Transition to Fee for Service

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Medicaid Reform in NJ

- February 2011 - Governor Chris Christie calls for a Medicaid reform plan during FY'12 budget address
- February 2011 to May 2011 – DHS, DOH, DCF review every facet of the program, examine other states' plans, look at every possible opportunity to improve and to reform
- May 2011 to August 2011 - Extensive public input process
- October 2012 – CMS approved Comprehensive Waiver
- The Comprehensive Waiver is a collection of reform initiatives designed to sustain the program long-term as a safety-net for eligible populations

Stakeholder Involvement

- DMHAS in partnership with NJ Medicaid developed a stakeholder input process to identify and leverage opportunities under Health Care Reform to support a transformed system.
- Stakeholder Steering Group convened January 2012
  - Four work groups were developed: Fiscal, Clinical, Access and Outcomes
- Stakeholder Steering Group information may be found at: http://www.state.nj.us/humanservices/dmahs/home/waiver.html

Introduction to Fee-for-Service

During his 2016 State of the State and Budget Addresses, Governor Chris Christie announced that $127 million would be invested in enhanced behavioral health services rates for providers. It is the largest overall increase to this community in over a decade and it's designed to strengthen the organizations that provide critical programs for some of New Jersey's most vulnerable residents.

FFS Rates – Budget Impact

- Behavioral Health Rate Increase: **$127.8 million in SFY 2017**
  - Enhanced federal match and third-party liability: **$107.8 million**
  - Net State investment = **$20 million for SFY 2017**
  - **State Fiscal Year 2018**
    - Proposed increased state investment of $9M, coupled with Medicaid increase of $8 million to support evaluation and management rates (includes medication management)

Fee for Service (FFS)
General Overview

- The rate study and rate setting processes had been underway for several months. Augmented with stakeholder input, a professional accounting firm and budget experts, the rates were determined and providers are being notified.
- Goal of creating equity across the DMHAS system
  - Increased system capacity
  - Create greater access for individuals seeking treatment
  - Standardization of reimbursement across providers
  - Create greater budgeting and expenditure flexibility for providers

Mental Health Programs transitioning to FFS

January 2017	July 2017	Programs under consideration
PACT	CSS	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		

Fee for Service (FFS) Rate Setting Considerations

- DMHAS conducted its own research into non-salary costs, wage rates and inflation.

- Subsequent to initial rate development by M&S, significant discussions were held between DHS/DMHAS Fiscal staff and program staff to review assumptions and make adjustments as appropriate

FFS Staffing and Financial Data Considerations

- For each service, rates build in assumptions on:
  - **Staffing make-up and credentials**, e.g., for Partial Care, Direct Staffing was comprised of a) Medical Director, b) Program Director (LSW), c) Supervisor (MA level), d) Case Coordinator and e) Service Worker.
  - Rates also built in the relative weight that each staff member comprises of the total Direct Staff cost.
  - **Financial Data** included review of contract database and expenditure reports, provider cost and time studies and Medicaid claims.
  - **Wage rates** for Direct Care staff were taken from the most recent Bureau of Labor Statistics (BLS) data specific to NJ. An inflation factor was applied to bring those wage rates to more current levels.
    - BLS wage categories were consistent with the functional titles for each service (i.e., considering required credentials)
  - **Fringe benefit** rates were applied based on available contract data and, to a lesser extent, data from a cost study of several providers that was conducted by M&S.

What went into the rates – Productivity Factor

Productivity factor was applied to the Direct Care wage/fringe benefit cost for each service. This factor was designed to "gross up" the costs to reflect the fact that staff are paid for more than just "face to face" time. Examples of the factors that drove each service's unique productivity adjustment were:

- Time required each day for documentation
- Required meeting time (consultations with other staff)
- Training/supervision
- Paid Time Off (holiday, vacation, sick)
- In cases where more than one staff member is required for site visits, travel time and the increased staff requirement were also considered in the productivity factor.

Regulatory Requirements and G&A Considerations

- If applicable (e.g., if regulation prescribed), a **client-staff ratio** was applied. In other words, if a certain service involves a group of clients receiving treatment delivered by staff simultaneously, the hourly wage cost was allocated to the client/service unit consistent with that ratio.

- Factors were applied to the wage/fringe benefit rates calculated with above data to account for estimated **General and Administrative costs**, **capital, supplies and infrastructure/overhead**. In general, rates were applied based on available contract data.

- DMHAS gave significant weight to existing regulations and compliance requirements in determining the cost inputs into each service.

FFS Rates for Services not reimbursed by Medicaid

- **Other Considerations**:
  - **Room and Board** components for Residential services reflect prevailing Fair Market Rents in New Jersey and then adding a factor for food costs per day. Medicaid does not cover room and board.
  - **Medicaid vs. State Only**
    - Where a service is Medicaid-eligible, State-Only rates set at 90% of the Medicaid rate
  - Since new reimbursement rates reflect providers' gross costs, we have assumed that the provider will continue to bill certain third party entities (e.g., Medicare, private insurance, client fees), which are *currently* credited to DMHAS deficit-funded contracts.

FFS Contract Transition – Cash Flow

- Cash flow considerations upon implementation
  - Upon FFS implementation, DMHAS will allow providers the opportunity to request up to two months of contract payments as an advanced payment against future FFS revenue
  - Proposed criteria under consideration for advanced funding:
    - Attestation of commitment to be a participating provider for 24 months
    - Provider must be in “good standing”
    - Provider must submit a 24 month cash flow analysis
    - Financial stability review

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.
- 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.

Phase 1 Transition to FFS
April 2016–January 2017

- 16 Providers transitioned to FFS January 2017
- All program elements represented except for PACT
- January 10th 2017 launch of NJMHAPP (NJ Mental Health Payment Processing Application)

When to Use NJMHAPP for Reimbursement

When to use NJMHAPP

Service	Medicaid Member	Uninsured
OP		√
PACT		√
ICMS		√
RESIDENTIAL		√
RESIDENTIAL ROOM/BOARD	√	√
PARTIAL CARE/HOSPITAL		√
PARTIAL CARE TRANSPORTATION		√
SUPPORTED EMPLOYMENT	√	√
SUPPORTED EDUCATION	√	√
PACT IN-REACH	√	√
ICMS IN-REACH	√	√
*BED HOLDS	√	√
*BED HOLD EXTENSIONS	√	√

*In a future version of NJMHAPP

Monthly Limits

- Providers will have monthly maximum limit of State funds.
- Monthly limit is set forth in its contract with the DMHAS
- Provider agencies that meet 90% of monthly billing limit may request an increase in the monthly limit for the following months, which shall be granted at the discretion of the DMHAS.

Phase II Unused Monthly Limits

- Agency's claims for payment that are under the monthly limit, the unused portion of the limit will roll over to the following month during months one and two
- After month two, the amount to be rolled over will be affected by whether or not the provider agency met the 80% threshold
  - the entire unused portion of the monthly limit will roll over to the following month only if the provider agency has met the 80% threshold
  - less than 80% of the monthly limit, then only 50% of the unused portion of the monthly limit will be roll over to the following month
  - Reviewed unused limits approved by DMHAS
- Variances between actual monthly expenses versus monthly limits will be closely monitored by Fiscal staff
- Adjustments may be made to monthly limits in future months for providers based on the trend in their financial activity or an approval of requested change.

Residential Room & Board

- **Not a Medicaid billable service**
- Covered within the cost reimbursement contract
- Offset some of the room & board cost via direct consumer residential fees

- **Under FFS:**
  - Medicaid enrolled consumers:
    - Medicaid billed for the appropriate level of care for services
    - Room & board billed to the state (per diem $27.47)
  - Non-Medicaid eligible consumers
    - State billed for the appropriate level of care for services
    - State billed for room & board concurrently
- Residential Fees/Co-pays:
  - Deducted from the room & board reimbursement

PACT & ICMS Hospital In-Reach

- Definition of '**In-Reach**' : Services provided consumers in an inpatient setting, or correctional facility

- Expectation is for the provision of these services to continue during periods of inpatient care & incarceration to ensure continuity of care and a successful discharge

- **Under FFS, all PACT & ICMS providers can bill for State reimbursement via NJMHAPP for In-Reach services**

Overnight Absence Reimbursement Guidelines

- The "bed hold" reimbursement guidelines apply when a consumer is absent from the facility for a minimum of an entire day, which is defined as a 24 hour period starting and ending at midnight.
  - Per diem rate for the appropriate level of care during the 30 Day Bed Hold period (excluding room & board).

- An "overnight absence" occurs when a consumer is present in the supervised housing setting for at least part of the day, but does not sleep in the supervised housing setting.

  - Residential providers may submit a claim for room & board payment for an overnight absence via NJMHAPP subject to limitations.

  - Room & board payments for overnight absences are limited to three (3) overnight absences, per consumer, per month.

What is a Bed Hold Extension Request?

A request for reimbursement will be considered by the Division for bed holds beyond the initial, required 30 day bed hold period when it is demonstrated that all the following criteria are met:

- Consumer's continued absence is due to ongoing receipt of inpatient hospitalization, residential addictions treatment or residential rehabilitative care
- The treatment team can project a discharge date in the reasonably foreseeable future
- Clinical information indicates imminent re-occupation of the bed
- Loss of placement would delay the consumer's discharge

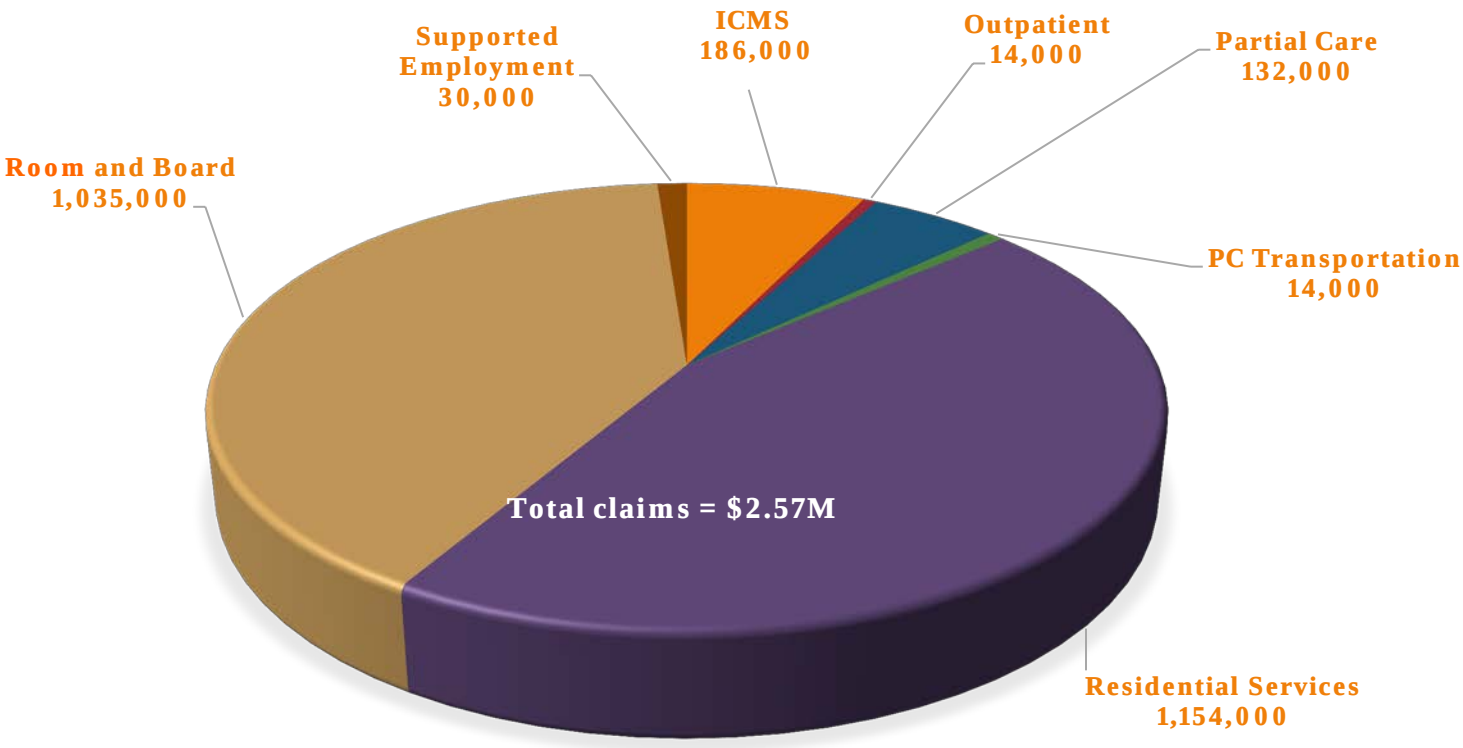
New Jersey Mental Health Application for Payment Processing (NJMHAPP)

- Ticket Management System
  - Responses within 1 business day
- Weekly Webinars
- Version 1.1 Provider Program Manual Released on February 21, 2017

Phase 1 Provider Feedback

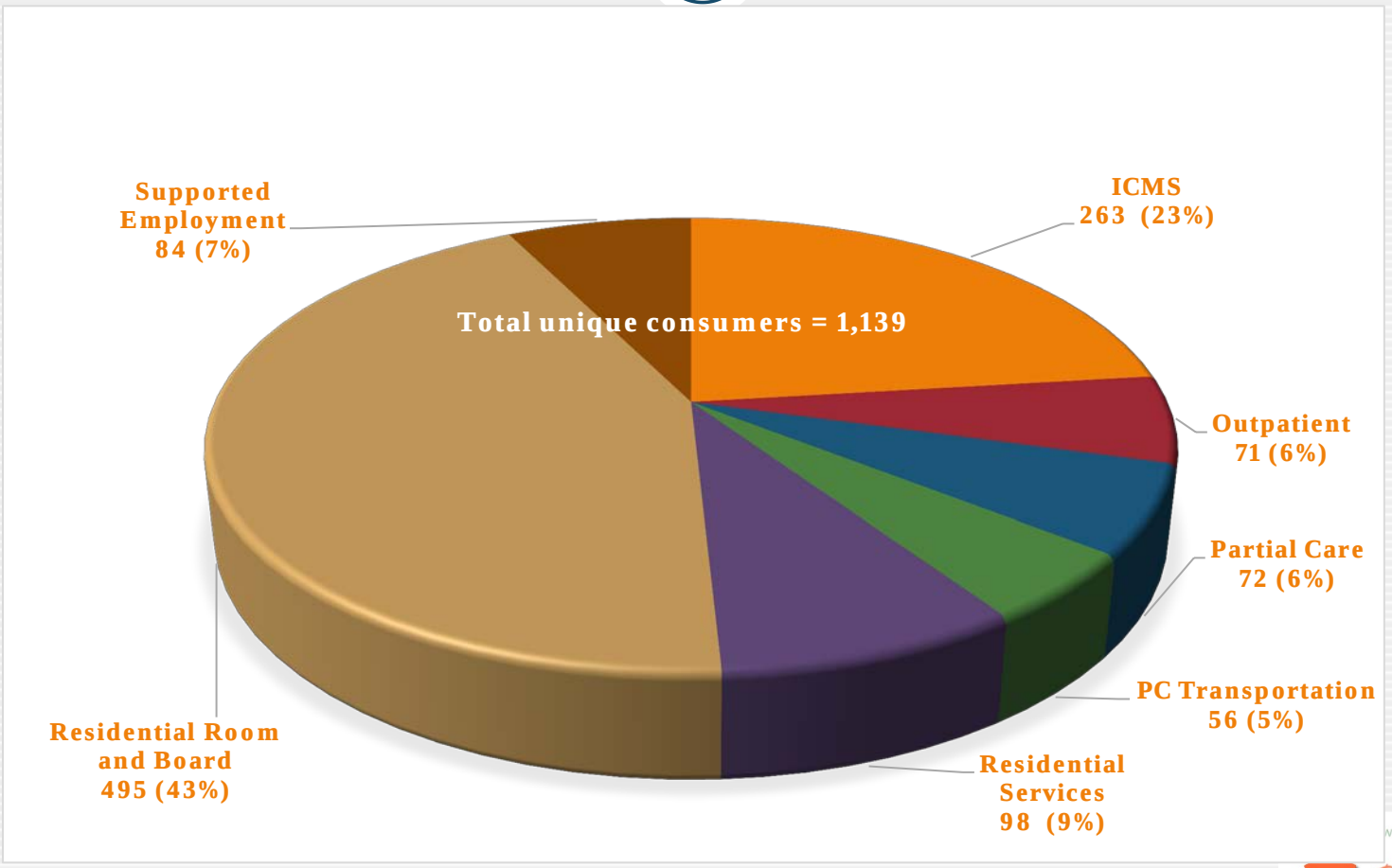
- Billing in NJMHAPP works well
- DMHAS staff responsive, IT staff
- Engaged in training and webinars

Claims by Service – January 2017 – March 2017



Data Source: NJMHAPP reports

Unduplicated Consumers by Service
January 2017 – March 2017



Data Source: NJMHAPP reports

Questions

ADDITIONAL QUESTIONS CAN BE SUBMITTED TO FFS.TRANSITION@DHS.STATE.NJ.US