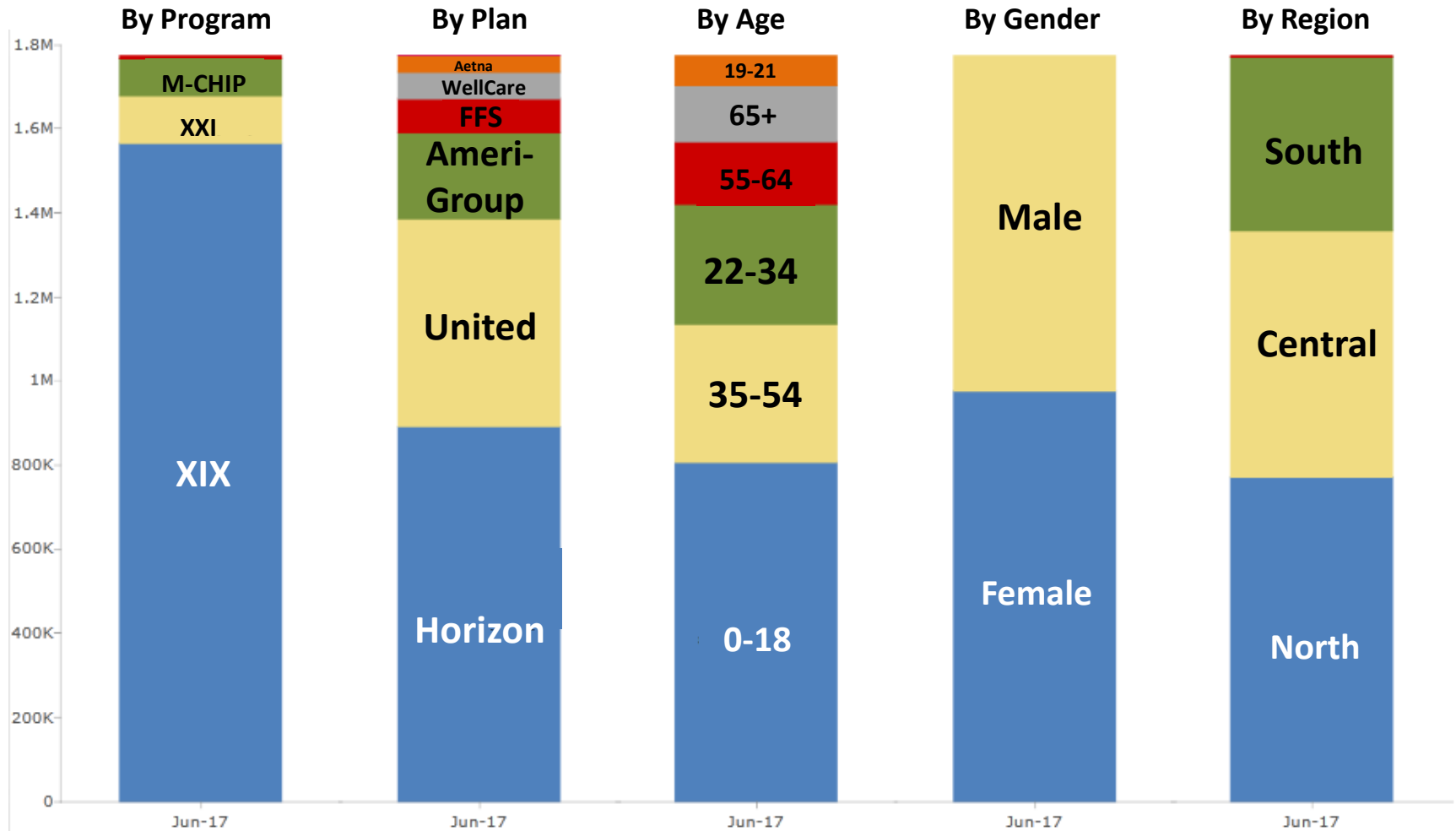
Source: Monthly eligibility statistics released by NJ DMAHS Office of Research available at <http://www.nj.gov/humanservices/dmahs/news/reports/index.html>;

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"

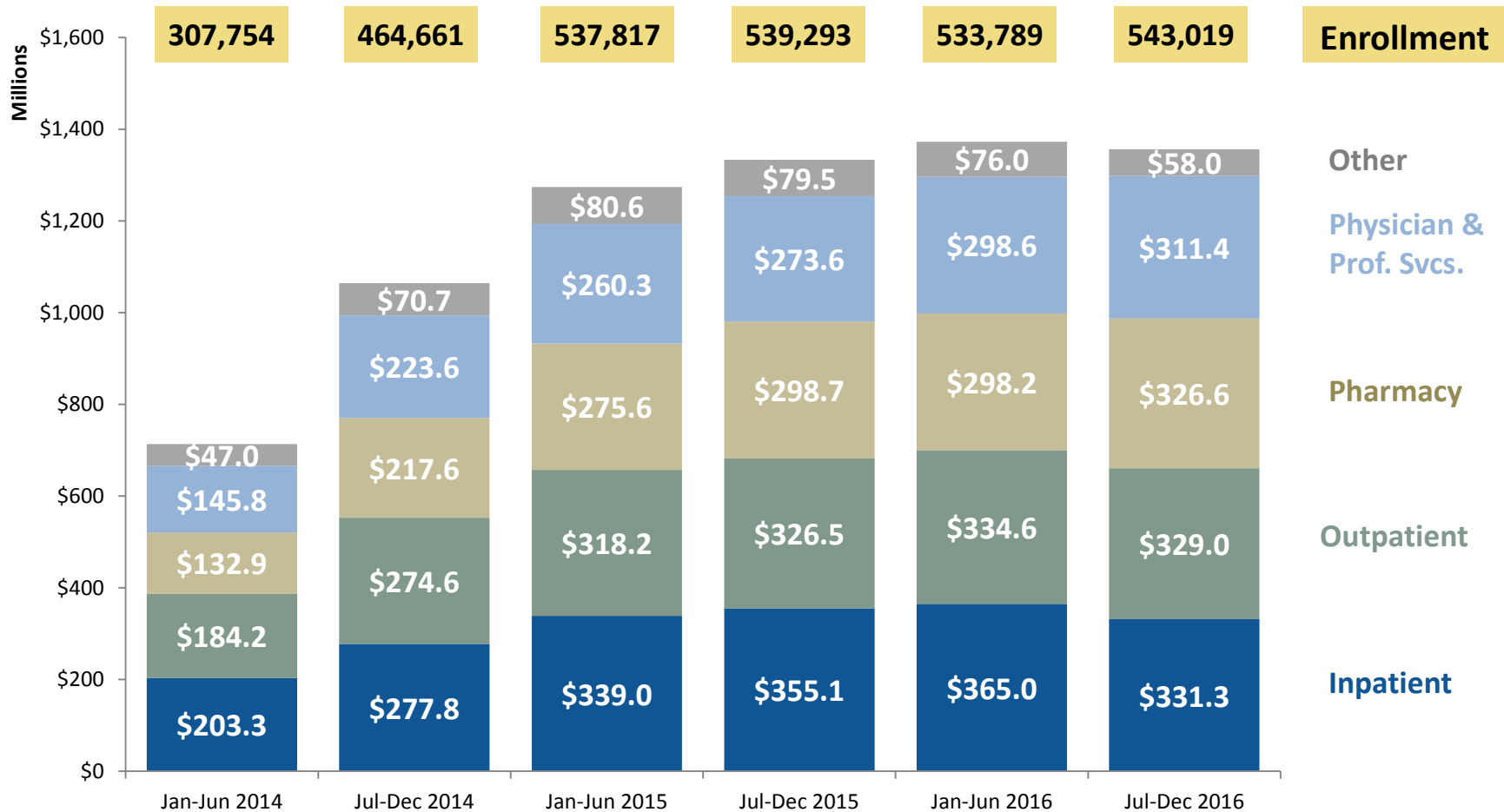
**Total Enrollment: 1,773,206**



Source: NJ DMAHS Shared Data Warehouse Snapshot Eligibility Summary Universe, run for June, 2017.

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 7/10/2017

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 7/10/17 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.

# The Future of Medicaid

# House Republicans Plan for Repeal and Replace: Medicaid

## American Health Care Act

- Passed in the House of Representatives on May 4, 2017
- Repeals enhanced match for expansion population effective 1/1/2020.
- After 1/1/2020 states could only enroll newly eligible individuals at the state's traditional matching rate.
- Proposes redeterminations every 6-months for the expansion population beginning 10/1/2017.
- Eliminates the 3-month retroactive eligibility period.
- Disproportionate Share Hospital (DSH) cuts would be repealed.
- Converts Medicaid to a per capita cap funding starting FY 2020.

# Senate Republicans Plan for Repeal and Replace: Medicaid

## Better Care Reconciliation Act of 2017

- Vote expected sometime after July 17, 2017
- Phases out enhanced match for expansion population effective by 2024.
- After January 1, 2020, states could only enroll newly eligible individuals at the state's traditional matching rate.
- Permits redeterminations every 6-months or less for the expansion population beginning October 1, 2017.
- Eliminates the 3-month retroactive eligibility period.
- Disproportionate Share Hospital (DSH) cuts would be repealed. However, expansion states DSH cuts would continue past 2020.

# Senate Republicans Plan for Repeal and Replace: Medicaid

## Better Care Reconciliation Act of 2017

- Converts Medicaid to per capita cap funding starting FY 2020.
- Includes a new state plan option (Qualified Inpatient Psychiatric Hospital Services) to include coverage for up to 30 consecutive days and 90 days total in a calendar year for individuals aged 21-65.
- Creates a new quality bonus payment program beginning in 2023.
- State's with existing 1915(b), 1932 or 1115 managed care waivers will not need to seek renewals unless the state is making a change to the waiver.
- Proposes to require input from State Medicaid Directors to the Secretary before the promulgation of new Medicaid regulations.

# 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 New Jersey**

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

# Children's Health Insurance Reauthorization Act (CHIPRA)

## An Update

- The Affordable Care Act (ACA) extended CHIP funding until September 30, 2015 and requires states to maintain eligibility standard thru 2019.
- The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 extended CHIP funding thru September 30, 2017. Legislative action is need to secure future funding.
- The AHCA proposes to extend CHIP funding for two years thru 2019, but without the enhanced federal funding currently available.



***Informational Update:***

**Managed Care**

# Why Changes to the Appeal Process?

## Managed Care Final Rule

Enables beneficiaries to have services continue during appeals of denials

Medicaid appeal timeframes are revised to better align with Medicare Advantage and Federal Marketplace Rules

Beneficiaries must exhaust the internal health plan appeal before proceeding to a state fair hearing.

<p align="center"><b><u>PREVIOUS UM APPEAL PROCESS</u></b> (in effect prior to July 1, 2017)</p>	<p align="center"><b><u>NEW/CURRENT UM APPEAL PROCESS</u></b> (effective July 1, 2017)</p>
<p><b><u>Stage 1 Appeal</u></b></p> <ul style="list-style-type: none"> <li>Members had up to <b>90 days</b> from date of denial notification letter to request.</li> <li>MCOs had up to <b>10 days</b> to reach a decision (<b>72 hours</b> for expedited appeals).</li> </ul>	<p><b><u>Internal Appeal</u></b> (<i>renamed</i>)</p> <ul style="list-style-type: none"> <li>Members now have up to <b>60 days</b> from date of denial notification letter to request.</li> <li>MCOs now have up to <b>30 days</b> to reach a decision (<b>72 hours</b> for expedited appeals).</li> </ul>
<p><b><u>Stage 2 Appeal</u></b></p> <ul style="list-style-type: none"> <li>Members had up to 90 days from the outcome of a Stage 1 appeal to request.</li> <li>MCOs had up to 20 business days to reach a decision.</li> </ul>	<p><b><u>Stage 2 Appeal – Eliminated</u></b></p> <ul style="list-style-type: none"> <li>The Stage 2 Appeal has been <b>eliminated entirely</b>; CMS no longer permits Medicaid MCOs to have more than one stage of internal appeal.</li> </ul>
<p><b><u>Stage 3 Appeal</u></b></p> <ul style="list-style-type: none"> <li>Members had up to <b>four (4) months</b> from the outcome of a <b>Stage 2 Appeal</b> to request.</li> <li>Resolution timeframe of <b>45 days</b>.</li> </ul>	<p><b><u>External (IURO) Appeal</u></b> (<i>renamed</i>)</p> <ul style="list-style-type: none"> <li>Members now have up to <b>60 days</b> from the outcome of an <b>Internal Appeal</b> to request.</li> <li>Resolution timeframe remains at <b>45 days</b>.</li> </ul>

## PREVIOUS UM APPEAL PROCESS

(in effect prior to July 1, 2017)

## NEW/CURRENT UM APPEAL PROCESS

(effective July 1, 2017)

### Fair Hearing

- Members could request a Fair Hearing immediately following an initial denial; they could also opt to pursue a Fair Hearing **concurrent with** or **instead of** a **Stage 1 Appeal**.
- Members could request a Fair Hearing **within 20 days of any adverse determination** (including initial denial and adverse outcomes of Stage 1, Stage 2, or Stage 3 appeals).

### Fair Hearing

- Members *must complete the Internal Appeal* before having the option to request a Fair Hearing.
- Members can opt to pursue a Fair Hearing **concurrent with** or **instead of** an **External (IURO) Appeal**.
- Members can request a Fair Hearing within **120 days** of the outcome of an Internal Appeal.
  - This is true whether or not a member requests an External (IURO) Appeal after their Internal Appeal; *the 120-day timeframe for requesting a Fair Hearing always starts with the outcome of the **Internal Appeal**.*

## PREVIOUS UM APPEAL PROCESS

(in effect prior to July 1, 2017)

### Continuation of Benefits

- Timeframes and other requirements for continuation of benefits) while an appeal is pending) were not previously described as explicitly as they are under the revised contract.
- During Fair Hearing: The member was required to request—in writing—that their benefits continue during the Fair Hearing process. This request was required within **20 days** of the date of **any adverse determination** (including initial denial and adverse outcomes of Stage 1, Stage 2, or Stage 3 appeals).

## NEW/CURRENT UM APPEAL PROCESS

(effective July 1, 2017)

### Continuation of Benefits

- During Internal Appeal: Benefits will continue automatically while the Internal Appeal is pending if the member requests appeal within 10 days of the date of the initial denial notification letter, or on or before the last day of the original authorization, ***whichever is later.***
- During External (IURO) Appeal: Benefits will continue automatically while the External Appeal is pending if the member requests appeal within 10 days of the date of the notification letter following the Internal Appeal, or on or before the last day of the original authorization, ***whichever is later.***
- During Fair Hearing: The member must request—in writing—that their benefits continue during the Fair Hearing process. This request must now be made:
  - within **10 days** of the date of the notification letter following the outcome of an Internal Appeal; ***or***
  - within **10 days** of the date of the notification letter following the outcome of an External/IURO Appeal (in cases where the member requests a Fair Hearing *after* the completion of an External/IURO Appeal, and the member's benefits were continued during that External/IURO Appeal).

# Utilization Management Resources

## Contact Information and Additional Resources:

If members have additional questions or need assistance, help is available.

- For questions about denial letters or Internal Appeals, members can contact the Member Services unit at their health plan. The phone number will be on their Member ID Card.
- For questions about (and help requesting) an External (IURO) Appeal, members can contact the NJ Department of Banking and Insurance, Consumer Protection Services, Office of Managed Care at 1-888-393-1062.
- If members need help understanding the appeal process, or would like legal representation and are not able to pay for it, they can contact one of the following:
  - Legal Services of New Jersey at [www.LSNJLawHotline.org](http://www.LSNJLawHotline.org) or call Legal Services of New Jersey at 1-888-576-5529
  - Disability Rights New Jersey (DRNJ) at [advocate@drnj.org](mailto:advocate@drnj.org) or call DRNJ at 1-800-922-7233 (TTY: 711) for free legal and advocacy services for people with disabilities
  - Community Health Law Project (CHLP) at [chlpinfo@chlp.org](mailto:chlpinfo@chlp.org) or call CHLP at 1-(973) 275-1175 to be directed to the appropriate office serving your county. A list of CHLP offices can also be found at [www.chlp.org](http://www.chlp.org).

***Informational Update:***

**Managed Long Term Services  
and Supports**

# Long Term Care (LTC) and Managed Long Term Services & Supports (MLTSS)





# Long Term Care Recipients Summary – June 2017

**Total Long Term Care Recipients\***

**51,793**

## Managed Long Term Support & Services (MLTSS)

**36,420**

MLTSS HCBS	19,629
MLTSS Assisted Living	3,056
MLTSS HCBS/AL (unable to differentiate)	19
MLTSS NF	13,484
MLTSS Upper SCNF	147
MLTSS Lower SCNF	85

## Fee For Service (FFS/Managed Care Exemption)

**14,434**

FFS pending MLTSS (SPC 60-64)	629
FFS Nursing Facility (SPC 65)	10,058
FFS SCNF Upper (SPC 66)	172
FFS SCNF Lower (SPC 67)	112
FFS NF – Other (Jan 2017)**	3,463

## PACE

**939**

Source: NJ DMAHS Shared Data Warehouse Regular MMX Eligibility Summary Universe, accessed 7/7/2017.

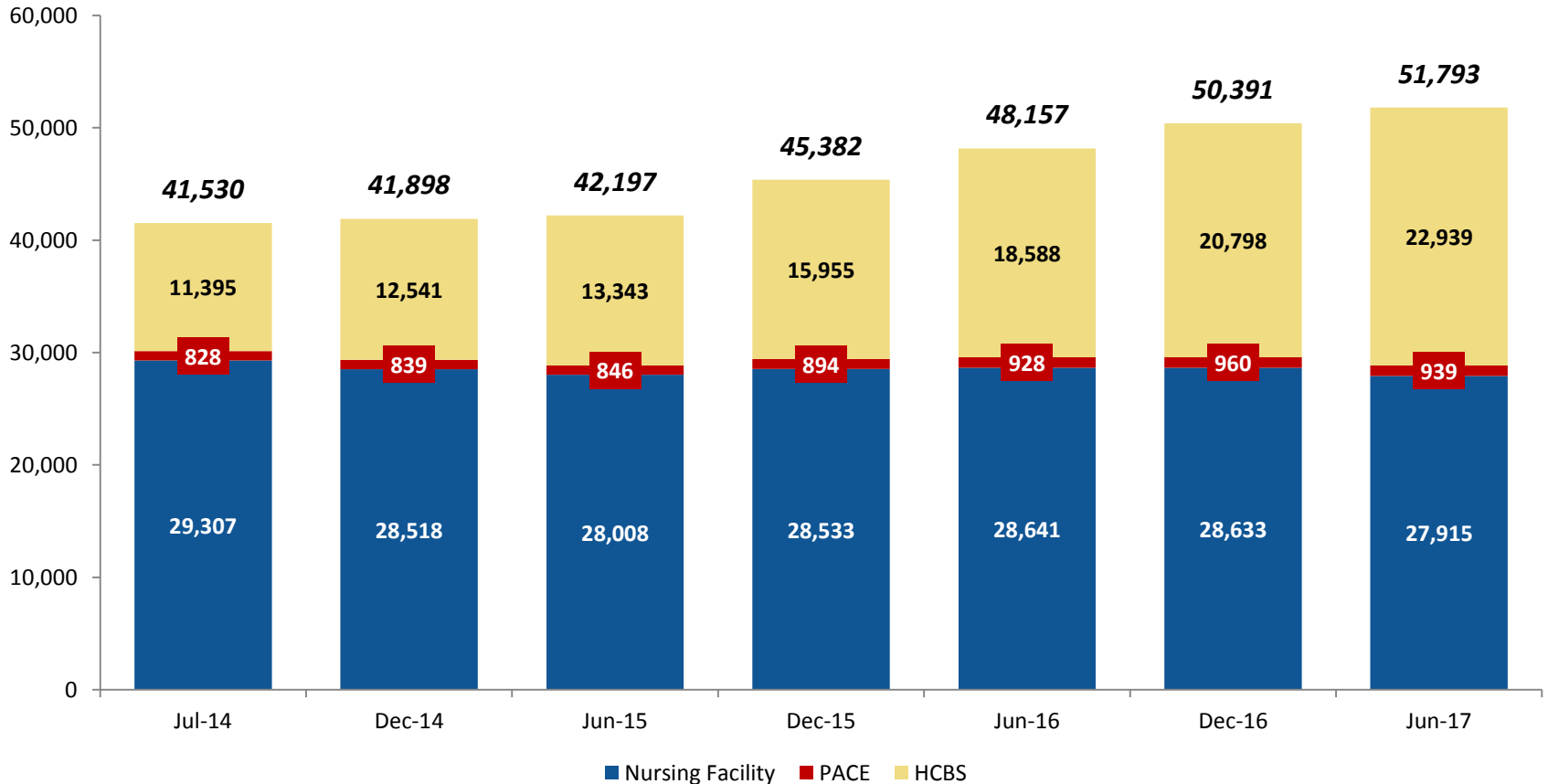
Notes: Information shown includes any person who was considered LTC at any point in a given month and includes individuals with Capitation Codes 79399, 89399, 78199, 88199, 78399, 88399, 78499 & 88499, Special Program Codes 03, 05, 06, 17, 32, 60-67, Category of Service Code 07, or MC Plan Codes 220-223 (PACE).

\* 'FFS NF – Other is derived based on the prior month's 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.

\*\* Includes Medically Needy (PSC 170,180,270,280,340-370,570&580) recipients residing in nursing facilities and individuals in all other program status codes that are not within special program codes 60-67 or capitation codes 79399, 89399, 78199, 88199, 78399, 88399, 78499 & 88499.

# Long Term Care Population by Setting

## 6-Month Intervals

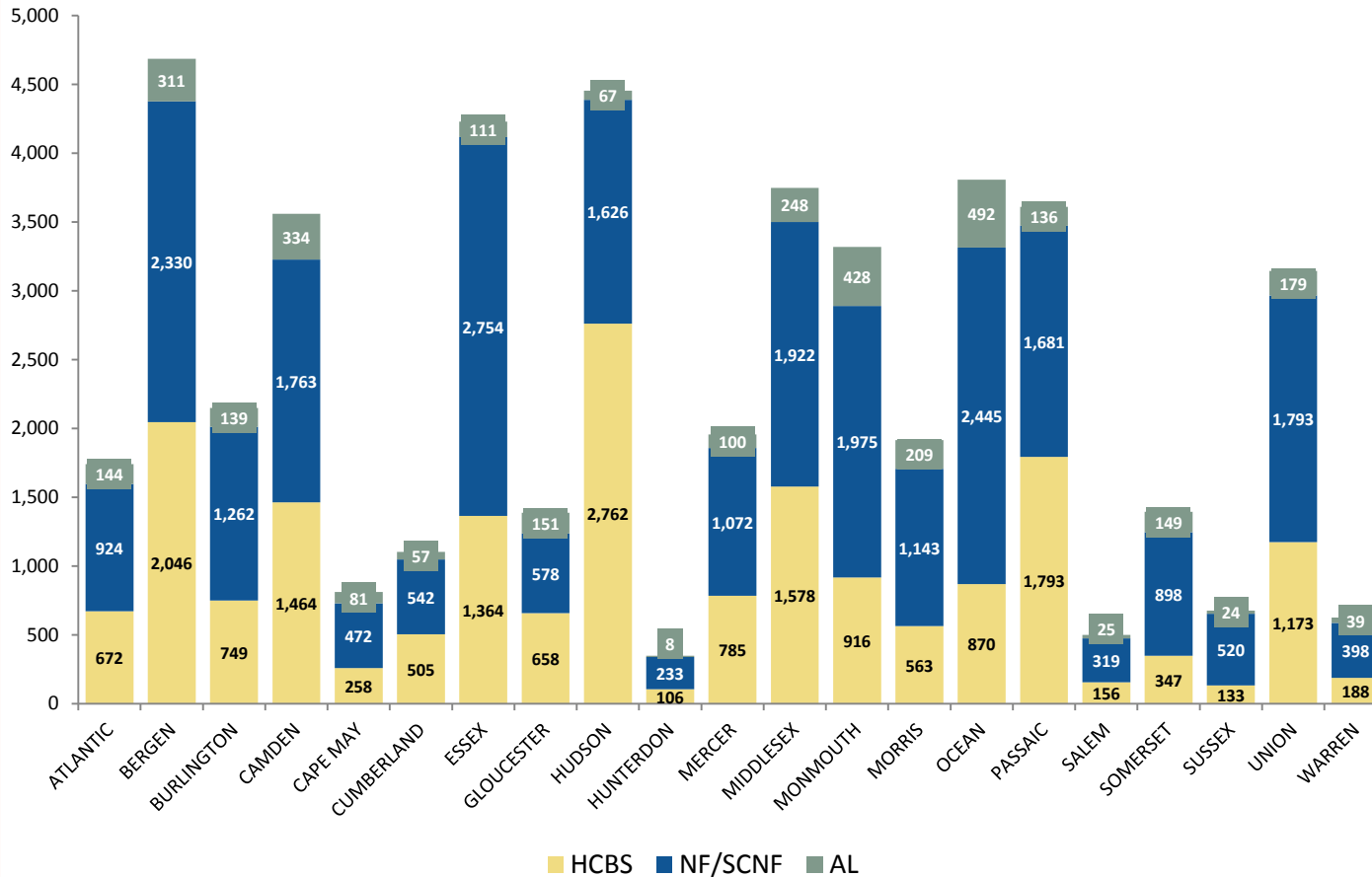


Source: Monthly Eligibility Universe (MMX) in Shared Data Warehouse (SDW), accessed on 7/7/2017.

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). \* Increase in overall LTC population indicative of the natural aging process.

# Long Term Care Population by County

May 2017\*



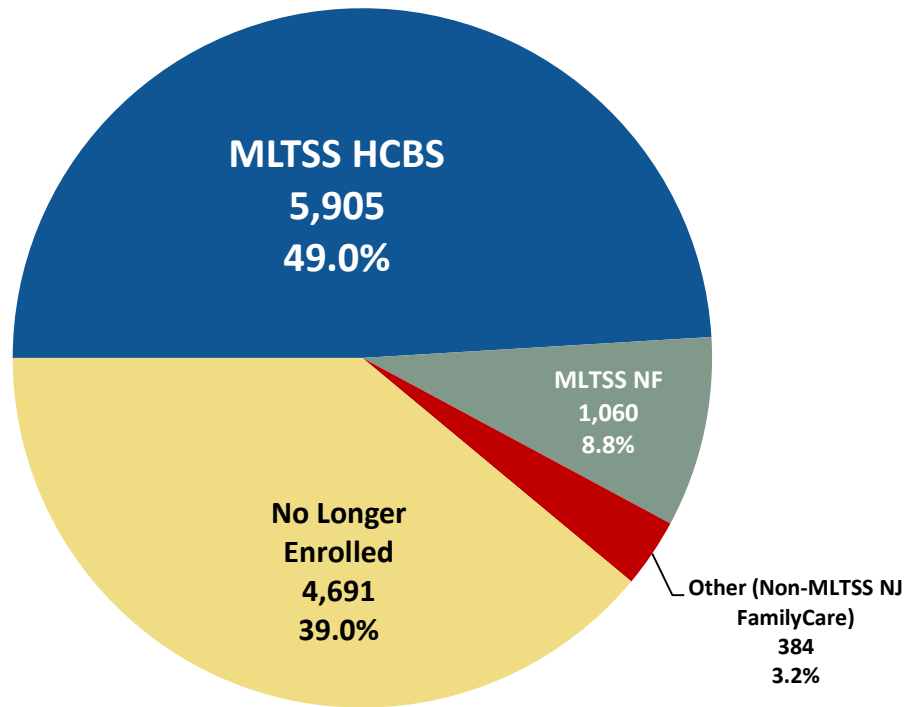
COUNTY	NJ FamilyCare	LTC
ATLANTIC	4.1%	3.5%
BERGEN	6.6%	9.5%
BURLINGTON	3.6%	4.4%
CAMDEN	8.1%	7.2%
CAPE MAY	1.1%	1.6%
CUMBERLAND	2.8%	2.2%
ESSEX	13.2%	8.6%
GLOUCESTER	2.8%	2.8%
HUDSON	10.4%	9.1%
HUNTERDON	0.6%	0.7%
MERCER	4.2%	4.0%
MIDDLESEX	7.7%	7.6%
MONMOUTH	4.8%	6.8%
MORRIS	2.5%	3.9%
OCEAN	7.5%	7.7%
PASSAIC	8.9%	7.3%
SALEM	0.9%	1.0%
SOMERSET	1.9%	2.8%
SUSSEX	0.9%	1.4%
UNION	6.6%	6.4%
WARREN	0.9%	1.3%

Source: DMAHS Shared Data Warehouse Monthly Eligibility Universe, accessed 7/10/17.

Notes: Information shown includes any person who was considered LTC at any point in a given month, based on CAP Codes 79399, 89399, 78199, 88199, 78399, 88399, 78499 & 88499, Special Program Codes 60-67, Category of Service Code 07, or MC Plan Codes 220-223 (PACE). \* Uses count for the prior month due to claims lag in identifying medically needy (PSC 170,180,270,280,340-370,570&580) and other non-exempt fee-for-service nursing facility recipients.

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

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

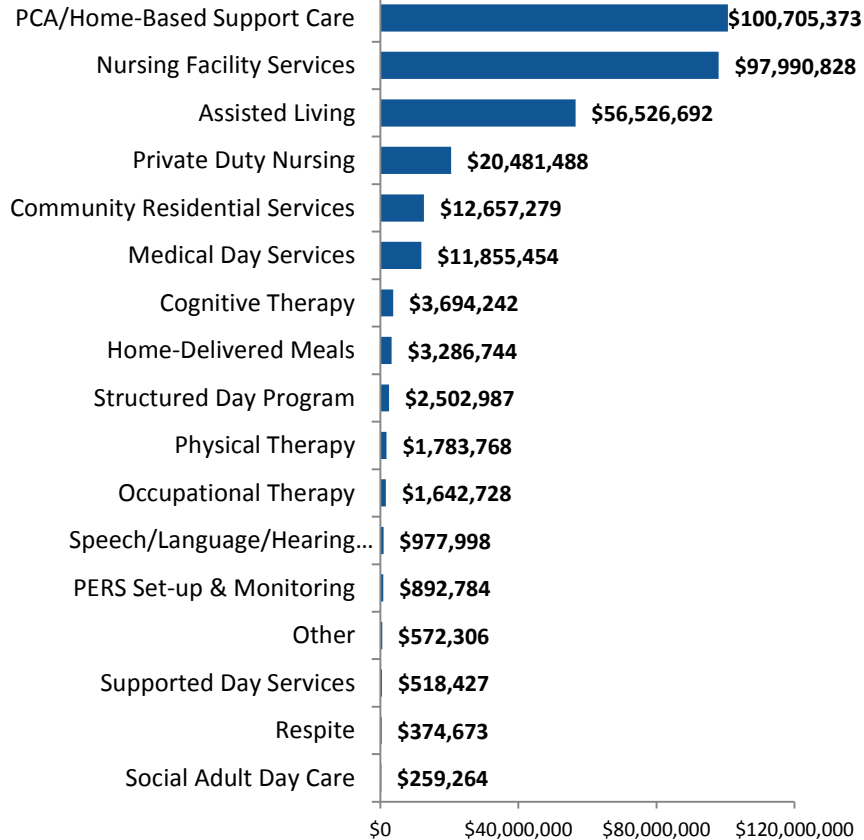


Source: DMAHS Shared Data Warehouse Monthly Eligibility Universe, accessed 7/10/17.

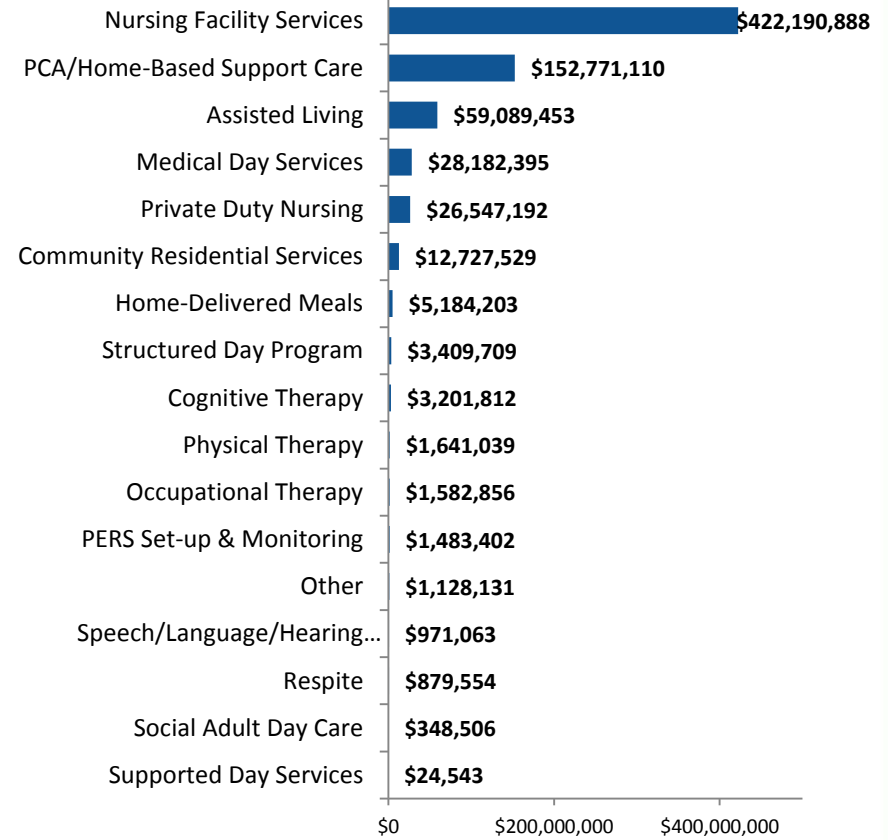
Notes: Includes all recipients who were in a waiver SPC (03, 05, 06, 17 or 32) on 6/30/14. Where they are now is based on capitation code or PSC. Those without a current capitation code or PSC are determined to be "No Longer Enrolled". Of the total number no longer enrolled, 93.8% (3,102) have a date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

# MLTSS Population's LTC Services Cost

## SFY15



## SFY16



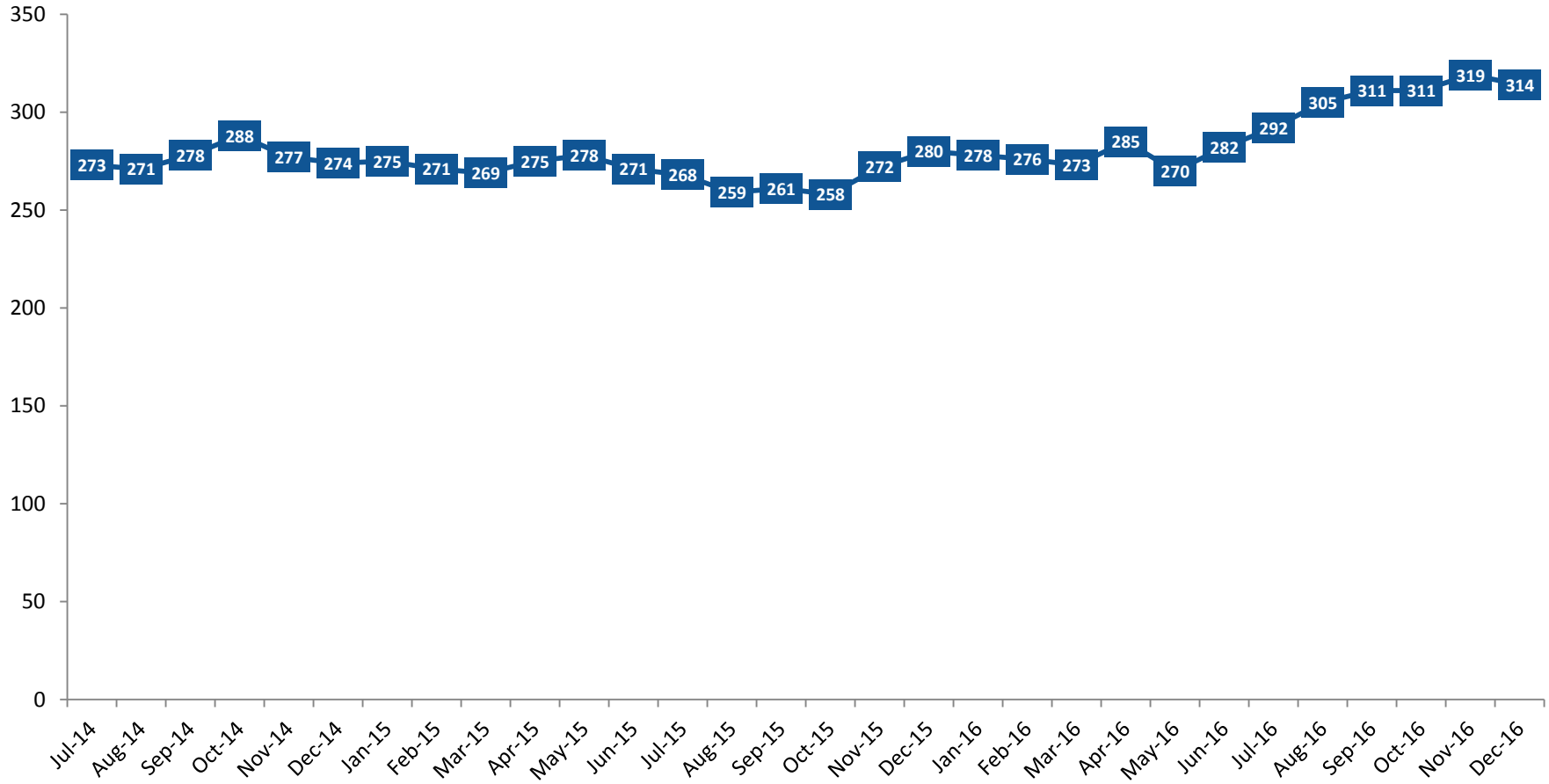
Monthly Average Number of MLTSS Recipients		
	Monthly Avg (SFY15)	Monthly Avg (SFY16)
HCBS/AL	11,982	15,693
All NF	1,439	7,060
<b>Grand Total</b>	<b>13,421</b>	<b>22,753</b>

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 with a TBI Diagnosis

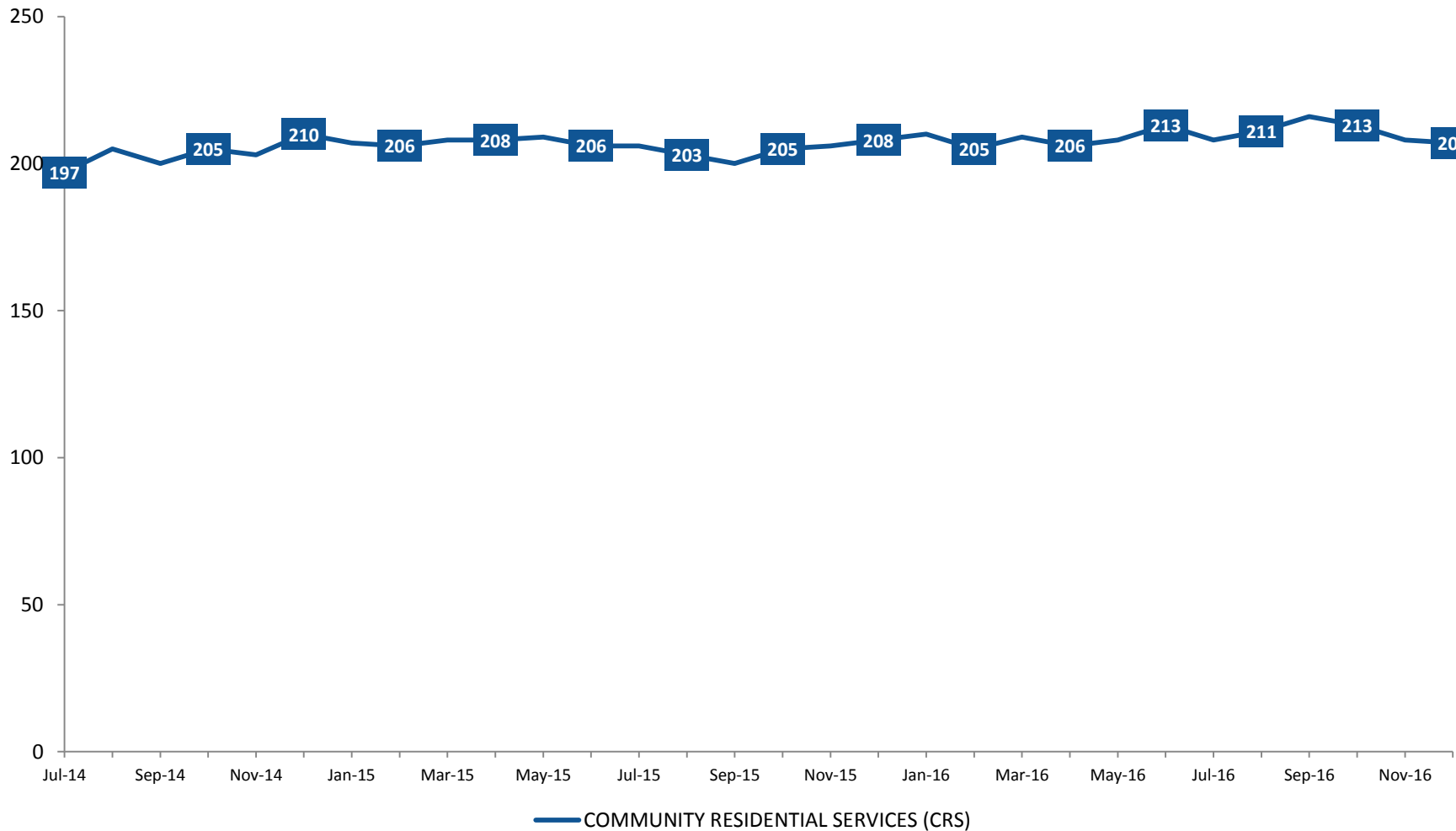
## MLTSS Recipients with a TBI Claim in Given Month



Source: NJ DMAHS Share Data Warehouse MLTSS Services Dictionary, accessed on 5/25/17.

Notes: Recipients had a MLTSS capitation code as well as a TBI Service as defined in the MLTSS Services Dictionary (Cognitive Therapy, Occupational Therapy, Physical Therapy, Speech/Language/Hearing Therapy or TBI Behavioral Management).

# MLTSS Recipients Using Community Residential Services

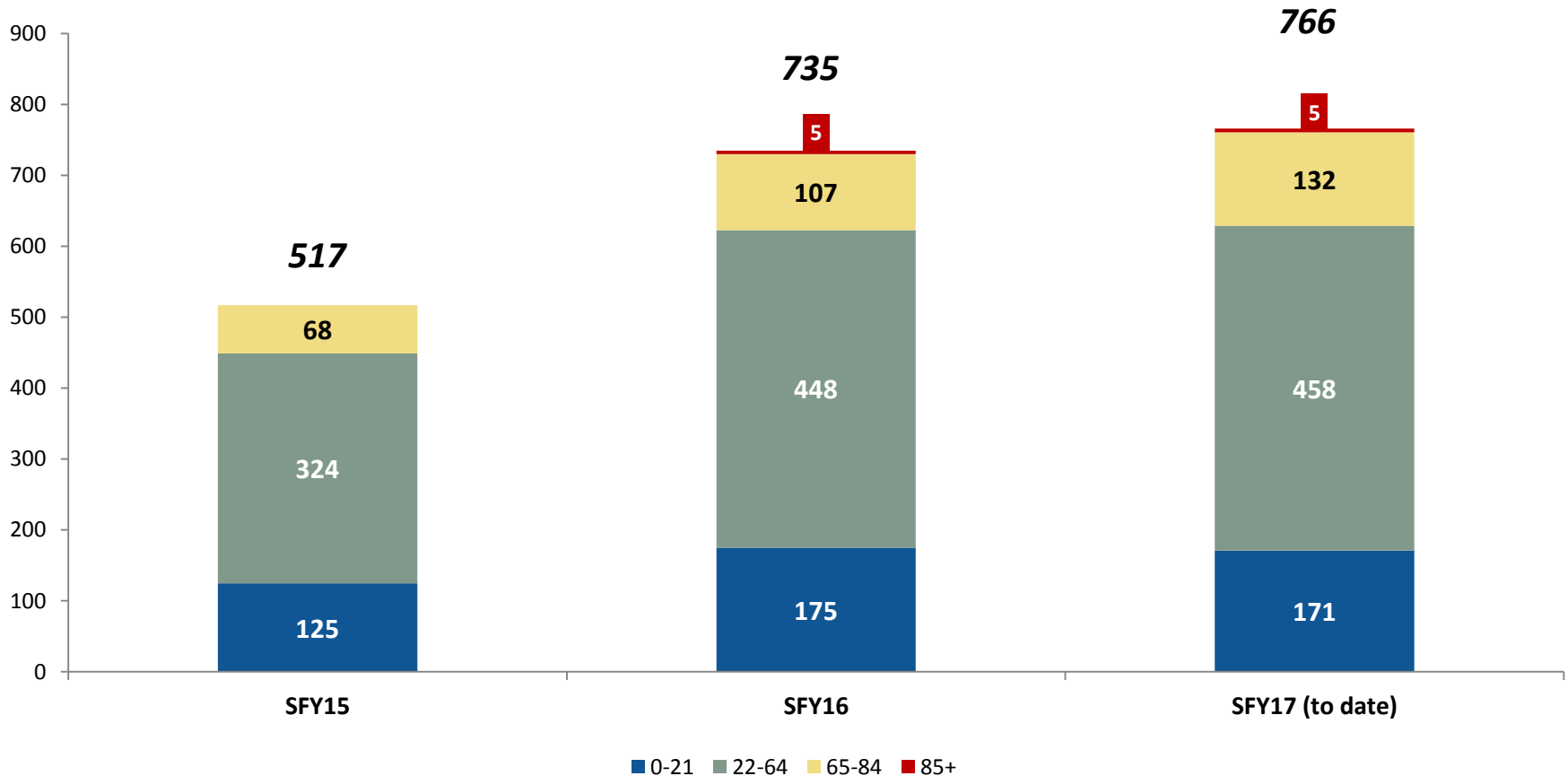


Source: NJ DMAHS Share Data Warehouse MLTSS Services Dictionary, accessed on 5/25/17.

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 Recipients

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



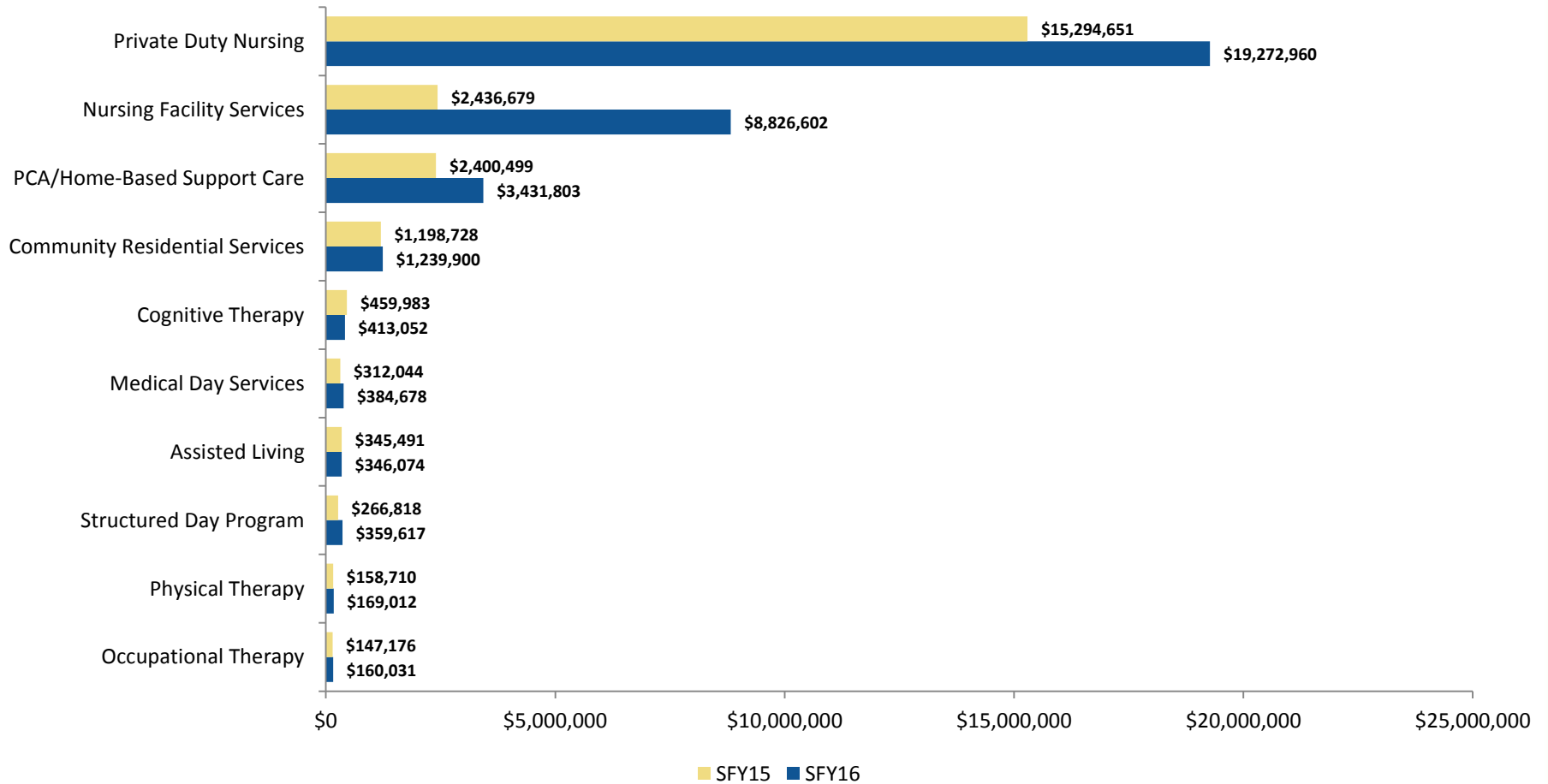
Source: NJ DMAHS Share Data Warehouse MLTSS Table and Claims Universe, accessed 5/26/17.

Notes: Includes all MLTSS recipients, as defined by capitation codes 79399;89399;78199;88199;78399;88399;78499;88499 with a DDD paycode designation on the RHMf. Includes 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. Recipients are grouped according to their age on the last day of each state fiscal year.



# MLTSS DDD Recipients' Service Utilization

## Top 10 LTC Services Utilized by MLTSS DDD Recipients



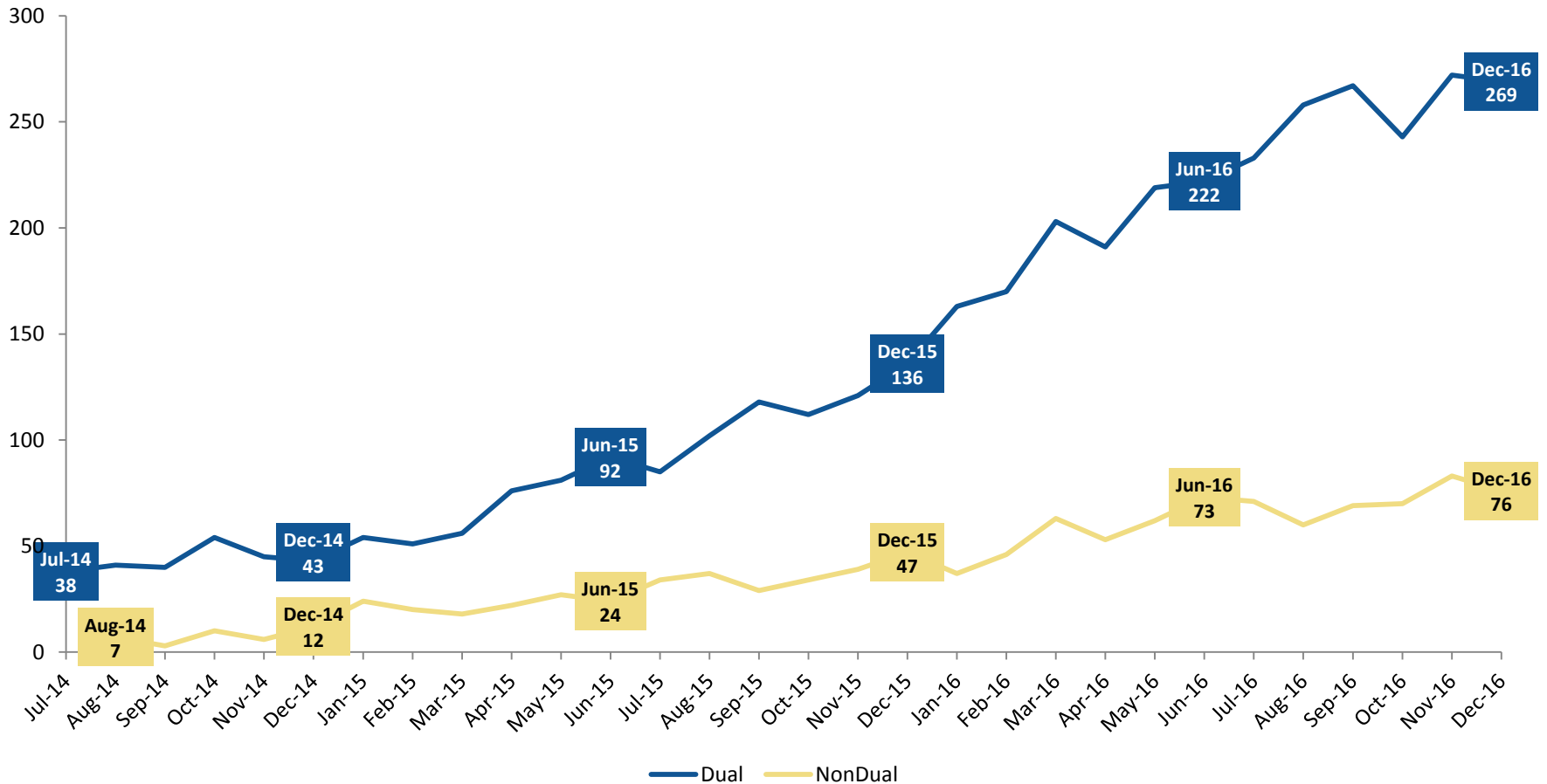
Source: NJ DMAHS Share Data Warehouse MLTSS Table and Claims Universe, accessed 5/26/17.

Notes: Includes all MLTSS recipients, as defined by capitation codes 79399;89399;78199;88199;78399;88399;78499;88499 with a DDD paycode designation on the RHMf. Includes 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). Includes all services defined as LTC based on the MLTSS Services Dictionary, including MDC & PCA.

# MLTSS Recipients Receiving Behavioral Health Services

## Monthly Counts, By Dual Status

MLTSS BH Recipients, by Dual Status

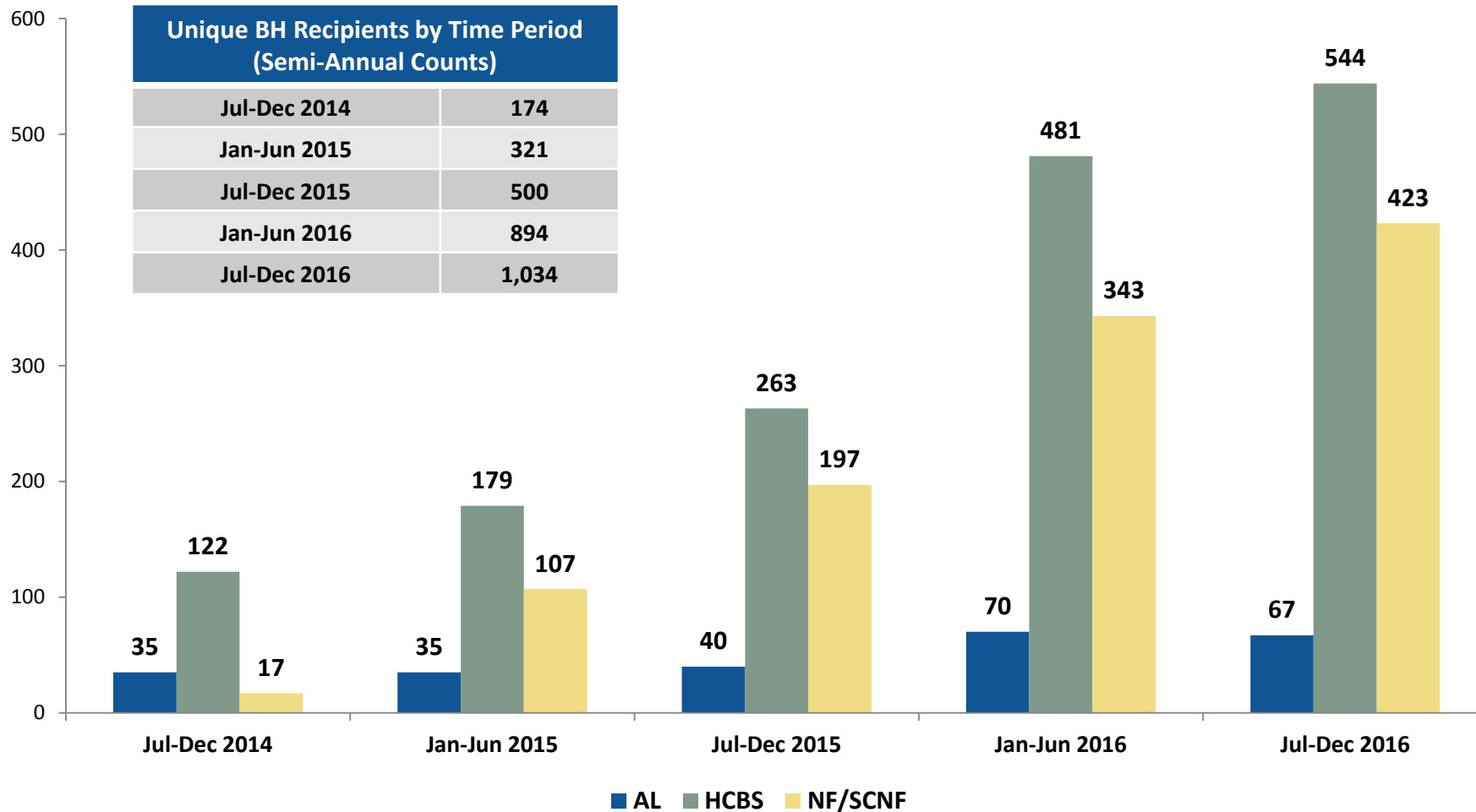


Source: NJ DMAHS Share Data Warehouse MLTSS Services Dictionary, accessed on 6/22/2017.

Notes: All recipients counted above are defined as MLTSS based on capitation code (79399;89399;78199;88199;78399;88399;78499;88499) and defined as BH based on receipt of services classified as BH based on procedure code or revenue code as defined in the MLTSS BH Services Dictionary. Does not include services meeting the definition of MLTSS Waiver, Medical Day Care or PCA as defined in the MLTSS Services Dictionary. Individual recipients may be counted more than once in a state fiscal year if they transitioned between settings (HCBS,AL,NF).

# MLTSS Recipients Receiving Behavioral Health Services

## Semi-Annual Counts, By Setting



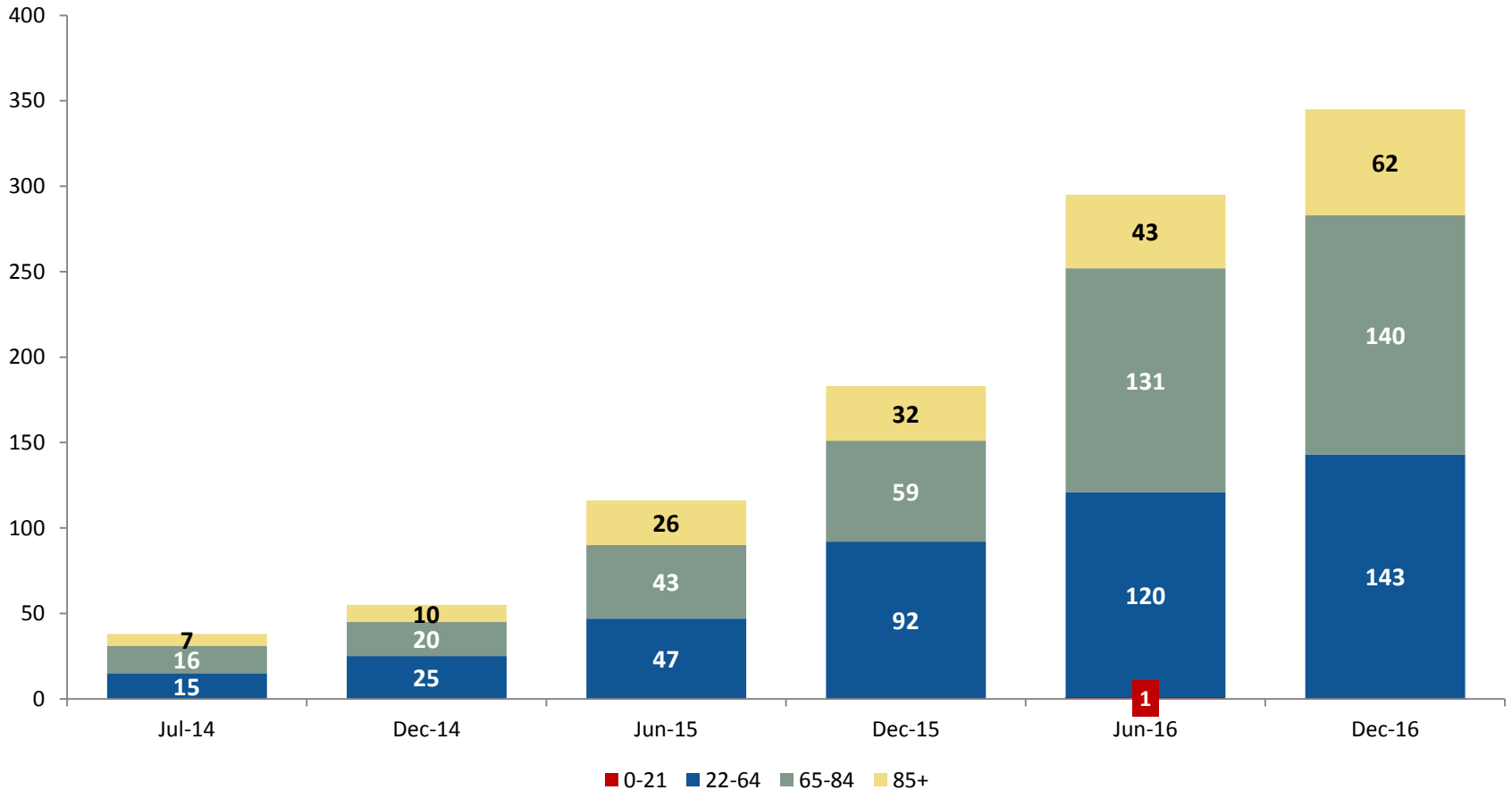
Source: NJ DMAHS Share Data Warehouse MLTSS Services Dictionary, accessed on 5/31/2017.

Notes: All recipients counted above are defined as MLTSS based on capitation code (79399;89399;78199;88199;78399;88399;78499;88499) and defined as BH based on receipt of services classified as BH based on procedure code or revenue code as defined in the MLTSS BH Services Dictionary. Does not include services meeting the definition of MLTSS Waiver, Medical Day Care or PCA as defined in the MLTSS Services Dictionary. Individual recipients may be counted more than once in a state fiscal year if they transitioned between settings (HCBS,AL,NF).

# MLTSS Recipients Receiving Behavioral Health Services

## Monthly Counts, By Age

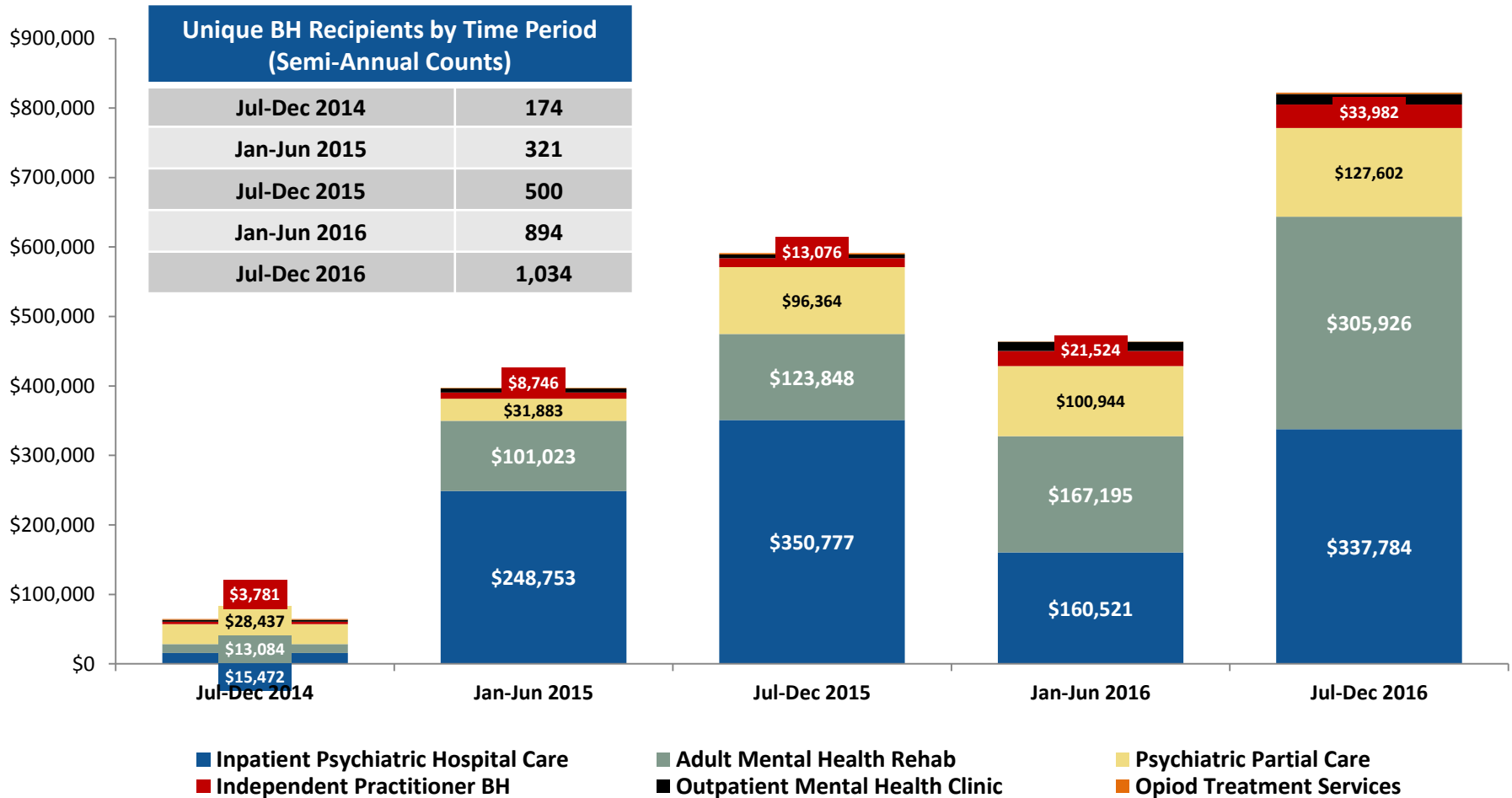
### 6-Month Intervals



Source: NJ DMAHS Share Data Warehouse MLTSS Services Dictionary, accessed on 5/31/2017.

Notes: All recipients counted above are defined as MLTSS based on capitation code (79399;89399;78199;88199;78399;88399;78499;88499) and defined as BH based on receipt of services classified as BH based on procedure code or revenue code as defined in the MLTSS BH Services Dictionary. Does not include services meeting the definition of MLTSS Waiver, Medical Day Care or PCA as defined in the MLTSS Services Dictionary. Individual recipients may be counted more than once in a state fiscal year if they transitioned between settings (HCBS,AL,NF).

# MLTSS Behavioral Health Services Utilization, by Service



Source: NJ DMAHS Share Data Warehouse MLTSS Services Dictionary, accessed on 5/31/2017.

**Notes:** Amounts shown by service dates. Services are classified as BH based on procedure code or revenue code as defined in the MLTSS BH Services Dictionary. 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 2/8/17 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. \*Psychiatric Partial Care includes both inpatient & outpatient partial care.

# Nursing Facility Quality Improvement Initiative

# Guiding Principles

1

Improved Resident Experience and Quality of Life

2

Transparency & Collaboration with the Stakeholder Community

3

Consistent approach to Quality Measurement

4

Quality Monitoring & Promoting Continuous Quality Improvement

5

Oversight and Protections

# 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.

The AWP provision currently requires the MCOs to contract with the NFs at least at the approved state Medicaid rates.

The AWP contracting policy for NFs was extended beyond its original two year period until 6/30/17.

Before eliminating AWP, NJ is developing NF provider network requirements and quality indicators that will be used in the contracting process between providers and the MCOs.



# Any Willing Qualified Provider (AWQP)

The three primary goals of the AWQP program are:

- Setting the stage for value based purchasing – the AWQP program needs to be aligned with value based purchasing because its focus is also on quality and outcomes of care
- Improving NF quality for long-stay residents (“raise all ships”) - by providing regular feedback on performance to NFs, they can design and implement quality improvement plans to improve outcomes for all residents
- Provide MCOs with a pathway towards stronger network management - in addition to rewarding quality through higher reimbursement to quality providers, MCOs will be able to share provider performance with members so they have the knowledge base to select high value service providers

# AWQP Focus

- This program is only applicable to Medicaid certified NFs that provide services to long-stay residents enrolled in the State's MLTSS program. The AWQP program does not apply to specialty care nursing facilities (SCNFs).

# AWQP and Value Based Purchasing

In general, value-based purchasing rewards health care providers for the quality of health care they give individuals. Value based purchasing is aligned with New Jersey's quality strategy to support the triple aim to provide:

- Better health care experience for individuals
- Better health for populations
- Lower health care costs

There are three key components of value-based purchasing<sup>1</sup>

- Measuring and reporting performance differences among providers
- Reimbursing individual providers based on performance
- Designing strategies to benefit an individual's health and incentives to encourage individuals to select high value services and providers

# Recap to Date

- Confirmed seven quality NF measures as threshold
- Non Medicaid NFs and Special Care Nursing Facilities (SCNFs) are excluded from this initiative
- Use CoreQ as the survey tool to measure NF resident and family satisfaction in NFs
  - National CoreQ expert Dr. Nick Castle of the University of Pittsburgh will administer the survey for DHS
  - NFs that already use CoreQ questions in their own surveys will be exported into the State's survey by Dr. Castle

# Quality Measures and Data Source

Measures	Data Source
1. Results 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 12.04%</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 96.45%</i> )	MDS

*Note: MDS statewide averages as of May 2017*

**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 6.42%</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 0.83%</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 2.40%</i> )	MDS

Note: MDS statewide averages as of May 2017

## DHS AWQP Dedicated Resources

- Division of Aging Services has created an AWQP Unit which will be responsible for the administrative oversight
  - Under Assistant Director Elizabeth Brennan with a Quality Assurance Coordinator and a part-time consultant
- Division of Medical Assistance and Health Services
  - Office of Managed Health Care
  - Office of Business Intelligence
- Technical assistance from Mercer Consulting and Center for Health Care Strategies (CHCS)
- Bi-weekly meetings at DHS to work the project plan

# Turning a Vision into Reality: Draft Documents

- Workflows
- Acronyms, Terms and Definitions
- Report Generation Timeline
- Project Work Plan
- Communications Plan
- FAQ Summary with Responses



# Key Areas of AWQP Work Plan for DHS

- Communications Plan
- State Website
- FTP Site for secure data exchange
- Contract Language
- AWQP Program Manual
- Provider Training
- MDS Measures Collection
- CoreQ and NF Question Collection
- Data Validation and Analysis
- NF Report Card Generation & Distribution including Timeline
- NF Appeal and NF Quality Performance Plan (QPP)
- MCO NF Resident Notification Process
- MCO NF QPP Oversight
- MCO NF Contracting

# Pre-implementation and Implementation Activities

Pre-Implementation	
<ul style="list-style-type: none"> <li>Share pre-baseline data with the NFs</li> </ul>	<ul style="list-style-type: none"> <li>Pre-baseline data will be the 5 MDS quality measures.</li> </ul>
<ul style="list-style-type: none"> <li>FAQs (initial), Webinars, TA/training, Web page</li> </ul>	<ul style="list-style-type: none"> <li>In preparation for sharing the pre-baseline data an initial set of FAQs will need to be developed. Additional FAQs will be developed as needed.</li> <li>DHS will establish a web page dedicated to the AWQP program.</li> <li>PowerPoint presentations will be developed for stakeholder training and technical assistance.</li> </ul>
<ul style="list-style-type: none"> <li>Evaluation and Testing Activities</li> </ul>	<ul style="list-style-type: none"> <li>Staff will review all processes to date and determine what modifications need to be made before awarding the first AWQP designations to nursing facilities.</li> </ul>
<ul style="list-style-type: none"> <li>Revise and Refine Activities</li> </ul>	<ul style="list-style-type: none"> <li>Based on the outcomes of the Evaluation and Testing activities, the State may need to revise and refine various tools, processes and program documentation.</li> </ul>

# Timeline (Abbreviated)

Timeline	Key DMAHS and DoAS Activities
July 2017	Pre-baseline data distribution (5 MDS quality measures)
January 2018	Prepare baseline data for distribution
February 2018	Baseline data is released
<b>March 2018</b>	<b>Receive and review NF Quality Performance Plans (QPP)</b> <b>Receive and review any NF appeals related to data</b>
July 2018	Prepare data for distribution
August 2018	Baseline interim data is released
September 2018	Receive and review NF Quality Performance Plans (QPP)
January 2019	Prepare 1 <sup>st</sup> annual data for distribution
February 2019	1 <sup>st</sup> annual data is released
March 2019	Receive and review NF Quality Performance Plans (QPP) Receive and review any NF appeals

# Timeline (Abbreviated)

Timeline	Key DMAHS and DoAS Activities
<b>April – June 2019</b>	<b>AWQP annual designation is provided <u>for the first time</u></b> MCO oversight/collaboration on QPPs
July 2019	Prepare data for distribution
August 2019	1 <sup>st</sup> annual interim data is released
September 2019	Receive and review NF Quality Performance Plans (QPP)
January 2020	Prepare data for distribution
February 2020	2 <sup>nd</sup> annual data is released
March 2020	Receive and review NF Quality Performance Plans (QPP) Receive and review any NF appeals related to data
<b>April – June 2020</b>	<b>AWQP annual designation</b> MCO oversight/collaboration on QPPs