Division of Mental Health & Addiction Services

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TRANSITION TO FEE FOR SERVICE

OVERVIEW FOR PROVIDER MEETINGS: COMMUNITY SUPPORT SERVICES (CSS)

March 2016

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Fee for Service (FFS) rate setting general Overview

- Goal of creating equity across the DMHAS system
  - Increased system capacity
  - Create greater access for individuals seeking treatment to access the level of care needed at the time needed
  - Standardization of reimbursement across providers
  - Create greater budgeting and expenditure flexibility for providers

Fee for Service (FFS) Rate Development

- **Overall objective was to build rates "from the ground up" that are reflective of full costs to provide services.**

- Key assumptions on the inputs for each service were provided to consultants Myers and Stauffer (M&S) by DMHAS program and policy staff, as well as through extensive discussions with providers (practice groups).

  - 7-8 meetings were held with providers to get their perspectives on key inputs that should be considered (e.g., staffing make-up, non-salary costs)

Fee for Service (FFS) Rate Setting Considerations

- Unifying disparate reimbursement methodologies between MH service contracts and SUD service contracts.
- Consideration of shift to Medicaid-reimbursed services as a result of Medicaid Expansion and changes in eligibility and benefit.
- DMHAS also 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.

FFS
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.
  - Fifty (50%) productivity

FFS
REGULATORY REQUIREMENTS AND G&A CONSIDERATIONS

- 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 proposed regulations and compliance requirements in determining the cost inputs into each service.

FFS
Rates for Services not reimbursed by Medicaid

- **Other Considerations:**
  - Analysis of impact of phasing in Mental Health State only clients in January 2017
  - **Medicaid vs. State Only**
    - Where a service is Medicaid-eligible, State-Only rates set at 90% of the Medicaid rate
  - Overall change in financing approach since current deficit-funded MH contracts support, to varying degrees, clients on Medicaid, Medicare or private insurance as well as clients with no insurance ("State only" clients).
    - Going forward, providers are expected to bill the relevant payer (Medicaid, Medicare or private insurance) and DMHAS will fund the State-only clients.
    - We did NOT assume State recoupment of providers' county or other government grants, or other fundraising revenues, which are currently credited to DMHAS in the deficit-funded contracts.

COMMUNITY SUPPORT SERVICES NEW RATES (2016) VS. PREVIOUS (2011)

Staffing Category/Credential	2016 Rates - (Medicaid) Units	2011 Rates	Change	% Change		2016 State-Only Rates @90%
Physician/MD - Individual Units	$104.67	$60.26	$44.41	74%		$94.20
Advance Practice Nurse (APN) / Psychologist - Individual Units	$53.93	$50.10	$3.82	8%		$48.53
Registered Nurse (RN)	$31.42	$30.56	$0.86	3%		$28.28
Licensed, Clinical	$35.85	$27.08	$8.77	32%		$32.27
Master's (MA) (inc., LSW, LAC)	$31.42	$27.08	$4.34	16%		$28.28
Bachelor's (BA) - Individual Units	$27.74	$18.40	$9.34	51%		$24.97
Bachelor's (BA) - Group Units	$6.94	$4.60	$2.34	51%		$6.24
Licensed Practice Nurse - Individual Units	$27.74	$22.97	$4.77	21%		$24.97
Licensed Practice Nurse - Group Units	$6.94	$5.74	$1.19	21%		$6.24
2 Year Associate of Arts (AA) - Individual Units	$16.62	$15.98	$0.64	4%		$14.96
2 Year Associate of Arts (AA) - Group Units	$4.16	$4.00	$0.16	4%		$3.74
Peer / High School Diploma (HS) - Individual Units	$16.62	$15.27	$1.36	9%		$14.96
Peer / High School Diploma (HS) - Group Units	$4.16	$3.82	$0.34	9%		$3.74

FFS
MEDICAID

- The appropriate Medicaid members and Medicaid covered services are to be billed to Medicaid prior to seeking state funding.
- Providers are required to enroll as a Medicaid provider if receiving state funds. A provider can submit application at http://njmmis.com
- SUD and CSS services funded through Medicaid and State dollars will be prior authorized by the IME.
- The rates require CMS approval.

FFS
Contract Transition – Cash Flow

- Contract dollars will not transition to FFS until July 2017
  - 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
    - Amount advanced must be paid back to the Division within the same State Fiscal Year
    - 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

CSS Time line

January 2016

- CSS training: supervisor and direct care staff, 3 locations

March 2016

- CSS documentation Training (3/11/16, 3/21/16)
- Medicaid Billing (3/28/16)

April 2016

- CSS documentation Training (4/1/16)
- Monitoring Tool Webinar

Spring 2016

- CSS Regulation Promulgation
- OOL Attestation and inspections for CSS licenses
- Medicaid Application submission for CSS
- Submission of IRP's to IME