Mercer

Government Human Services Consulting

Long-Term Care Study

Final Report

State of New Jersey

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Contents

Section 1
Executive Summary

In Fall 2020, the New Jersey Legislature approved and the Governor signed into law P.L. 2020, c.89 concerning long-term care (LTC) facilities, and mandated "a study of the costs and payments associated with nursing home care focusing on and including recommendations for adjusting reimbursement rates to account for differences in resident acuity levels, as well as other factors as may be relevant to nursing home costs and payments".[1] The New Jersey Department of Human Services (State) requested that Mercer Government Human Services Consulting (Mercer), as part of Mercer Health & Benefits LLC, assist the State to respond to this legislative mandate.

Historically, state Medicaid programs relied on institutional settings such as nursing facilities (NFs) to provide long-term services and supports (LTSS). However, over the past two decades, New Jersey, like other states, has focused on developing robust LTSS continuums of care, ensuring access to not only high-quality NF services but also non-institutional home- and community-based services (HCBS). HCBS can support beneficiary preferences to stay in their own communities for as long as possible, with services typically being more cost effective than NF services. A majority of Americans (77%) over age 50 want to live in their communities for as long as possible, but only 59% anticipate being able to.[2] At the same time, even in light of the Coronavirus Disease 2019 (COVID-19) pandemic, the majority of adults still hold a favorable impression of NFs.[3]

States have also historically provided services to Medicaid members through a Fee-for-Service (FFS) program model under which all providers who meet program standards are reimbursed based on volume of services provided. In 2014, the State elected to move away from a FFS model for LTSS, to a managed care service delivery model to better manage cost, utilization, and quality of services by contracting with managed care organizations (MCOs). As of July 2021, 97% of all the State's Medicaid and Children's Health Insurance Program (CHIP) Medicaid beneficiaries are enrolled in a MCO.[4]

This report focuses on New Jersey Medicaid members who are elderly or disabled and receive LTSS in a NF or in the community through FFS or the Managed Long-Term Services and Supports (MLTSS) program. These members are included in the New Jersey FamilyCare (NJFC) program, which is the statewide Medicaid program covering eligible children and adults in need of publically funded insurance. MLTSS is a component of the overall managed care program and is designed to expand HCBS, promote community inclusion, and ensure quality and efficiency.

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[1] State of New Jersey Legislature. *P.L. 2020, c. 89.* Trenton, NJ: September 16, 2020. Available at: https://www.njleg.state.nj.us/2020/Bills/PL20/89_.HTM

[2] AARP: 2018 Home and Community Preferences: A National Survey of Adults Ages 18-Plus. Revised July 2019. August 2018. Available at: https://www.aarp.org/research/topics/community/info-2018/2018-home-community-preference.html?CMP=RDRCT-PRI-OTHER-LIVABLECOMMUNITIES-032218

[3] AARP: Nursing Homes and Assisted Living Are Still Popular, Despite Coronavirus Outbreaks. November 2020. Available at: https://www.aarp.org/research/topics/care/info-2020/nursing-home-long-term-care-attitudes.html

[4] NJ Family Care Comprehensive Demonstration: Draft Renewal Proposal: September 2021: Available at: NJ FamilyCare Comprehensive Demonstration

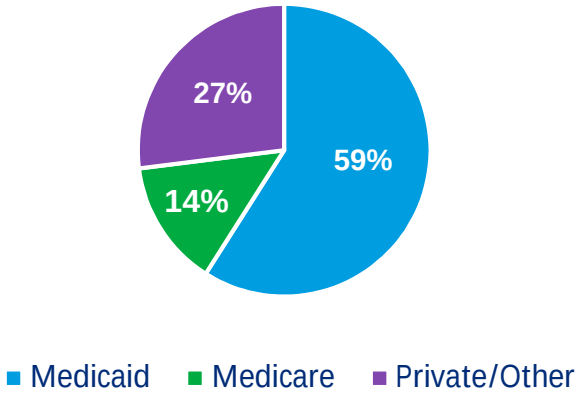
The intent of this report is to provide the State with the information necessary to understand the interdependency of NF rates and rate setting considerations; the report also recognizes the HCBS provision given that the prospective employment pool of direct service workers is similar for both settings. Therefore, this report addresses the requirements of P.L. 2020, c.89, specific to NF rates, and provides information and considerations pertaining to bolstering the State's LTSS continuum of care.

LTC Landscape

NF care is only one part of a much broader continuum of LTSS. LTSS consist of a broad range of day-to-day help needed by people with chronic or complex medical conditions, and include support for housekeeping and paying bills, personal care such as bathing, dressing, and toileting and assistance with medications and wound care. LTSS are provided across many different settings including at home, in an assisted living facility, or other supportive housing settings, and in NFs.

NF services are the second-largest category of Medicaid spending nationally (after hospital services), and Medicaid is the primary payer for NF care in the country.[5] In 2020, more than 41,000 New Jersey residents lived in NFs, where approximately 24,000 of those residents were Medicaid beneficiaries.[6] The graph below shows the CY 2020 distribution of NF residents by primary payer based on point in time data from surveyed facilities and does not highlight the potential changes in primary payer throughout the year[7].

Distribution of NF Residents in Certified Beds in New Jersey during CY 2020



The State's overall goal is to promote the LTSS continuum of care by:

- Ensuring adequate NF rates to maintain access to NF services for those who need them, and

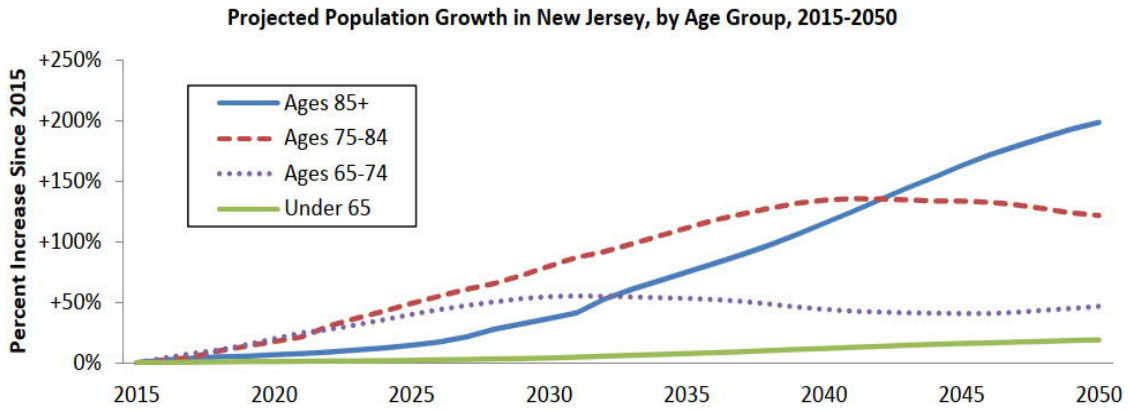
[5] Medicaid and CHIP Payment and Access Commission (MACPAC): *Nursing Facilities: Long Term Services and Supports*. 2020. Available at: https://www.macpac.gov/subtopic/nursing-facilities/

[6] Kaiser Family Foundation: *Analysis of Certification and Survey Provider Enhanced Reports (CASPER) data for CY 2020*. 2020. Available at: https://www.kff.org/other/state-indicator/distribution-of-certified-nursing-facilities-by-primary-payer-source/

[7] *ibid*

- Expanding access to high-quality home and community-based services for NJFC members.

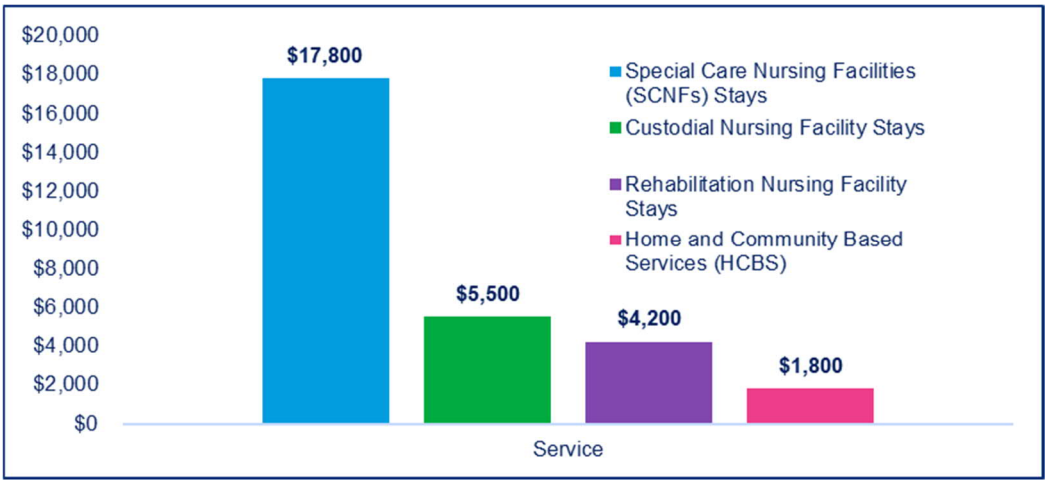
As shown in the graphic below, this is particularly important when the demand for LTSS in New Jersey is projected to increase exponentially due to population growth for those needing care.[8]



This projected increase is expected to have an impact on many aspects of LTSS delivery, with particular concern regarding the adequacy of the direct care workforce for both institutional and community care settings.

Figure 1 highlights the variation in the average monthly costs across the New Jersey LTSS continuum based on CY 2019 utilization.[9]

Figure 1: CY 2019 Average Monthly New Jersey Medicaid Expenditures per User, by Service Type



[8] AARP Policy Institute: Across the States 2018: Profile of Long-Term Services and Supports in New Jersey. Available at: https://www.aarp.org/content/dam/aarp/ppi/2018/08/new-jersey-LTSS-profile.pdf

[9] The HCBS figures reflect all community-based LTC services covered by Medicaid. These figures include FFS members, but have not been adjusted to include member cost sharing.

The New Jersey Medicaid program has made significant progress in advancing the use of HCBS as an alternative to NF services. Key accomplishments include:[10]

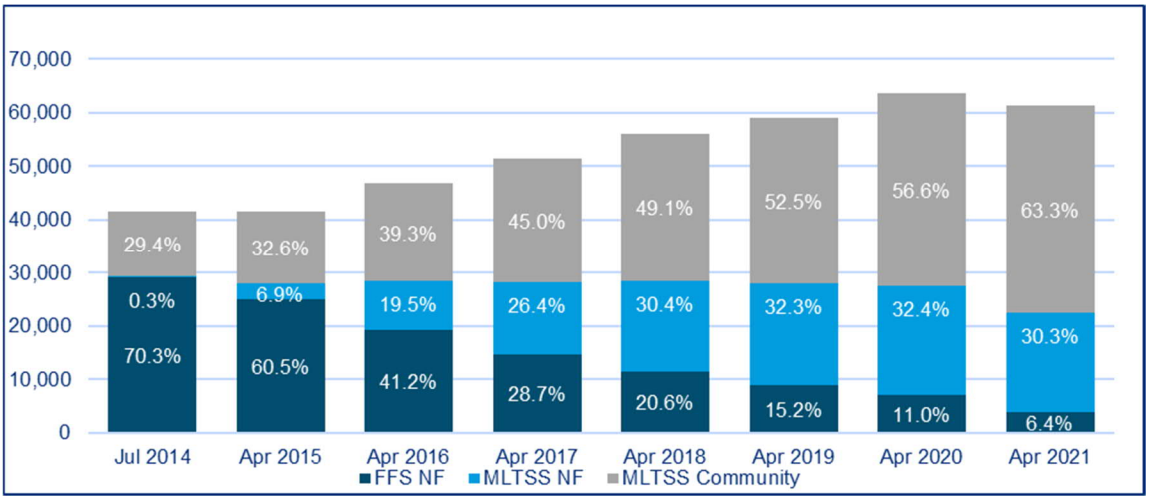
- An increased percentage of individuals receiving HCBS in 2018 as compared to 2014 (prior to the implementation of MLTSS), resulting from HCBS program growth in combination with specific rebalancing of Medicaid LTC.
- The National Core Indicators-Aging and Disabilities (NCI-AD) 2018–2019 survey showed that New Jersey outperformed the national average on the following measures: individuals that have had a physical and wellness exam, flu shots, dental visits, and vision exams in the past year.
- Recognition of New Jersey by The Scan Foundation with its *2020 Pacesetter Prize for Choice of Setting and Provider* which called New Jersey "a national leader in utilizing managed care to give people needing LTSS more choices of care providers and settings for receiving care."[11]
- A decline in the total Medicaid NF census in New Jersey between 2014 and 2019, despite the fact that New Jersey's elderly population grew over the same time period.

In addition to rebalancing NF and HCBS, the State has reduced the number of NF members in the FFS program by redirecting these members to the MLTSS program to promote community inclusion, streamlined fragmented care between acute care services and LTSS, and provided access to care management services. Figure 2 below illustrates how the LTSS program has evolved from FFS-funded NF services to MLTSS-funded NF services and community-based MLTSS services. It also illustrates how the State has increased the percentage of MLTSS community members and reduced the percentage of NF members over time.

[10] NJ Family Care Comprehensive Demonstration: Draft Renewal Proposal: September 2021: Available at: NJ FamilyCare Comprehensive Demonstration

[11] The Scan Foundation, 2020 Pacesetter Prize Winner: Available at: https://www.thescanfoundation.org/recognizing-excellence/pacesetter-prize/2020-choice-of-setting-and-provider-winner-new-jersey/

Figure 2: New Jersey Medicaid LTSS Enrollment Summary, 2014–2021[12]



Summary of Recommendations and Key Considerations

To provide the State with the necessary information regarding the interdependency of NF rates, rate setting considerations, and HCBS provisions, this report addresses the requirements of P.L. 2020, c.89 specific to NF rates, and provides information and considerations pertaining to the State's LTSS goals.

Mercer has summarized recommendations below related to the NF rates and reimbursement, in addition to alternative community services, with additional detail in the other sections of this report. These recommended initiatives are intended to promote the LTSS continuum of care by strengthening the underlying NF reimbursement methodology and reinforcing the community-based portion of the LTSS continuum of care in New Jersey.

NF Rate and Reimbursement Methodology

Currently, the FFS NF reimbursement rates serve as the basis for NF payments in managed care. Mercer recommends a multi-year process that starts with the development of a framework to design a reimbursement methodology, including the assessment of member needs, collecting current cost data, and conducting a detailed analysis of costs and payments to inform program decisions. We have outlined a proposed timeline in our recommendations; however, potential procurement delay is a key factor that will impact the timeline.

In Table 1 below, Mercer presents the general NF rate recommendations, with further detail provided in the *Nursing Facility Rate and Reimbursement Methodology* section of the report.

Table 1: NF Rate Recommendations

Year	Recommended Activities
Year 1 – SFY 2023 ***Conduct planning activities to develop a framework for***	• Engage stakeholders • Hire personnel to manage new process

[12] State of New Jersey Department of Human Services. *Long Term Care (LTC) and Managed Long Term Services & Supports (MLTSS) Presentation.* Trenton, NJ; 2021. Data provided in the 2021 State LTC and MLTSS monitoring report, which was developed using DMHAS Shared Data Warehouse Monthly Eligibility Universe available through June 2021.

Year	Recommended Activities
assessing individuals' needs and evaluating costs versus reimbursement	• Develop a NF reimbursement framework, which identifies the key steps and associated timeline to reinstate a cost-based reimbursement methodology • Collect NF cost data • Assess NF member acuity tools and select preferred approach
Year 2 – SFY 2024 ***Finalize planning and initiate implementation activities***	• Finalize the NF reimbursement framework • Conduct initial reimbursement activities • Evaluate and identify the options for each of the components for the NF reimbursement methodology • Continue stakeholder communications • Finalize the rebased NF FFS rates
Year 3 – SFY 2025 ***Implement rebased NF rates and conduct rebalancing activities***	• Release public notice of rebased NF FFS payment rates • Update State administrative code and submit State Plan Agreement (SPA) to Centers for Medicare & Medicaid Services (CMS) for approval of NF reimbursement methodology • Notify the MCOs of rebased NF FFS rates and any change in requirements in managed care • Implement the rebased NF FFS payment rates • Continue to evaluate quality payments and explore opportunities to leverage for rebalancing efforts
Year 4 – SFY 2026 ***Conduct monitoring and refinement activities***	• Monitor implementation of rebased NF FFS payment rates • Continue Stakeholder communications • Anticipate to rebase on a 2-4 year timeline • Evaluate and refine the system as needed

Alternative Community Services

In New Jersey, there are a number of effective LTSS available to many Medicaid members based on their assessed care needs. These services support individuals in their desire to live in the community for as long as possible. While there are many HCBS available in New Jersey, for the purposes of this report, the following selected services were considered the most impactful to further improve access to and develop a high-quality community-based LTSS continuum of care that supports members' needs and preferences:

- Assisted living facility services
- Caregiver supports (training and respite)
- Residential modifications
- Social and medical day care (MDC) services

- Personal care assistants (PCAs) (both agency and self-directed)
- Private duty nursing (PDN)
- Adult family care (AFC)
- Program of All Inclusive Care for the Elderly (PACE)
- No Wrong Door System initiative

Mercer recommends that the State continue its efforts to support community-based alternatives to NF care by:

- Exploring, and when appropriate, adopting promising practices in place in other states with high quality, innovative HCBS programs. For further detail, see the *Alternative Community Services Evaluation* section of the report.
- Continuing efforts to improve the stability of the direct care workforce through wage increases and other financial incentives such as referral, recruitment and retention bonuses, as well as non-financial incentives such as workforce development, training, and tuition and licensing fee reimbursement.
- Leveraging the opportunities to enhance HCBS through utilization of funds available through the American Rescue Plan (ARP) of 2021.
- Continuing efforts to enhance caregiver respite and support services and increasing access to other caregiver supports such as residential modifications.
- Continuing efforts for statewide expansion of PACE.

Section 2
NF Rate and Reimbursement Methodology

Overview of New Jersey NFs

In New Jersey, while NF services are provided to members through the MLTSS program as well as FFS, a majority of NF individuals are served through MLTSS:

- More than half of NF residents are enrolled in Medicaid — of those Medicaid enrollees, 85% are enrolled in MLTSS as of September 2021.[13]
- NF services account for 58% of the total Medicaid LTSS program expenditures in CY 2019.[14]

The FFS NF reimbursement rates serve as the basis for NF payments in managed care. Given the State's focus to maintain access to high-quality care throughout the LTSS continuum of care, it is important to evaluate the FFS NF reimbursement rates and methodology to ensure the rates can sustain the operation of these facilities while promoting efficiency and quality.

NFs in New Jersey are defined as licensed facilities that provide health care under medical supervision and continuous nursing care for 24 or more consecutive hours to patients who do not require the degree of care and treatment which a hospital provides and who, because of their physical or mental condition require continuous nursing care and services above the level of room and board. Residents require services that address the medical, nursing, dietary, and psychosocial needs (including end of life care and fall prevention) that are essential to obtaining and maintaining the highest physical, mental, emotional, and functional status. Care and treatment should be directed toward development, restoration, maintenance, or the prevention of deterioration. Care should be delivered in a therapeutic health care environment with the goal of improving or maintaining overall function and health status.[15]

NFs can deliver custodial care where a longer length of stay is required, but also provide rehabilitation care to members in need through a short-term stay. A small number of children and adults with highly complex medical needs beyond the scope of conventional custodial NF services are served in special care nursing facilities (SCNFs).

[13] State of New Jersey Department of Human Services. *Long Term Care: Trend*. Available at: http://www.njfamilycare.org/analytics/LTC_trend.html

[14] Mercer's analysis using CY 2019 (pre-pandemic) encounter and FFS claims data on an incurred basis for MLTSS and Non-MLTSS populations for the applicable services. These figures have not been adjusted to include member cost sharing.

[15] State of New Jersey, *DMAHS MLTSS Service Dictionary*. Available at: https://www.nj.gov/humanservices/dmahs/home/MLTSS_Service_Dictionary.pdf

As of March 2021, there were 368 Medicaid participating NFs in New Jersey, separated into the following groups:

327 Non-Government Facilities

8 Government–owned (County-operated) Facilities

33 SCNFs

As displayed in Table 2 below, the **average Medicaid payments per month** (including managed care and FFS enrollees) for each member residing in a NF is $5,477 for a custodial stay, $4,184 for a rehabilitative stay, and $17,775 for a SCNF stay; 95% of members are receiving custodial services in NFs.

Table 2: CY 2019 Average NF Medicaid Payments per member per month (PMPM) for MLTSS and FFS Enrollees[16]

	CY 2019		
Type of NF Stay	**Monthly Average Medicaid Expenditures**	**Average Monthly User Count**	**Average Medicaid Payments PMPM**
Custodial NF Stays	$149,923,655	27,373	$5,477
Rehabilitation NF Stays	$4,347,024	1,039	$4,184
Subtotal (Government and Private NFs)	*$154,270,678*	*28,412*	*$5,430*
SCNF Stays	$9,303,795	523	$17,775
Total	**$163,574,473**	**28,935**	**$5,653**

It is common to establish NF payment rates using actual provider costs. New Jersey based its NF rates on cost report submissions until SFY 2015 when the reports were waived for all facilities except the eight county-operated facilities. The reports were waived with the implementation of MLTSS in July 2014 and the State's intention to transition the rate development to the MCOs, but this exchange did not occur. Since then, the FFS rates have not been rebased using more recent NF costs, but NFs have received some payment increases as outlined in more detail below. While the collection of cost reports has been waived for the majority of facilities, the State continues to collect facility-reported, high-level cost data through the New Jersey Health Care Facilities Financing Authority (NJHCFFA) for monitoring purposes. Due to the limited detail in these reports coupled with other data quality concerns, these reports are not sufficient for the purposes of rebasing the NF FFS rates.

In this section, Mercer presents available information related to the State's NF rates and reimbursement methodology to evaluate NF costs and payments. Ultimately, the State's

[16] Custodial NF stays are long-term, non-specialized NF stays in both government and private facilities. Rehabilitation NF stays are short-term stays in both government and private facilities. Category of service information associated with the claims was used to identify rehabilitation from custodial stays. SCNF stays are long-term, specialized NF stays and were identified using the member's rate cell information or special program code information.

objective is to reimburse NFs fairly and adequately to maintain quality services to New Jersey's Medicaid members in NFs and support the continuum of care.

NF Reimbursement across the Country

States have flexibility in how they reimburse for NF services and most currently use a per diem payment rate, which is a daily rate paid to each facility that typically includes adjustments for case mix, peer groups, and high-needs patients. The adjustment for the patient case mix (or acuity adjustment) accounts for the relative resource intensity that would typically be associated with each patient's clinical condition identified through the resident assessment process (based on resource utilization groups). Resource utilization groups (RUGs) is a patient payment classification system traditionally used by Medicare that categorizes residents into a payment group based upon their care and resource needs to determine reimbursement levels. Medicare implemented the RUGs reimbursement methodology for NF payments in 1998.[17]

In the past, most Medicaid programs modeled their reimbursement approaches after Medicare RUGs with specific adjustments to consider the Medicaid population, each state's environment, and the provider community. In 2019, Medicare transitioned its NF reimbursement to the Patient-Driven Payment Model (PDPM). The PDPM reimburses skilled nursing facilities (SNFs) based on patient conditions and health care needs rather than the volume of services provided. Generally, the Medicaid population served in NFs is a different demographic than those served from the Medicare-only population, where Medicaid includes individuals with more complex medical needs, higher utilization of therapy services and longer lengths of stay. PDPM was designed to support the shorter lengths of stay associated with Medicare's coverage limits for SNFs and was not developed to accommodate longer-term and fluctuating therapy needs that are more common for the Medicaid population.

While many states are still using RUGs-based systems, the implementation of PDPM prompted some changes to the minimum data set (MDS), Medicare's assessment used to generate RUG scores; therefore, it may become more difficult for states to continue using a RUGs-based system in the future. Given this, states may need to evaluate whether there are components of the PDPM that can be leveraged for Medicaid if RUGs is no longer available for use, or identify other options for adjusting for patient acuity. It is not clear at this time when RUGs would no longer be feasible for use in Medicaid programs, but states are evaluating other options to transition away from a RUGs-based system.

In addition to the acuity-adjusted per diem payment rates, states may also provide one (or more) of the following payments:

Supplemental payments: Lump sum payments to NFs that are not directly linked to an individual nursing service. Payments may be based on quality.

Incentive payments: Payments of various types that are associated with performance measures or outcomes.

[17] Center for Medicare Advocacy. *Medicare Reimbursement For Skilled Nursing Facilities Remains High For 2012 Despite Reductions In Overpayments.* Aug 25, 2011. Available at: https://medicareadvocacy.org/medicare-reimbursement-for-skilled-nursing-facilities-remains-high-for-2010-despite-reductions-in-overpayments/

Reimbursement methodologies are generally grouped into two overall categories, retrospective or prospective. See Table 3 below for a comparison of the two categories.

Table 3: Comparison of Retrospective and Prospective Reimbursement Approaches

Type	Benefits	Considerations
Retrospective *Payment amount is determined after care is delivered*	• Provides reimbursement that aligns with annual costs (i.e., cost settlement) • Allows providers to tailor treatment to the patient, without limitations of fixed payment amounts	• Difficult to accurately predict Medicaid spending • Does not encourage providers to provide efficient care and may result in overuse of services or treatments
Prospective *Fixed payment determined before service is delivered*	• Allows states to manage and predict Medicaid spending • Encourages efficient care delivery • Allows states to develop programs that will create program savings	• May not reimburse for 100% of costs for each provider • Providers may reduce quality of care to increase profit

Although payment rates can be developed in different ways with different components, most states pay NFs on a per day basis (i.e., per diem rates) using a prospective approach. The prospective per diem payments can be developed as:

Cost-based: Rates are established based on each NF's reported costs.

Price-based: Rates are established based on an allowable price, typically based on the costs of a group of facilities.

Based on a 2019 Medicaid and CHIP Payment and Access Commission (MACPAC) study of states' Medicaid FFS NF payment policies.[18]

- 31 states use cost-based systems
- 15 states use price-based systems
- 5 states use a combination of cost- and price-based systems (or another approach)

While states vary in their approaches for NF payment in managed care, Pennsylvania, Delaware, and Virginia require the MCOs to pay NFs using the state plan FFS fee schedule as the minimum for all or a portion of their NFs. Massachusetts does not require the MCOs to

[18] MACPAC, *States' Medicaid FFS NF Payment Policies*. October 2019. Available at: https://www.macpac.gov/publication/nursing-facility-payment-policies/

pay based on the FFS fee schedule; however, half of the MCOs do follow the state's FFS rates for NF payment.

While allowing MCOs to develop NF reimbursement rates is an option for the State for some or all of the NFs, this approach limits the State's control and requires additional oversight to monitor payment adequacy for multiple MCOs who may contract differently with each NF. Linking managed care payments to the state plan FFS fee schedule provides a foundation for NF reimbursement, allowing the State to promote quality care and access, especially for such a vulnerable population.

Due to NF's reliance on Medicaid and Medicare payments as the primary source of revenue, as well as the high-cost of care, cost reports are the typical source of rate development information to most accurately support the cost of service delivery. Overall costs are subject to variability between providers based on:

- Variations in wage rates and benefits
- Debt and property costs, typically depend upon location, the age of the facility, and financing arrangements
- Mix of acuity and therapy services
- Quality of care, reflecting staffing ratios and staff experience/pay

States frequently review NF rates due to their relative size within the Medicaid budget, resulting in frequent changes to payments. Medicaid rates may be complicated based on all the above, reflecting layered changes over time and changing costs/program requirements.

Below are the reimbursement methodology components that we evaluate further in this report for the development of payment rates, as well as additional components that contribute to the NF rate development that are beyond the scope of this report.

NF Reimbursement Methodology Components Evaluated in this Report

- Use of cost reports
- Rebasing frequency
- Inflation adjustments
- Acuity adjustments
- Supplemental payments
- Incentive payments
- Peer groupings (e.g., limits, price basis, size, geography)

Additional NF Reimbursement Methodology Components

- Capital component (e.g., Fair Rental Value [FRV], cost, flat)
- Minimum occupancy rate (none, 80%, 85%, 90%, calculated)
- Bed holds
- New facility/change of ownership or operator rates
- Direct care reimbursement (whether or not limited, and how limit calculated)
- Pass-through components
- Special services (e.g., ventilator, head injury, AIDS, behavioral health)

History of New Jersey FFS Reimbursement Methodology

Medicaid reimbursement for NF services in New Jersey was approximately $1.8 billion in SFY 2020 and will likely increase as NF service utilization increases when the public health emergency ends.[19] The State currently sets the Medicaid FFS reimbursement rates for NFs, and the methodology is reviewed and approved by CMS before it is incorporated into the Medicaid State Plan.

To fund the non-federal share of Medicaid NF expenditures, the State utilizes a combination of the following:

- Appropriations
- NF provider tax revenues
- Certified public expenditures (CPEs)

Through the annual budgeting process, the State allocates funds to support Medicaid NF services (i.e., appropriations). The NF provider tax was signed into law on July 1, 2003[20], and is collected quarterly. The tax rate effective July 1, 2019 is $14.67 per non-Medicare day

[19] New Jersey Office of Management and Budget. *State of NJ, The Governor's FY2022 Budget, Detailed Budget*. Trenton, NJ: February 23, 2021. Available at: https://www.nj.gov/treasury/omb/publications/22budget/pdf/FY22GBM.pdf

[20] The authorizing language for the tax is available at: https://www.njleg.state.nj.us/2004/Bills/PL04/41_.HTM

generating approximately $152.8 million during SFY 2020 to support Medicaid rates.[21] Federal rules allow Medicaid providers to include the Medicaid share of the cost of the tax in their cost reports, and Medicaid reimbursement rules only recognize Medicaid's share of the tax. The Medicaid State tax rate variable used in the current NF FFS reimbursement methodology differs from the tax rate described above.

County-operated NFs fund a portion of the state share of their Medicaid payments by certifying costs identified within the facilities' cost reports (known as CPEs). For states funding Medicaid payments with CPEs, CMS requires cost reporting to identify the actual incurred costs for providing the Medicaid services — in addition, Medicaid reimbursement methodologies funded by CPEs should also tie to actual cost.

States that rely on provider funding, either through provider taxes or through CPEs or intergovernmental transfers, often must include providers in the development of reimbursement strategies as the providers seek to leverage their direct contributions to reimbursement.

Methodology from July 1, 2010 through June 30, 2013[22]

The Medicaid State Plan methodology in effect from July 1, 2010 through June 30, 2013, created a prospective, cost-based per diem using state fiscal year costs that were updated annually based on annual cost reports for Class I and Class II providers (as defined below). The State reimbursed Class II and III providers using full cost rates, settling the payments made throughout the year to the actual annual costs once cost reports were submitted. Facilities are divided into three classes:

- Class I: Voluntary and proprietary
- Class II: Governmental facilities
- Class III: SCNFs

The per diems developed for Class I and Class II are facility-specific and included the following adjustments:

- Applied separate cost caps for three individual components — direct care, indirect care, and administrative. These caps were based on a percentage of the median per diem to avoid paying for costs significantly above the Medicaid reported median.
- Applied inflation factors to adjust the cost-based per diem rates to the future contract period.
- Adjusted the direct care costs to account for the facility's average member acuity based on RUGs and electronically submitted MDS data.

[21] New Jersey Department of the Treasury. *Department of the Treasury, Division of Taxation, Notice: Nursing Home Provider Assessment: Per Diem Assessment Rate Increased to $14.67*. Trenton, NJ: March 18, 2020. Available at: https://www.state.nj.us/treasury/taxation/nursinghomeprovidernotice.shtml

[22] State of New Jersey Department of Human Services. *State Plan Under Title XIX of the Social Security Act Medical Assistance Program, Attachment 4: Payment and Rates.* Trenton, NJ: June 30, 2015. Available at: https://www.state.nj.us/humanservices/dmahs/info/state_plan/Attachment4_Payments_and_Rates.pdf

- Set the operational and administrative cost components to the median, when the value varied between Class I and Class II NFs.
- Applied facility-specific adjustments for fair rental value to account for changes in number of beds and depreciation in capital assets.
- Added a provider tax calculated pass-through to the calculated per diem.

If the calculated annual per diem exceeded the specific target legislative appropriations, the State would reduce the per diem accordingly. Rates paid to Class III facilities are cost-based and trended forward each year. The State ultimately cost settled the payments to Class II and Class III facilities once actual cost experience was available for the applicable state fiscal year. Class I facilities are paid prospective per diem payments; therefore, there is no cost settlement (as seen with retrospective payments). However, the Class I facilities were still required to submit timely and complete cost reports, and the State Plan identified penalties that could be levied for failing to submit.

Methodology as of July 1, 2013[23]

Effective July 1, 2013, the State suspended the NF annual per diem rate development activities and instead implemented annual increases for all NFs applied uniformly to the rate in effect on June 30 of the prior year (excluding the provider tax add-on). With the implementation of the MLTSS program in 2014, the expectation was that the MCOs would develop and/or negotiate payment rates with NFs. However, legislative rate increases for the FFS rates directly impacted managed care rates, as the managed care contract requires MCOs to pay according to the Medicaid State Plan, at a minimum.

In SFY 2020, the State introduced six quality metrics where NFs could earn an additional $0.60 per day for each metric if the facility achieved the performance target. The State also implemented a minimum per diem rate that was set as the floor for reimbursement. Specific to Class II providers, the State added a supplemental payment resulting in total Medicaid reimbursement at the federally defined upper payment limit (UPL) for these facilities.

In SFY 2021, the State required in P.L.2020, c.90 that NFs had to use at least 60% of the rate increase to increase wages or supplemental pay for Certified Nurse Aides (CNAs) or the funds had to be returned to the State. This rate increase was a 10% increase to the existing NF FFS rates, which was worth approximately $175 million on an annual basis. In addition, the State implemented other laws in response to COVID-19 — for example, the provision of personal protective equipment (PPE) and the implementation of certain infection control protocols. Up to 40% of the additional revenue made available to a facility through P.L.2020, c.90 may be used to support new costs a facility is incurring to meet these preparedness and response requirements. [24] To verify the use of funds, the State distributed and collected an attestation and wage schedule file to all NFs to identify the baseline wages and expected increases, along with the expenditures for other COVID-19 costs. The SFY 2021 final attestation will serve as the SFY 2022 baseline, and the SFY 2022 final attestation will serve as the SFY 2023 baseline.

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[23] State of New Jersey Department of Human Services. *State Plan Under Title XIX of the Social Security Act Medical Assistance Program, Attachment 4: Payment and Rates.* Trenton, NJ: June 30, 2015. Available at: https://www.state.nj.us/humanservices/dmahs/info/state_plan/Attachment4_Payments_and_Rates.pdf

[24] State of New Jersey Department of Human Services, *Nursing Facility Rate Increases and Reporting Presentation*. July 21, 2021. Available at: https://nj.gov/humanservices/library/slides/NF%20Rate%20Presentation%202021-07-21.pdf

Table 4 below summarizes the NF per diem rate increases for the FFS payments between SFY 2014 and SFY 2022. As displayed in the table the annual rate increases ranged from no increase in SFY 2017 to a 10% increase in SFY 2021, with varying levels of increases in the other state fiscal years.

Table 4: SFY 2014–2022 Annual Medicaid NF per diem Rate Increases[25]

SFY	Per Diem Increase	Add-ons	Quality
SFY 2014	Class III specific per diem increase only	Provider tax add-on for qualified NFs equal to tax	NA
SFY 2015	Class I and II $12.4 million per diem increase Class III 7.4% effective January 1, 2015	Provider tax add-on for qualified NFs equal to tax	NA
SFY 2016	Class I, II, and III $1.06 per diem increase	Provider tax add-on for qualified NFs equal to tax	NA
SFY 2017	No increase	Provider tax add-on for qualified NFs equal to tax	NA
SFY 2018	Class I, II, and III $1.07 per diem increase	Provider tax add-on for qualified NFs equal to tax	NA
SFY 2019	Class I, II, and III $2.13 per diem increase	Provider tax add-on for qualified NFs equal to tax	NA
SFY 2020	Class I, II, and III $3.01 per diem increase The State established a NF per diem floor rate of $188.35, inclusive of the quality care add-on	Provider tax add-on is $13.67 for qualified NFs[26]	Performance add-on $0.60 per metric for qualifying NFs
SFY 2021	Class I, II, and III receive 10% per diem increase (resulting in an average rate increase of	Provider tax add-on is $13.67 for qualified NFs	Performance add-on $0.60 per metric for qualifying NFs

[25] State of New Jersey Department of Human Services. *State Plan Under Title XIX of the Social Security Act Medical Assistance Program, Attachment 4: Payment and Rates.* Trenton, NJ: June 30, 2015. Available at: https://www.state.nj.us/humanservices/dmahs/info/state_plan/Attachment4_Payments_and_Rates.pdf

[26] Beginning in SFY 2020, the State Plan language specifically identified $13.67 per day as the tax add-on, which represented a change from the language used in previous years.

SFY	Per Diem Increase	Add-ons	Quality
	$25.56 per day across all NFs)		
SFY 2022	Class I, II, and III SFY 21 rates continue plus an additional $3.60 per diem increase	Provider tax add-on is $13.67 for qualified NFs	Performance add-on $0.60 per metric for qualifying NFs

The NF per diem FFS rates in effect for SFY 2021 (before the provider tax and performance add-ons) can vary significantly from facility-to-facility, as shown below by type of NF.[27] The MCOs are required to use the State Plan FFS fee schedules as the minimum fee schedule for NF payments in MLTSS; however, MCOs can contract with individual facilities at higher rates. It is Mercer's understanding that there are only few instances where an MCO chooses to contract at higher rates and generally contract at the required minimum of the State Plan FFS fee schedule. The State can engage in policy discussions with stakeholders regarding the MCO contract requirements.

Medicaid Provider NFs	County-operated Facilities	SCNFs
$210.62 to $311.48 (Base per diem range)	$226.69 to $297.71 (Base per diem range)	$340.01 to $946.51 (Base per diem range)

Considerations for NF Reimbursement in New Jersey

New Jersey will need to evaluate its methodology to develop future NF per diem rates that address recent reimbursement concerns and/or legislative requirements. Involving stakeholders, such as the NF providers and NF Association, early in the process will be useful to New Jersey as they can provide meaningful input on various aspects of the reimbursement methodology. Additional characteristics for further exploration are detailed below.

Data to Collect and Evaluate NF Costs

As previously described, most states reimburse NFs on a per diem basis using a cost-based system. Cost reports are typically used as the primary data source to determine NF per diem rates. The State has waived the cost report requirements for all NFs except for the eight county-operated facilities since SFY 2015 and has only collected high-level cost reports through NJHCFFA for the rest of the facilities that do not provide the adequate detail to rebase the rates. For the State to implement a cost-based reimbursement methodology, collecting

[27] State of New Jersey Department of Human Services. *Nursing Home Rates (LTC) FY2021.* Trenton NJ: 2020. Available at: https://www.njmmis.com/hospitalinfo.aspx

recent Medicaid cost information will be necessary **to establish a baseline of current cost levels for NF services**. The general options for identification of costs are as follows:

- **Most Accurate:** Request and obtain Medicaid cost reports from all State NFs, including custodial/rehabilitation facilities, county-operated facilities, and SCNFs.
- **Alternative/Temporary Options:** These options will not provide the level of detail or validation that is needed to be a reliable option for rebasing the NF FFS rates; however, these could be used in the interim while more detailed cost reports are being collected.
  - Evaluate the most recent cost reports collected from the eight county-operated NFs to extrapolate costs for the other State NFs (note that this will be an estimate only).
  - Expand the quarterly **NF-1** form to request more detail from each facility regarding the Medicaid-specific revenues and expenses. Currently, this form collects data for all NF residents to determine the overall **health** of the facility. The State could consider using this form to get high-level statistics regarding total Medicaid expenses and total Medicaid expenditures for each facility, as the facilities are familiar with this routine reporting structure. As an example, this form could be expanded to request additional cost-related items such as payroll, nursing supplies, and raw food expenses.

Rebasing Frequency

The rate development process typically begins with selecting the primary data source that will be relied upon and adjusted to project expected costs for a future contract period. Rebasing is the comprehensive exercise of entirely developing new rates using more recent data as the primary source (i.e., “base”), rather than simply applying adjustments to previously developed rates. The frequency the rates are rebased can vary depending on State priorities, available resources, policy changes, or other factors that influence direct care costs.

Based on the 2019 MACPAC study, 15 state Medicaid programs rebase NF per diem rates every two-to-four years and 21 states annually rebase the rates[28]. States that use a cost settlement NF reimbursement approach may also elect to rebase less frequently because the actual incurred costs are eventually reconciled with the prospectively developed rates. Establishing a consistent pattern of rebasing on a two-to-four year schedule, with interim rate adjustments between rebasing years, allows the State to balance administrative limitations with providing appropriate reimbursement to facilities. In addition, other components of the reimbursement methodology would influence rate changes in between rebasing years, such as acuity adjustments, and states can include other policies to account for other cost changes that may occur in between periods.

Similar to many other states, New Jersey could elect for less frequent rebasing (e.g., every two-to-four years) with interim adjustments to account for inflation or cost of living changes and any other pertinent cost factors such as changes in underlying patient acuity. This approach maintains reimbursement based on reasonably recent NF costs, but balances the administrative effort and other considerations. There are advantages and considerations to both approaches and each state must weigh the options to implement the best approach for each respective program.

[28] MACPAC, *States’ Medicaid FFS NF Payment Policies*. October 2019. Available at: https://www.macpac.gov/publication/nursing-facility-payment-policies/

Oftentimes NF regulation or policy changes can necessitate per diem rates rebasing as a result of requiring changes in operations or service provision. However, rebasing can occur less frequently when regulations remain unchanged for several years. It may take several years for regulatory changes to appear within the costs on a cost report. The timing of these changes should be considered when determining the next planned NF per diem rebase.

Member Acuity

One of the many challenges in NF reimbursement design is ensuring equitable distribution of funds across providers based on resident health status. Direct care costs vary depending on the underlying needs and conditions of NF residents. Within the payment methodology, it is important to create an incentive for NFs to admit higher needs members by accounting for their acuity and acknowledging their heightened costs. Including this component in the methodology will reward NFs based on performance and efficient care, rather than for admitting patients with less complex medical needs. Otherwise, members with complex medical needs may be unable to retain access to critical health care services. This issue is also particularly important as states rebalance their LTC systems, because many lower-acuity members may be more likely to be able to be served in the community, increasing the average acuity of members in NFs over time.

There are a variety of methods to consider acuity differences within reimbursement strategies, some states have special arrangements for higher need subpopulations (e.g., members on ventilators or with Alzheimer's or Dementia) by:

- Developing separate rates for these population groups.
- Establishing an add-on payment to the base per diem.
- Providing supplemental payments.

Some states have taken a broader approach by evaluating each member's acuity using Medicare's RUGs methodology that classifies members into different groups based on the NF assessment responses. NFs are then paid a per diem rate that reflects the underlying acuity (risk) of their residents. Massachusetts developed its own approach to evaluate acuity (rather than use RUGs) by estimating the management minutes required to support different activities of daily living (ADL) and other functional needs for NF residents. The rate paid to the NFs vary based on the estimated differences in the overall management minutes required to care for the members.

As Medicare has transitioned from RUGs to a PDPM-based NF reimbursement, several states (Illinois, Virginia, West Virginia, and Tennessee) have begun collecting data to compare the two acuity methods. In the meantime, these states continue to make NF payments based on RUGs, but will reevaluate their approach in the upcoming years.

As part of the NF reimbursement methodology evaluation, Mercer recommends a feasibility study of the various acuity tools (e.g., RUGs, PDPM, or state-specific case mix) to identify the necessary assessment data that would need to be obtained in addition to the advantages and considerations for each acuity model, specifically for New Jersey's NF population. Regardless of the reimbursement methodology selected, the State should collect NF resident assessment data, such as the information in the MDS or the New Jersey Choice assessment, but the appropriate data source and any modifications would be further explored in the feasibility study.

Options to Evaluate the Impact of NF Regulatory Changes

In fiscal year 2021, Governor Murphy's administration and the legislature worked together on a package of NF laws to address the impact of COVID-19. Along with new standards, these laws also recognized that new funding was necessary to build and sustain quality care, including a long-term workforce.

An increase to NF reimbursement is planned to support the several laws mandating new facility standards, including:

- Minimum wage levels for CNAs (P.L.2020, c.89)
- Required staffing ratios (P.L.2020, c.112)
- Stockpiling of PPE (P.L.2020, c.135)
- Additional COVID-19 reporting and testing requirements as stated in the CARES Act

Labor Cost Impact – Minimum Wage

Effective November 1, 2020, CNAs are required to be paid at a minimum rate $3.00 higher than the minimum hourly wage set at N.J.S.A. 34:11-56a4(a). Therefore, the January 1, 2021, minimum hourly wage of $12.00 required CNAs to be at a minimum of a $15.00 hourly wage[29].

The May 2020, US Bureau of Labor Statistics for New Jersey showed a median hourly wage at $15.42 and the mean hourly wage at $15.88 for nursing assistants.[30] While these figures are above the $15.00 new minimum wage, the following factors may further influence NF costs associated with these minimum wage requirements:

- Disproportionate cost impact to lower economic geographic areas.
- Cost pressure to compete with other direct care workers in similar service areas.
- Cost pressure to increase wages for other NF workers such as dietary and environmental services.

Labor Cost and Reporting Impact – Minimum Staffing Ratios

Currently all Medicare and Medicaid certified SNFs submit Payroll Based Journal (PBJ) staffing reports on a quarterly basis to CMS that depict Registered Nurse (RN), Licensed Practical Nurse (LPN), and Nursing Assistant hours on a per member per day basis. While the State can leverage this existing CMS Care Compare data site for collecting daily total direct care hours, P.L.2020, c.112 (approved on October 23, 2020) requires one direct care staff member per eight residents for the day shift, one to every 10 residents for the evening shift, and one to every 14 residents for the night shift.[31]

[29] State of New Jersey Legislature. *Second Reprint, Assembly, No. 4482.* Trenton, NJ: July 30, 2020. Available at: https://www.njleg.state.nj.us/2020/Bills/A4500/4482_R2.PDF

[30] U.S. Bureau of Labor Statistics. *Occupational Employment and Wage Statistics.* March 31, 2021. Available at: https://www.bls.gov/oes/current/oes_nj.htm#31-0000

[31] U.S. Centers for Medicare and Medicaid Services. *Find & Compare Nursing Homes, Hospitals & Other Providers Near You.* Available at: https://www.medicare.gov/care-compare/

To address the mandated ratio of direct care workers to NF residents, which will likely impact NF costs also, the State should consider the following:

- Direct care staffing ratios have not been collected historically from the NFs.
- To monitor NF compliance with this regulation, the State should create a new report to capture direct care staffing ratios along with each cost report, where the time periods for the two sets of reports align.
- A potential ongoing reporting option might include adapting form **NF-1** of LTC Facility Quarterly Financial Data to incorporate staffing ratio reporting.

As it will take several years for this new regulation to be inherent within the NF cost reports, the impact of this change on NF costs should initially be evaluated by comparing historical staffing ratios to the new required levels.

Methods to Reward for Delivery of High Quality of Care

There are many different ways to approach awarding quality in NF per diem rate setting. It is important to evaluate State and legislative priorities to establish impactful measures, assess progress, determine compliance, and set benchmarks in designing the reward structure.

The State is conducting an internal review of the Quality Incentive Payment Program (QIPP) among State subject matter experts and stakeholders. The State's future reimbursement methodology proposals will seek to build a larger share of NF payments into incentive-based compensation. This should include reviewing the framework of the current quality of care add-on that increases per diem reimbursement by $0.60 for each of six performance metrics achieved, in addition to how these increases are currently funded through the provider tax structure.

The enhancement of the quality incentive model will be resource intensive to develop and should be considered along with the planned NF cost rebasing work; specifically, what portion of the overall NF reimbursement should be only awarded through incentive-based compensation.

The Health Care Payment Learning and Action Network Alternative Payment Model Framework is a widely used categorization of models that organize reimbursement arrangements along a continuum of increasing risk.[32] This model ranges from *Category 1: FFS no link to quality and value* to *Category 4: population-based payment*. Some examples of models to reward delivery of high value care include:

- Health Care Quality Surcharge: Includes a directed payment for the MCOs to pay for NF performance on established quality measures.
- Pay for Performance: Bonuses for achieving established quality performance.
- Pay for Reporting: Bonuses for reporting data or penalties for not reporting data.

[32] Alternative Payment Models. *The APM Framework.* Available at: http://hcp-lan.org/workproducts/apm-framework-onepager.pdf

- Value-Based Purchasing: Requirements placed on MCOs[33] that reinforce value based contracting across providers, and used to achieve a certain percentage of payments tied to NFs.
- Differential Adjusted Payment: Increases to per diem rates for NFs that achieve defined quality measures (similar to the State's current QIPP).

Quality measures are used across methods to reward for delivery of high quality care to translate policy objectives into measureable outcomes. A well-curated set of program quality measures balance program priorities, feasibility, and administrative complexity to determine whether a given program is progressing towards strategic goals. In a review of research guidance, the Agency for Healthcare Research and Quality suggests that states think through the following questions when choosing quality measures.[34]

- Does the measure support the quality goal(s)?
- Does the measure improve accountability?
- Do consumers view the measure as important?
- Is the measure relevant to the intended audience?

General Reimbursement Methodologies for Consideration

Based on Mercer's review of Medicaid NF reimbursement methodologies used across the country, New Jersey's current environment, and the available approaches that may be most appropriate for State Medicaid programs, Table 5 outlines three high-level reimbursement design options for consideration. The first option, facility-specific rates under a prospective methodology, is consistent with the approach the State used prior to SFY 2014. Ultimately, all methods should be reviewed through the lens of supporting quality service provision and balancing fiscal stewardship.

[33] Medicaid Managed Care Contracts as Instruments of Payment Reform. Available at: https://www.catalyze.org/wp-content/uploads/woocommerce_uploads/2019/12/Medicaid-MCOs-as-Agents-of-Payment-Reform-1.pdf

[34] Key Questions When Choosing Health Care Quality Measures. Available at: https://www.ahrq.gov/talkingquality/measures/measure-questions.html

Table 5: Overview of Three High-Level Reimbursement Design Options for Consideration

Method	Description	Key Characteristics	Advantages	Considerations
Prospective Rate Methodologies				
Facility-Specific Rates Medicaid programs using this approach[35]: • Benchmark states: Connecticut and Tennessee • 29 other state programs (including New Jersey)	Per diem rates developed using NF cost reports, where the rates paid are unique to each facility based on reported costs. This approach can include peer groups, with varying criteria for each (e.g., different "floors" or "ceilings").	Option to incorporate "ceilings" and "floors" for the cost components of the rate: • The reported costs are adjusted by predetermined ceiling amounts to avoid paying rates based on excessive costs. • Implement a cost "floor" to avoid paying a rate that is lower than deemed appropriate. When determining the ceiling and/or floor amounts, NFs with similar characteristics are combined and the results vary by peer group.	• Prospective payment rates give states the ability to project expenditures. • Incentivizes facilities to be more efficient as each year's costs are not paid (i.e., cost settled). • Not necessary to rebase annually, states typically rebase every two-to-four years with inflation adjustments in between. • Able to set payment rates specific to each facility's historical costs (within certain bounds). This approach could be designed to be budget neutral. • Use of "floors" and "ceilings" gives states the ability to have a level of control NF expenditures.	• Requires collection and validation of submitted cost reports. • Requires design and development of the methodology and payment rates.

[35] States' Medicaid FFS NF Payment Policies. MACPAC, October 2019. Available at: https://www.macpac.gov/publication/nursing-facility-payment-policies/

Method	Description	Key Characteristics	Advantages	Considerations
Peer Group Rates Medicaid programs using this approach[36]: • Benchmark states: Massachusetts and New York • 13 other programs	Per diems rates based on an allowable price, typically based on a percentage of the median cost or an average using NF cost reports.	The state determines the "allowable price" for each peer group based on cost analysis.	• Prospective payment rates give states the ability to project expenditures. • Incentivizes facilities to be more efficient as each year's costs are not paid (i.e., cost settled). • Not necessary to rebase annually, states typically rebase every two-to-four years with inflation adjustments in between. • May require additional considerations for outlier policies to accommodate facilities with special circumstances and costs well above the allowable price.	• More winners/losers since the payment for all facilities within a group is based on the same allowable price, which may be above or below the facility's actual costs • Requires external vendor to collect, aggregate and validate submitted cost reports. • Requires external vendor to design and develop the methodology and payment rates.
Retrospective Rate Methodology				
Cost Settlement Used in New Jersey for county-operated NFs and SCNFs in	Compare the prospective rates to actual NF costs and make a cost settlement adjustment that can increase or decrease the payments to the NFs.	Allows NFs to be reimbursed at full cost.	• NFs recoup all expended costs for delivered services.	• Cost settlement occurs after the completion of the year and once cost report is available (i.e., settlement lag). • NFs receive an interim per diem payment

[36] States' Medicaid FFS NF Payment Policies. MACPAC, October 2019. Available at: https://www.macpac.gov/publication/nursing-facility-payment-policies/

Method	Description	Key Characteristics	Advantages	Considerations
SFY 2011– SFY 2013[37]				throughout the year, typically based on a previous year's costs.

[37] State of New Jersey Department of Human Services. *State Plan Under Title XIX of the Social Security Act Medical Assistance Program, Attachment 4: Payment and Rates.* Trenton, NJ: June 30, 2015. Available at: https://www.state.nj.us/humanservices/dmahs/info/state_plan/Attachment4_Payments_and_Rates.pdf

Summary of NF Rate and Reimbursement Recommendations

Although the State previously had a detailed, cost-based NF reimbursement methodology in place before SFY 2014, it has become outdated and no longer linked to current facility cost levels. To evaluate the current NF payment rates, adjust them appropriately to adequately cover the costs of service delivery, and obtain necessary approvals from the State legislature and CMS, it is critical to allow sufficient time and will require a multi-year process.

Based on the information presented and the considerations outlined above, Mercer recommends that the State start this process by establishing a framework that includes assessing member needs, collecting current cost data, and conducting a detailed analysis of costs and payments to inform program decisions. The next step would then be to finalize the framework, design the reimbursement methodology and develop rebased payment rates, obtain input from necessary stakeholders and approval from CMS, and lastly to implement the rebased nursing facility rates.

Mercer provides recommendations for the specific activities that the State pursue over multiple years to result in stable, cost-based NF FFS rates that could also be used as the basis for payments in managed care. Regardless of the FFS reimbursement methodology that the State selects (i.e., prospective or retrospective), we suggest that the State collect recent data and use the outlined process as a guide. This is one option for a general timeline that can be followed, but would need to be refined as part of the framework development. A factor that will impact the timeline is whether the State needs to contract with an external vendor to facilitate any steps in the process.

Year 1: Conduct planning activities to develop a framework for assessing individuals' needs and evaluating costs versus reimbursement

In Year 1 of this plan, identify and outline the steps in a formal framework that will serve as a guide to the State for the NF reimbursement methodology evaluation. Activities may include the following:

- **Develop a NF reimbursement framework.** Identify the key steps and associated timeline to reinstate a cost-based reimbursement methodology for the States NF FFS payment rates, which could be linked to managed care payments. This would include activities that address the entire process of a reimbursement update such as data collection, analysis of data, evaluation of program components and State decisions, stakeholder outreach activities, identification of operational needs including staffing resources, state regulation updates, public notice and submission and approval of a SPA.
- **Engage stakeholders.** Initiate communications with stakeholders — particularly providers to facilitate data collection and rate development. This would include developing a communications plan to outline the goals of the NF reimbursement framework and potentially obtain input from key stakeholders.
- **Collect NF cost data.** Begin to request and obtain cost reports from each NF to determine the baseline of current NF costs and evaluate the various reimbursement components

(e.g., peer groups). This may require contracting with an external vendor for cost report collection and analysis.

- **Assess NF member acuity.** Conduct a study to evaluate member acuity tools and collect the required member assessment data, which could include the MDS information. Based on current environment, it may be most practical to resume the RUGs-based approach to determine acuity differences amongst NFs.

Year 2: Finalize planning and initiate implementation activities

In Year 2 of the plan, finalize the framework developed in Year 1 based on discussions with State staff and leadership. This includes any required contracted vendors and staff resources required to assist in the implementation of any activities. Year 2 items may include the following:

- **Finalize the NF reimbursement framework.** Confirm the proposed framework with State staff and leadership to obtain buy-in to the process and timeline. Begin developing the language for the SPA, as well as the State administrative code. Obtain legislative and/or CMS approval as needed to meet all statutory and regulatory requirements.
- **Conduct initial reimbursement activities.** While some activities may begin in Year 1, Mercer anticipates that many of the study activities would occur after recent data is collected and discussions have occurred with the appropriate parties at the State. Year 2 would include the detailed analysis of costs and payments, evaluation of the various reimbursement components, (e.g., peer groups, acuity adjustments, and quality incentives) and options associated with each one. Further review of related quality programs, such as the QIPP would likely occur in Year 2 as well.
- **Evaluate and identify the components for the NF reimbursement methodology.** The State will review the options and decide on the key components of the FFS reimbursement methodology, such as an acuity tool, quality incentive payments and the frequency for rebasing.
- **Continue stakeholder communications.** Schedule meetings with various stakeholder groups to present the proposed reimbursement methodology, including the components being considered and planned timing for implementation. Stakeholder groups will likely include providers, beneficiaries, MCOs, NF association, and the Legislature along with any others identified by the State.
- **Finalize the rebased NF FFS rates.** Confirm all NF rate calculations and revised payment rates.

Year 3: Implementation of rebased NF rates and rebalancing activities

In Year 3, the State will implement the rebased NF rates. The pace of the earlier steps will influence the timing in which this occurs. For example, some of the steps below may occur at the end of Year 2 or during Year 3.

- **Release public notice of rebased NF FFS payment rates.** Publish the public notice of the rebased FFS rates for public comment.
- **Update State administrative code and submit SPA to CMS for approval of NF reimbursement methodology.** Finalize the language for the SPA, as well as the State administrative code, to reflect the updates to the NF rate methodology. Submit the SPA to CMS and obtain approval.
- **Notify the MCOs of rebased NF FFS rates and any change in requirements in managed care.** If the State chooses to incorporate the rates differently from how they are linked to FFS today (i.e., serve as the minimum per diems), an adjustment to the directed payment may be required.
- **Implement the rebased NF FFS payment rates.**
- **Continue to evaluate quality payments and explore opportunities to enhance services along the long-term services continuum.** The State can also review ways to use quality payments to support transition to community-based settings as appropriate for the individual.

Year 4: Conduct monitoring and refinement activities

Year 4 of the process will focus on State oversight and monitoring activities to confirm that the rebased NF rates are operating as expected and allow adjustments to the methodology or systems as needed. Some items may include:

- **Monitor implementation of rebased NF FFS payment rates.** Review initial experience with rebased NF rates to identify any operational adjustments, system issues, or other unintended results.
- **Continue stakeholder communications.**
- **Anticipate to rebase on a 2-4 year timeline.**
- **Evaluate and refine the system as needed.**

As noted throughout this section of recommendations, these are high-level steps and timing in which they may occur. Through the framework development in Year 1, the State will have flexibility to set the timeline based on other influencing factors, such as available budget, staff availability and possible procurement of a vendor.

Section 3
HCBS

Community-Based LTSS Services in New Jersey

Historically, state Medicaid programs relied on institutional settings such as NFs to provide LTSS. However, over the past two decades, New Jersey, like other states, has focused on expanding the LTSS continuum of care with a focus to expanding the availability of non-institutional community-based LTSS. This evolution is particularly important given the population growth and that community-based LTSS are often the preferred option for members and their families who are most often interested in the least restrictive setting.

Some typical LTSS are provided under the New Jersey Medicaid State Plan and are available to all community dwelling NJFC members who demonstrate a medical need for the service. HCBS waiver services are available to NJFC members who live in the community, meet nursing facility level of care (NFLOC), and are enrolled in the State's MLTSS program.

To meet the NFLOC, members must be assessed to require hands-on assistance with several ADLs, such as bathing, dressing, toilet use, transfer, locomotion, and eating. Individuals with cognitive deficits must be assessed to require supervision with several ADLs.

Community-Based Alternatives to NF Care

In New Jersey, there are a number of LTSS available to Medicaid members as part of the broader LTSS continuum of care. These services support individuals' desire to live in the community for as long as possible.

This section of the report provides information about key alternative community-based LTSS services and describes promising initiatives in other states that provide similar services. Considerations for potential enhancements to the State's current community-based LTSS services are included.

References to the ARP of 2021 are made throughout this section. Through the ARP, states were given an opportunity to submit a plan to the federal government in order to receive a 10% increase in their Federal Medical Assistance Percentage (FMAP) for qualifying HCBS services, with the additional funding to be used for enhancing HCBS services. New Jersey, like other states, submitted an initial plan outlining how the State intends to utilize the additional funds. This plan is commonly referred to as the **HCBS Spending Plan**.

To identify promising initiatives supporting community-based LTSS, states with high quality, innovative HCBS programs were researched. Connecticut, Massachusetts, New York, and Tennessee were selected using the following resources:

- AARP Public Policy Institute LTSS Scorecard, which provides a broad view of LTSS across states, in which each state is ranked across a variety of domains.[38]
- Mathematica LTSS Expenditure Report uses state-provided expenditures data to calculate percentage of state LTSS expenditures paid towards HCBS.[39]
- Discussion with New Jersey Division of Aging Services and Division of Medical Assistance and Health Services staff.

Table 6 outlines utilization for the selected alternative community-based services for this study that have the greatest opportunity to further provide access to and develop a high-quality community-based portion of the LTSS continuum of care.

Table 6: New Jersey Alternative LTSS Services Expenditures

Service Category	Total CY 2019 Expenditures
Personal Care Assistant	$513,100,000
Self-Directed Personal Care Assistant (Self-Direction)	$230,700,000
Medical Day Care	$308,500,000
Private Duty Nursing	$134,300,000
Assisted Living	$64,600,000
Caregiver Supports (Training and Respite)	$3,100,000
Residential Modification	$1,300,000
Social Adult Day Care	$500,000
Adult Family Care	$200,000

Source: Mercer's analysis using CY 2019 (pre-pandemic) encounter and FFS eligibility data on an incurred basis for MLTSS and non-MLTSS populations for the applicable services. **Note:** Expenditures exclude member cost sharing contributions and have been rounded to the nearest $100,000.

Alternative Community Services Evaluation

The following section focuses on an evaluation of selected alternative community services that could be used to bolster the LTC continuum of care in New Jersey.

[38] Reinhard, Susan, Ari Houser, Kathleen Ujvari, Claudio Gualtieri, Rodney Harrell, Paul Lingamfelter, and Julia Alexis. *Long-Term Services and Supports State Scorecard 2020 Edition: Advancing Action: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers.* Washington, DC: AARP Foundation, the Commonwealth Fund, and the Scan Foundation, 2020. Available at: https://www.longtermscorecard.org/2020-scorecard/preface

[39] Murray, Caitlin, Alena Tourtellotte, Debra Lipson, and Andrea Wysocki. *Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Years 2017 and 2018.* Chicago, IL: Mathematica, January 7, 2021. Available at: https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures-2017-2018.pdf

Each service-specific section evaluates the State's services in comparison to similar services offered in other selected states (Connecticut, Massachusetts, New York, and Tennessee). Each service-specific section also provides details into proposed opportunities for the State to consider that could strengthen the service and the program overall.

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Assisted Living (AL) Facility Services

AL services are personal care and health-related services, available 24 hours per day, including medication oversight and administration, support for ADLs, and social activities. Residents typically need supportive care because they can no longer live safely in the community, but do not require 24-hour care and monitoring. Medicaid does not cover room and board. These are HCBS and are only available to MLTSS members.[40]

The State recognizes the important role of ALs in supporting members to remain living in the community and has received approval to utilize ARP funds to increase the per diem rate paid to AL facilities to $87.00.[41] This was also legislatively passed in P.L. 2021, c.133 (State appropriations legislation for FY2021–2022 codified June 29, 2021).

The State currently requires 10% of all AL facility beds be made available to Medicaid members and received approval to utilize ARP funds to create an AL tiered rate incentive where AL facilities that take on a higher percentage of Medicaid beneficiaries are rewarded with higher daily rates. This approach could provide increased access to AL services for MLTSS members.[42]

Key Highlights In Other States

Massachusetts has a Moving Forward Plan (MFP) waiver program that focuses on transitioning members out of NFs, and allows members who require supervision and staffing seven days per week to access these services in an AL facility. Additionally, Massachusetts has a specific (higher) Optional State Supplement (OSS) payment level for those in AL facilities, which helps them pay room and board costs that are not covered by Medicaid. Massachusetts residents may be eligible for the OSS even if their income exceeds Supplemental Security Income limits.[43]

When compared to New Jersey, other surveyed states typically pay higher per diems on average for AL facility stays. Currently, New Jersey reimburses on average an $82.85 per diem. Even with the potential increase to $87.00 per diem, the other selected states' average per diem reimbursements are higher:

[40] State of New Jersey, Department of Human Services. *MLTSS Service Dictionary*. Available at: https://www.nj.gov/humanservices/dmahs/home/MLTSS_Service_Dictionary.pdf

[41] State of New Jersey, Department of Human Services. *Home and Community-based Services Enhanced FMAP Spending Plan.* July 12, 2021. Available at: https://nj.gov/humanservices/assets/slices/NJHCBSspending.pdf

[42] *ibid*

[43] Massachusetts Executive Office of Health and Human Services. *Moving Forward Plan (MFP) Waivers*. Boston, MA. Available at: https://www.mass.gov/info-details/moving-forward-plan-mfp-waivers

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- In Connecticut, the average per diem is $93.00, but can range to be as high as $140.91 depending on the facility.[44]
- In Massachusetts, the average per diem is $104.53.[45]
- In New York, the average per diem is $94.92.[46]

Opportunities

The State could consider options to bolster this service in New Jersey, including:

- Examine additional opportunities for increasing the AL per diem.
- Evaluate opportunities to increase the OSS payment level for those in AL facilities.
- Continue to explore ways to incentivize ALs to accept more Medicaid members.

Caregiver Supports (Training and Respite)

Caregiver supports consist of caregiver/participant training and respite services. These supports are HCBS services and are only available to MLTSS members.

Caregiver/participant training is instruction provided to a client and/or caregiver in either a one-to-one or a group situation to teach a variety of skills necessary for independent living. These skills include, but are not limited to, coping skills to assist the individual in dealing with disability, coping skills for the caretakers to deal with supporting someone with LTC needs, and skills to deal with care providers and attendants.[47]

Respite services are provided to participants unable to care for themselves that are furnished on a short-term basis, because of the absence or need for relief of an unpaid informal caregiver (those persons who normally provide unpaid care) for the participant.[48]

Caregiver supports are key to maintaining community tenure and diverting or delaying NF placement. Based on expenditure data it appears utilization of caregiver supports in New Jersey is low relative to other services.

As part of its NJFC Comprehensive Demonstration 1115 waiver renewal, the State has proposed new caregiver respite and support services by adding a NH diversion service that increases caregiver respite services from 30 to 90 days per year, and provides caregiver counseling services and additional nutritional supports such as a one-time pantry stocking for individuals who transition from an institution back to the community.[49]

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[44] Connecticut Department of Social Services. *Residential Care Homes (RHC) Fees/Payments*. Hartford, CT. Available at: https://portal.ct.gov/DSS/Health-And-Home-Care/Long-Term-Care/Residential-Care-Homes-RCH/Fees

[45] Massachusetts Executive Office of Health and Human Services. *RATES FOR HOME AND COMMUNITY-BASED SERVICES WAIVERS.* Boston, MA: February 16, 2021. Available at: https://www.mass.gov/doc/rates-for-home-and-community-based-services-waivers-effective-april-1-2020-june-1-2020-july-1-2020-and-january-1-2021-0/download

[46] New York State Department of Health. *January 1, 2020 Minimum Wage Rate Schedule*. Albany, NY. Available at: https://www.mass.gov/info-details/moving-forward-plan-mfp-waivers

[47] State of New Jersey, Department of Human Services. *MLTSS Service Dictionary*. Available at: https://www.nj.gov/humanservices/dmahs/home/MLTSS_Service_Dictionary.pdf

[48] *ibid*

[49] State of New Jersey, Department of Human Services. *NJ FamilyCare Comprehensive Demonstration-Draft Renewal Proposal.* September 10, 2021. Available at: https://www.state.nj.us/humanservices/dmahs/home/1115_NJFamilyCare_Comprehensive_Demonstration_Draft_Proposal.pdf

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Key Highlights In Other States

Tennessee requires an annual assessment (or more frequently if there is a change in member status) of the family members providing services to the member to determine the willingness and ability of the family members to contribute effectively to the needs of the member. Caregiver stress is also among the areas evaluated.[50]

Massachusetts[51], Connecticut[52], and Tennessee[53] have all requested approval in their HCBS Spending Plan to support caregiver support initiatives intended to stabilize and support caregivers and prevent burnout, which puts community tenure at risk. Initiatives include expanding access to respite care, providing mental health supports to caregivers, and offering additional funds to family caregivers to purchase respite care, adult day health services, assistive technology, adaptive equipment, and minor home modifications.

Opportunities

The State could evaluate opportunities to further support this service in New Jersey, including:

- Identifying caregivers in need of respite and support services by adding a requirement for MCO care managers to complete an assessment of caregiver strengths, stressors and needs, similar to the approach used in Tennessee. The State could leverage caregiver assessments utilized in other states as well as other nationally recognized assessments.
- Examining how MCOs can increase member and caregiver awareness of caregiver respite, support services, and develop outcome measures for utilization of these services.
- Piloting additional caregiver supports to assess the costs, benefits, and impacts on the program without committing ongoing funding for services that may not resonate with New Jersey caregivers.

Residential Modifications

Residential modifications are physical modifications/adaptations to a member's private primary residence required by his/her plan of care, which are necessary to ensure the health, welfare, and safety of the member, or enable him/her to function with greater independence in the home or community without which the member would require institutionalization.[54]

Home modifications are growing in popularity to facilitate aging in place and a survey of older adults found that two-thirds of respondents who made modifications to their homes believed

[50] State of Tennessee, Department of TennCare. Amendment Number 14--*Statewide Contract Between The State of Tennessee, d.b.a. TennCare and UnitedHealthcare Plan of the River Valley, Inc.* Nashville: TN. Available at: https://www.tn.gov/content/dam/tn/tenncare/documents2/UnitedHealthcareCommunityPlan.pdf

[51] Massachusetts Executive Office of Health and Human Services. *Massachusetts Home and Community-Based Services (HCBS) Spending Plan*. Boston, MA: June 17, 2021. Available at: https://www.medicaid.gov/media/file/ma-arpa-hcbs-spending-plan-initial.pdf

[52] State of Connecticut Department of Social Services. *Spending Plan for Implementation of the American Rescue Plan Act of 2021, Section 9817*. July 12, 2021. Available at: https://www.medicaid.gov/media/file/ct-arpspending-plan0.pdf

[53] State of Tennessee Division of TennCare. *Initial HCBS Spending Plan Project and Narrative*. Nashville, TN: September 15, 2021. Available at: https://www.medicaid.gov/media/file/tn-initial-plan-for-arp-enhanced-hcbs.pdf

[54] State of New Jersey, Department of Human services. *MLTSS Service Dictionary*. Available at: https://www.nj.gov/humanservices/dmahs/home/MLTSS_Service_Dictionary.pdf

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the adjustments would allow them to remain in their home longer than if they had not made the modifications.[55]

Home modifications are an essential element to supporting caregivers and members to maintain community tenure. Examples of common home modifications include ramps to allow for egress from the home, bathroom grab bars, and lifts used to move members from bed to chair. This is an HCBS and is only available to MLTSS members in New Jersey. While modifications to individual homes can help older adults live more comfortably, they are not always sufficient in supporting an older adult in remaining independent. These modifications should be considered with other social service supports.[56]

Currently, New Jersey limits residential modifications to $5,000 per calendar year, $10,000 lifetime. The State does allow MCOs to provide residential modifications as an *In Lieu of Services,* although it is unclear how frequently MCOs do.[57]

Key Highlights In Other States

New York includes adaptations to the home, which are considered necessary to ensure the health, welfare, and safety of the member and includes vehicle modifications. There is a process for approving/starting home (and vehicle) modifications prior to a waiver participant moving or returning to the community from an institution, designed to facilitate safe and effective transitions.[58]

Massachusetts covers additional assistive technologies such as special equipment for washroom and adaptive lighting (resources for both technologies and modifications).[59]

Massachusetts ($50,000 per lifetime)[60], Connecticut (no limit)[61], Tennessee ($6,000 per project, $10,000 per year and $20,000 per lifetime)[62], and New York ($15,000 per year)[63] all have higher calendar year limits than New Jersey. New York and Connecticut do not have lifetime limits.

Opportunities

[55] Maisel, Jordana, Eleanor Smith, and Edward Steinfeld. Increasing Home Access: Designing for Visitability. Washington, DC: AARP Public Policy Institute, August 2008.

[56] AARP Public Policy Institute. Home Modifications to Promote Independent Living. Washington, DC: Fact Sheet 168, March 2010. Available at: https://assets.aarp.org/rgcenter/ppi/liv-com/fs168-home-modifications.pdf.

[57] State of New Jersey, Department of Human services. *MLTSS Service Dictionary.* Available at: https://www.nj.gov/humanservices/dmahs/home/MLTSS_Service_Dictionary.pdf

[58] New York State Department of Health. *Environmental Modifications Services (E-mods)*. Albany, NY: September 2008. Available at: https://www.health.ny.gov/facilities/long_term_care/waiver/nhtd_manual/section_06/e-mods.htm#emods_def

[59] Massachusetts Executive Office of Health and Human Services. *Attachment A—Waiver Service Definitions*. Boston, MA. Available at: https://www.mass.gov/doc/attachment-a-waiver-service-definitions/download

[60] Massachusetts Executive Office of Health and Human Services. *ABI-MFP Participant Handbook*. Boston, MA. Available at: https://www.mass.gov/doc/abi-mfp-participant-handbook/download

[61] State of Connecticut Department of Social Services. *CT HCBS for Elders (0140.R07.00).* Hartford, CT: June 1, 2020. Available at: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81201

[62] State of Tennessee Division of TennCare. *TennCare III Medicaid Section 1115 Demonstration.* Nashville, TN: January 8, 2021. Available at: https://www.tn.gov/content/dam/tn/tenncare/documents/tenncarewaiver.pdf

[63] New York State Department of Health. *Application for a 1915(c) Home and Community-Based Services Waiver.* Albany, NY: July 1, 2021. Available at: https://opwdd.ny.gov/system/files/documents/2021/06/cms-approved-7-1-21-amendment.pdf

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The State could examine opportunities to strengthen this service in New Jersey, including:

- Increasing the annual limit, creating a higher 3-year limit and/or increasing the lifetime limit for residential modifications.
- Piloting increased allowances to assess the costs, benefits, and impacts on the program without committing ongoing funding for the services.

Medical Day Care (MDC), Pediatric Medical Day Care, and Social Adult Day Health Care

MDC (also referred to as Adult Day Health Care [ADHC] services) provides preventive, diagnostic, therapeutic, and rehabilitative services under medical and nursing supervision in an ambulatory care setting to meet the needs of individuals with physical and/or cognitive impairments in order to support their community living.[64]

Pediatric Medical Day Care (PMDC) is a program available only to NJFC children under the age of 6, that provides medically necessary services in an ambulatory care setting to children who reside in the community and who, because they are technology-dependent and/or medically complex, require continuous rather than part-time or intermittent care of a RN in a developmentally appropriate environment and whose needs cannot be met in a regular day care or pre-school handicapped program.[65]

MDC and PMDC are provided under the New Jersey Medicaid State Plan and are available to community dwelling NJFC members who demonstrate a medical need for the service and meet other established requirements (i.e. age, community setting).

Social Adult Day Care (SADC) is a community-based group program designed to meet the nonmedical needs of adults with functional impairments through an individualized plan of care and provides a variety of health, social, and related support services in a protective setting during any part of a day but less than 24-hour care. This is an HCBS service and is only available to MLTSS members.[66]

In New Jersey, MDC services are more costly and more highly utilized than SADC services, which are reimbursed at a lower rate. Additionally, MCOs recently reported that most counties do not have at least two SADC providers, which limits access to this service.[67]

Key Highlights In Other States

[64] State of New Jersey Department of Human Services. *Contract to Provide Services, Service Descriptions, Medical Day Care (Adult Day Health Services).* Trenton, NJ: January 2021. Available at: https://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf

[65] *ibid*

[66] State of New Jersey, Department of Human services. *MLTSS Service Dictionary.* Available at: https://www.nj.gov/humanservices/dmahs/home/MLTSS_Service_Dictionary.pdf

[67] State of New Jersey, Department of Human Services. SFY23 MCO Supplemental Data Request_Non-Rx_11-5 UHC, 1. General Questions, 9. Social Adult Day Care. Trenton, NJ: November 5, 2021.

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In New York, current licensing regulations prohibit facilities from operating ADHC and SADC programs in the same physical space during the same period.[68]

In Massachusetts, the ADHC program serves as respite care, allowing informal family caregivers to work during the day.[69]

Tennessee uses Social Services Block Grant (SSBG) Funds to support ADHC for Adult Protective Services clients.[70]

Opportunities

To increase access to SADC services, the State could consider allowing MDCs to offer SADC services (at the SADC rate) for members who are in need of day care services, but do not need MDC. Alternatively, the State could utilize acuity-based rate ranges that would vary by amount of medical services required during day care stay.

Personal Care Assistant (PCA), including Agency and Self Direction

PCA services are health-related tasks performed by a qualified individual in a beneficiary's home, under the supervision of a RN, as certified by a physician in accordance with a beneficiary's written plan of care.[71]

PCA services may be delivered through an Agency that employs the PCA workers or through Participant Direction. Participant Direction, also known as consumer direction or self-direction is a service delivery mechanism that emphasizes autonomy and empowerment by expanding the participant's/representative's degree of choice and control over their LTSS. It allows participants/representatives who have elected to participate in the Personal Preference Program (PPP) to serve as the common law employer, responsible for directly hiring, training, supervising, and firing their paid caregivers.[72]

PCA hours are allocated based on the state developed and approved PCA assessment tool. PCA services are provided under the New Jersey Medicaid State Plan and are available to all community dwelling NJFC members who demonstrate a medical need for the service and as an HCBS service for MLTSS members who require additional PCA services above the state plan limit.

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[68] New York State Department of Health, Assistant Secretary for Planning and Evaluation (ASPE). *Regulatory Review of Adult Day Services: Final Report, 2014 Edition, New York, Overview*. Washington, D.C.: 2014 Edition. Available at: https://aspe.hhs.gov/sites/default/files/private/pdf/108011/adultday14-NY.pdf

[69] Massachusetts Executive Office of Health and Human Services. *MA Frail Elder (0059.R07.00)*. Boston, MA: August 3, 2021. Available at: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/82036

[70] Tennessee Department of Human Services. *Social Services Block Grant*. Nashville, TN. Available at: https://www.tn.gov/humanservices/for-families/social-services-block-grant.html

[71] State of New Jersey, Department of Human Services. *New Jersey Administrative Code, Title 10. Human Services, Chapter 60. Home Care Services*. Trenton, NJ: June 3, 2019. Available at: https://www.state.nj.us/humanservices/providers/rulefees/regs/NJAC%2010_60%20Home%20Care%20Services.pdf

[72] State of New Jersey, Department of Human Services. *New Jersey Administrative Code, Title 10. Human Services, Chapter 142. Personal Preference Program.*

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Receipt of PCA services is highly dependent upon the availability of personal care attendants. New Jersey, like most other states, is experiencing difficulty in maintaining sufficient qualified personal care attendants to meet NJFC member needs, which puts members at risk for NF admission.

Workforce development and retention have been noted as an ongoing problem nationally for supporting members living in the community. Wages and a lack of a career path for direct support workers have historically been noted to contribute to the workforce shortage, and the public health emergency has exacerbated this problem across the country[73].

The State recently responded to the need to increase wages by increasing PCA reimbursement rates for Agency PCA providers to $22.00 per hour as legislated in P.L. 2021, c.133 (State appropriations legislation for FY2021–2022 codified June 29, 2021) and has received approval to utilize ARP funds for an additional PCA rate increase of $1.00 per hour to $23.00 per hour through March 2024.[74]

PCA pay rates for Self/Participant Directed services were not increased; however, the State has received approval to utilize ARP funds to increase PPP rates to $19.00 per hour, in an effort to achieve greater alignment with PCA pay rates.[75]

Additionally, the State has received approval to utilize ARP funds for Home Health Workforce Development initiatives to address the increased difficulty in hiring direct care workers. These initiatives include[76]:

- Investing in training self-directed caregivers
- Recruitment and retention bonuses for agency assistants
- Funding rewards for agencies with high member satisfaction rates

Key Highlights In Other States

- In Connecticut, payment rates fall within a range of $20.12 per hour to $30.48 per hour.[77]
- In Massachusetts, PCA reimbursement varies with overtime and holiday pay (i.e., regular PCA is $18.15 per hour or with overtime or holiday pay up to $27.23 per hour).[78]

[73] KFF. *Direct Care Workforce Shortages Have Worsened in Many States During the Pandemic, Hampering Providers of Home and Community-Based Services.* August 10, 2021. Available at: https://www.kff.org/coronavirus-covid-19/press-release/direct-care-workforce-shortages-have-worsened-in-many-states-during-the-pandemic-hampering-providers-of-home-and-community-based-services/

[74] State of New Jersey, Department of Human Services. *Home and Community-based Services Enhanced FMAP Spending Plan.* Trenton, NJ: July 12, 2021. Available at: https://nj.gov/humanservices/assets/slices/NJHCBSspending.pdf

[75] *ibid*

[76] *ibid*

[77] State of Connecticut Department of Social Services. *CT Home Care 9/1/2020: Personal Care Services Fee Schedule.* Hartford, CT: September 1, 2020.

[78] Massachusetts Executive Office of Health and Human Services. *Notice of Proposed Changes in Statewide Methods and Standards for Setting Payment Rates: PCA Rates.* Boston, MA: June 25, 2021. Available at: https://www.mass.gov/regulations/101-CMR-30900-rates-for-certain-services-for-the-personal-care-attendant-program

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- In New York, PCA reimbursement varies by services performed (i.e., PCA services or per diem live-in services) as well as by organization.[79]

All of the profiled states have proposed activities in their HCBS Spending Plan that support, stabilize, and expand the HCBS direct support workforce. Initiatives include:

- Wage increases (Connecticut[80], Tennessee[81]) for direct support providers.
- Referral, recruitment, and retention bonuses (Connecticut[80], Massachusetts[82], New York[83], and Tennessee[81])
- Tuition reimbursement and loan forgiveness for workers who provide HCBS (New York[83])
- Workforce transportation reimbursement initiative (New York[83])
- Enhanced training on topics such as health equity, evidence-based models, and acquired brain injury (Connecticut[80])
- Paid training opportunities (New York[83]), and incentivized competency-based training by offering a wage increase for completion of the training (Tennessee[81])

Opportunities

New Jersey has proposed PCA recruitment and retention bonuses in its HCBS Spending Plan and has proposed incentives for PCA agencies with high member satisfaction rates based on standardized member surveys.[84]

The State could consider further options to support, stabilize, and expand the PCA workforce through tuition reimbursement, loan forgiveness, and enhanced training.

Private Duty Nursing (PDN)

PDN services provide individual and continuous nursing care, are provided in the community only (the home or other community setting of the individual), and not in hospital inpatient or NF settings. PDN services are a State Plan benefit for children under the age of 21. PDN services for adults 21 years of age or older are a covered service only for those members enrolled in MLTSS and the Division of Developmental Disabilities Supports plus PDN program.[85]

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[79] State of New Jersey Department of Human Services. *Home and Community-based Services Enhanced FMAP Spending Plan.* Trenton, NJ: July 12, 2021. Available at: https://nj.gov/humanservices/assets/slices/NJHCBSspending.pdf

[80] State of Connecticut Department of Social Services. *Spending Plan for Implementation of the American Rescue Plan Act of 2021, Section 9817.* Hartford, CT: July 12, 2021. Available at: https://www.medicaid.gov/media/file/ct-arpspending-plan0.pdf

[81] State of Tennessee Division of TennCare. *Initial HCBS Spending Plan Project and Narrative.* Nashville, TN: September 15, 2021. Available at: https://www.medicaid.gov/media/file/tn-initial-plan-for-arp-enhanced-hcbs.pdf

[82] Massachusetts Executive Office of Health and Human Services. *Massachusetts Home and Community-Based Services (HCBS) Spending Plan.* Boston, MA: June 17, 2021. Available at: https://www.medicaid.gov/media/file/ma-arpa-hcbs-spending-plan-initial.pdf,

[83] New York State Department of Health. *Spending Plan for Implementation of American Rescue Plan Act of 2021, Section 9817.* Albany, NY: July 12, 2021. Available at: https://www.medicaid.gov/media/file/nys-hcbs-spending-plan-draft0.pdf

[84] State of New Jersey, Department of Human Services. *Home and Community-based Services Enhanced FMAP Spending Plan.* Trenton, NJ: July 12, 2021. Available at: https://nj.gov/humanservices/assets/slices/NJHCBSspending.pdf

[85] State of New Jersey, Department of Human services. *MLTSS Service Dictionary.* Available at: https://www.nj.gov/humanservices/dmahs/home/MLTSS_Service_Dictionary.pdf

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PDN services are key to supporting NJFC members with highly complex medical conditions in the community. Challenges in accessing sufficient PDN supports have been noted in New Jersey and are attributed to various factors including an overall shortage of nurses and Medicaid reimbursement rates[86].

Key Highlights In Other States

In Massachusetts, PDN is authorized when there is clear and specific medical need for a nursing visit of more than two continuous hours that requires skills of RN/LPN, or services are medically necessary to treat and illness or injury. Additionally, PDNs are reimbursed based on the region and time of week that service is being rendered. PDN reimbursement is increased when the service is provided on a weekend or outside of regular business hours.[87]

Similar to New Jersey's PDN program, Tennessee requires agencies that deliver PDN also be Medicare-certified as home health agencies in order to ensure the quality of these services. Reimbursement is based on billed charges not to exceed a set limit.[88]

Opportunities

New Jersey could consider implementing a range of reimbursement schedules for PDN that varies based on geographic region, day of week, or time of the day to ensure adequate access and provider coverage. This approach could promote retention and support the workforce, while also encouraging providers to continue to care for members with high acuity needs.

Although this approach could increase costs in the PDN service category, these costs could potentially be offset by diverting or delaying more costly NF/other institutional services.

Adult Family Care (AFC)

AFC enables up to three unrelated individuals to live in the community in the primary residence of a trained caregiver who provides support and health services for the resident. AFC may provide personal care, meal preparation, transportation, laundry, errands, housekeeping, socialization and recreational activities, monitoring of participant's funds when requested by the participant, up to 24 hours a day of supervision, and medication administration. This is an HCBS service and is only available to MLTSS members.[89]

Key Highlights In Other States

Connecticut pays for AFC services at four different levels based on the number of ADLs and Instrumental Activities of Daily Living. Connecticut also allows its members to move into a

[86] Courier News and Home News Tribune. *NJ's shortage of private duty nurses taking toll on families.* July 15, 2019. Available at: https://www.mycentraljersey.com/story/news/health/2019/07/15/njs-shortage-private-duty-nurses-taking-toll-families/1571474001/.

[87] Massachusetts Executive Office of Health and Human Services. *Rates for Continuous Skilled Nursing Services Effective July 1, 2020*. Boston, MA: July 24, 2020. Available at: https://www.mass.gov/doc/rates-for-continuous-skilled-nursing-services-effective-july-1-2020/download

[88] TennCare. Chapter 1200-13-1 General Rules. Nashville, TN: June 2008. Available at: https://www.tn.gov/content/dam/tn/health/documents/1200-13-01.pdf

[89] State of New Jersey, Department of Human services. *MLTSS Service Dictionary*. Available at: https://www.nj.gov/humanservices/dmahs/home/MLTSS_Service_Dictionary.pdf

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friend or family member's house/have a friend or family member move into the member's house.[90]

Massachusetts pays two different rates based on the level of clinical need for its members and has a program called Group Adult Foster Care that provides care assistance in a congregate setting, which includes personal care in a public housing complex for members at risk of institutionalization.[91]

Tennessee offers adult foster care homes that can serve between one to five people. Community living support includes a shared home or apartment where no more than three people live with a trained host family. The level of support provided depends on member needs and can include hands-on assistance, supervision, transportation, and other supports needed to remain in the community. For members that need more hands-on support (ventilator or traumatic brain injury) there is a critical adult care home, which is a home where no more than four people live with a health care professional that takes care of special health and LTC needs.[92]

Opportunities

The State could consider ways in which to bolster this service in New Jersey, including:

- Allowing family members to be AFC providers by removing the "unrelated individuals" requirement. This would be in addition to any services provided under self-direction, with the home open to both family members and other unrelated Medicaid members in need of AFC services. The AFC home would need to follow any certification or other requirements in order to be considered a qualified provider.
- Paying for AFC at different rates based on level of care.

Program of All Inclusive Care for the Elderly (PACE)

PACE programs serve individuals who are age 55 or older, certified to need nursing home care, able to live safely in the community at the time of enrollment, and live in a PACE service area[93]. PACE programs provide a continuum of care and services to individuals with chronic care needs while maintaining their independence in their home for as long as possible. Services are coordinated through an interdisciplinary team and include but are not limited to, primary care, prescription drugs, day care, home and personal care services, nutrition, and hospital care. Most PACE enrollees receive services within their own home or community setting, although nursing home placement is available for enrollees as their care needs change.

[90] Connecticut Department of Social Services. *Connecticut Adult Family Living Program*. Hartford, CT: March 9, 2021. Available at: https://www.payingforseniorcare.com/connecticut/adult-family-living

[91] Massachusetts Executive Office of Human and Health Services. *Massachusetts Group Adult Foster Care (GAFG) and SSI-G*. Boston, MA: March 9, 2021. Available at: https://www.payingforseniorcare.com/massachusetts/medicaid-waivers/group-adult-foster-care

[92] State of Tennessee Division of TennCare. *What Home Care Services are covered in Choices?* Nashville, TN. Available at: https://www.tn.gov/tenncare/long-term-services-supports/choices/what-home-care-services-are-covered-in-choices.html

[93] National PACE Association. *PACE by the Numbers.* Washington, DC: July 2021. Available here: https://www.npaonline.org/sites/default/files/PDFs/5033_pace_infographic_update_july2021.pdf

According to the National PACE Association (NPA), in 2021 there were 140 PACE organizations operating in 30 states serving over 55,000 participants[94]. New Jersey currently has six PACE programs throughout the State, which served approximately 1,100 members in CY 2019 resulting in a total capitation expense of $60.6 million.

The State continues to publish Request for Applications (RFA) for counties without a PACE program to solicit organizational interest with a goal to offer PACE statewide. Upon the identification of a PACE organization, the process to develop and become a licensed provider can take up to 2 years. The State can examine opportunities to issue more frequent RFAs to reach the statewide goal more quickly.

No Wrong Door System Initiative

The No Wrong Door (NWD) System initiative is a collaborative effort of Administration for Community Living (ACL), CMS, and the Veterans Health Administration. The NWD System initiative builds upon the Aging and Disability Resource Center (ADRC) program and CMS' Balancing Incentive Program, and supports states' efforts to streamline access LTSS options for older adults and individuals with disabilities. NWD Systems simplify access to LTSS, and are a key component of LTSS systems reform.[95]

In New Jersey, the ADRCs serve as the NWD single-entry point for those in need of services and their family members.[96] The State's plan to utilize ARP funds to strengthen the NWD System is in alignment with its goal to strengthen the LTSS continuum of care by providing informational resources to community members regarding available HCBS under Medicaid.

Summary of Key Alternative Services Opportunities and Considerations

The State should continue its efforts to support community-based alternatives to NF care by:

- Exploring and, when appropriate, adopting promising practices in place in other states with high quality, innovative HCBS programs.
- Continuing efforts to improve the stability of the direct care workforce through wage increases, other financial incentives such as referral, recruitment and retention bonuses and non-financial incentives such as workforce development, training, and tuition and licensing fee reimbursement.
- Leveraging the opportunities to enhance HCBS services through utilization of funds available through the ARP of 2021. In addition to the initiatives described in the service-

[94] Ibid.

[95] Administration on Community Living. *Aging and Disability Resource Centers Program/No Wrong Door System.* March 2021. Available at: https://acl.gov/programs/connecting-people-services/aging-and-disability-resource-centers-programno-wrong-door#:~:text=The%20No%20Wrong%20Door%20%28NWD%29%20System%20initiative%20is,Services%20%28CMS%29%2C%20and%20the%20Veterans%20Health%20Administration%20%28VHA%29.

[96] New Jersey Department of Human Services. *State Strategic Plan on Aging: October 1, 2017 to September 30, 2021.* Trenton, NJ: 2017. Available at: https://www.state.nj.us/humanservices/doas/documents/NJ%20State%20Plan%202017-21%20Part%201%209.7.17.pdf

specific section, the State also has received approval for the following additional initiatives[97]:

- **Nursing Facility Transitions to Community Services**: Assist and enhance the moving of members from a custodial care setting to a home and community-based setting.
- **Traumatic Brain Injury Provider Payment:** One-time payment for Traumatic Brain Injury Providers to offset costs associated with health and safety protocols required by COVID-19.

- Continuing efforts to enhance caregiver respite and support services and increasing access to other caregiver supports such as residential modifications.
- Continuing efforts for statewide expansion of PACE.

[97] State of New Jersey, Department of Human Services. *Home and Community-based Services Enhanced FMAP Spending Plan.* Trenton, NJ: July 12, 2021. Available at: https://nj.gov/humanservices/assets/slices/NJHCBSspending.pdf

Section 4

Conclusion

The State has a strong LTSS system that supports Medicaid members across a broad continuum of community-based and facility-based health and social services. P.L. 2020, c.89 provided the State with the opportunity to study the costs and payments associated with NF care, focusing on and including recommendations for adjusting reimbursement rates to account for differences in resident acuity levels, as well as other factors relevant to NF costs and payments.

The State has recognized the interdependency of NF services and HCBS by establishing goals to further bolster the LTSS continuum of care to ensure Medicaid members have the greatest possible access to a full array of LTSS. As demand for LTSS increases with a growing aging population, it is essential that the State develop innovative strategies to meet Medicaid members' needs. Since establishing a managed care service delivery model for LTSS in 2014, the State has promoted directing FFS members to managed care and has made significant progress in advancing the use of HCBS as an alternative to NF services.

Continuing with this momentum, this report provides specific recommendations for adjusting reimbursement rates for NF care as well as key recommendations and considerations for promoting effective and accessible HCBS. For NF reimbursement rates, this report recommends a multi-year process that starts with the development of a framework to design a reimbursement methodology, including the assessment of member needs, collecting current cost data, and conducting a detailed analysis of costs and payments to inform program decisions. The HCBS recommendations focus on continuing already established efforts to strengthen the program, while exploring promising practices in place in other states, and leveraging the available funds through the ARP of 2021.

The New Jersey Department of Human Services should review the recommendations within this report and determine appropriate and adequate plans to continue to develop New Jersey's Medicaid LTSS system.

Appendix A

Recent HCBS Reimbursement Changes

Service	Effective Date	Reimbursement Change	Source
AL	July 1, 2021	State implemented per diem rates of $87.00 for AL facilities, $77.00 for comprehensive personal care homes, and $67.00 for AL programs	P.L. 2021, c.133 (State appropriations legislation for FY2021–2022 codified June 29, 2021)
AL	Pending	Assisted living tiered rate initiative to reward facilities with higher daily rates if the facilities serves more Medicaid members than the 10% minimum requirement.	State of New Jersey Home and Community-Based Services Enhanced FMAP Spending Plan, submitted to CMS on July 12, 2021
MDC	October 1, 2020	State implemented minimum per diem reimbursement rate of $82.00	P.L.2020, c.97 (State appropriations legislation for FY2020–2021 codified September 29, 2020)
MDC	July 1, 2021	State implemented a per diem rate of $86.10	P.L. 2021, c.133 (State appropriations legislation for FY2021–2022 codified June 29, 2021)
PCA	July 1, 2019	PCA hourly rate increased to $18.00 per hour	P.L.2019, c.150 (State appropriations legislation for FY2019–2020 approved June 30, 2019)
PCA	October 1, 2020	PCA hourly rate increased to $20.00 per hour	P.L.2020, c.97 (State appropriations legislation for FY2020-2021 codified September 29, 2020)
PCA	July 1, 2021	PCA hourly rate increased to $22.00 per hour	P.L. 2021, c.133 (State appropriations legislation for FY2021–2022 codified June 29, 2021)
PCA	Pending	PCA hourly rate increase to $23.00 per hour	State of New Jersey Home and Community-Based Services Enhanced FMAP Spending Plan, submitted to CMS on July 12, 2021

Service	Effective Date	Reimbursement Change	Source
PCA	Pending	Personal preference program rate increase to $19.00 per hour (includes administrative cost)	State of New Jersey Home and Community-Based Services Enhanced FMAP Spending Plan, submitted to CMS on July 12, 2021
PCA	Pending	Home health workforce development initiatives to bolster hiring of direct care workers	State of New Jersey Home and Community-Based Services Enhanced FMAP Spending Plan, submitted to CMS on July 12, 2021
PDN	October 1,2020	State implemented minimum hourly reimbursement rates for PDN services of $60.00 and $48.00 for RN and LPNs, respectively.	P.L.2020, c.97 (State appropriations legislation for FY2020–2021 codified September 29, 2020)

Notes

- Anticipating legislative updates to PCA hour rate increases, New Jersey received CMS approval to increase PCA hourly rates to $19.00 per hour beginning July 1, 2020; however, in light of COVID-19, the State subsequently received CMS approval to increase the hourly PCA rate to $21.00 per hour between June 1, 2020 and August 31, 2020, to help ensure access to care for Medicaid enrollees. As a result, in CY 2020, the hourly PCA reimbursement was set at the following rates:
  - $18.00 per hour from January 1–May 31
  - $21.00 per hour from June 1–August 31
  - $19.00 per hour from September 1–September 30
  - $20.00 per hour from October 1–December 31

Appendix B
Recent LTSS Legislation

Chapter Law	Description	Date Approved
P.L.2020, c.88	Establishes New Jersey Task Force on LTC Quality and Safety	September 16, 2020
P.L.2020, c.112	Establishes minimum direct care staff-to-resident ration in NHs	October 23, 2020
P.L.2020, C.113	Requires LTC facilities, as a condition of licensure, to implement policies to prevent social isolation of residents	October 23, 2020
P.L.2020, c.132	Revises requirements for health care service firms to report financial importation to the Division of Customer Affairs	December 14, 2020
P.L.2020, c.135	Requires LTC facilities and hospitals to maintain minimum supply of PPE	December 14, 2020
P.L.2021, c.5	Requires health care facilities to report certain COVID-19 data related to health care workers and certain first responders	February 4, 2021
P.L.2021, c.33	Establishes certain requirements concerning rights of lesbian, gay, bisexual, transgender, undesignated/non-binary, questioning, queer, intersex, and HIV-positive residents of LTC facilities	March 3, 2021
P.L.2021, c.95	Revises licensure, operational, and reporting requirements for NHs	May 12, 2021
P.L.2021, c.190	Revises requirements for LTC facilities to establish outbreak response plans	August 5, 2021

Appendix C
Federal Programs to Support LTSS

- **Money Follows the Person (MFP)[98]:**
  - Provides participating state Medicaid programs enhanced FMAP for services and supports to transition certain Medicaid enrollees from institutional- to community-based settings.
  - Provides a 75% enhanced FMAP for MFP-eligible services (which represents an increase above the 50% FMAP for services that are not eligible for MFP).
- **The ARP Act[99]:**
  - Provides a 10% FMAP increase for qualifying HCBS services from April 1, 2021 through March 31, 2022.
  - States are required to use the enhanced funding to supplement existing HCBS services.

[98] Centers of Medicare and Medicaid Services Money Follows the Person. Available at: https://www.medicaid.gov/medicaid/long-term-services-supports/money-follows-person/index.html

[99] Kaiser Family Foundation Potential Impact of Additional Federal Funds for Medicaid HCBS for Seniors and People with Disabilities. Available at: https://www.kff.org/medicaid/issue-brief/potential-impact-of-additional-federal-funds-for-medicaid-hcbs-for-seniors-and-people-with-disabilities/

Appendix D
Acronyms

Acronym	Definition
ACL	Administration for Community Living
ADLs	Activities of daily living
ADRC	Aging and Disability Resource Center
AFC	Adult family care
AL	Assisted living
ARP	American Rescue Plan
CHIP	Children's Health Insurance Program
CNA	Certified nurse assistant
CPE	Certified public expenditures
FFS	Fee-for-service
FMAP	Federal medical assistance percentage
IADLS	Instrumental activities of daily living
HCBS	Home- and community-based services
LPN	Licensed Practical Nurse
LTC	Long-term care
LTSS	Long-term services and supports
MACPAC	Medicaid and CHIP Payment and Access Commission
MDC	Medical day care
MDS	Minimum data set
MFP	Money Follows the Person
MCO	Managed care organization
MLTSS	Managed long-term services and supports
NCI-AD	National Core Indicators-Aging and Disabilities
NH	Nursing home
NFLOC	Nursing facility level of care
NJFC	New Jersey FamilyCare
NWD	No Wrong Door

Acronym	Definition
PCA	Personal care assistant
PDN	Private duty nursing
PDPM	Patient-Driven Payment Model
PMPM	Per member per month
QIPP	Quality Incentive Payment Program
RN	Registered Nurse
SADC	Social adult day care
SCNF	Special care nursing facility
SNF	Skilled nursing facility
UPL	Upper payment limit

Appendix E
Supporting Data

New Jersey CY 2019 Average Monthly LTSS Expenditures per Member

- Members residing in the community receive LTSS totaling $1,900 per month on average.
- Community members (except for AL and AFC residents) may use an array of different LTSS to meet their needs.
- To show how service expenditures vary across the LTSS continuum, the following figure displays the average monthly service expenditures per user for each service category within the LTC study, including NF-related services. For the non-institutional services (i.e., PDN, MDC, PCA, Self-direction, and SADC), the average costs include the mix of services utilized by these members.
- Caregiver Respite and Training, and Residential Modification Services were not included, as these were not services that members were using on a monthly basis.

Figure 3: New Jersey CY 2019 Total Monthly Expenditures per Member

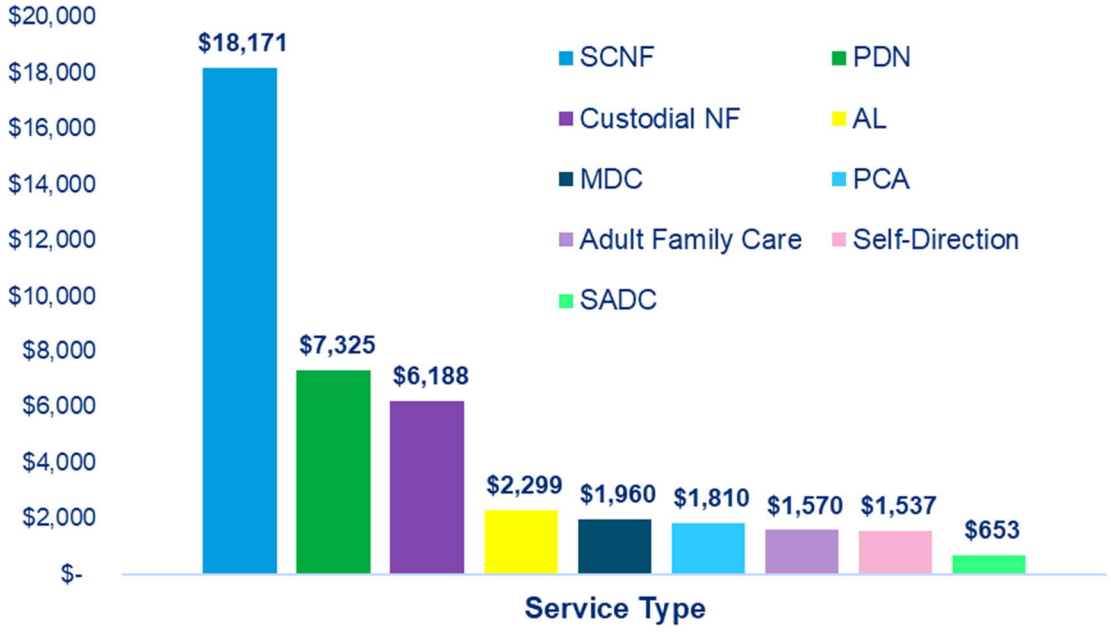

Figure 4: Notes

- Source of data: Mercer's analysis used CY 2019 (pre-pandemic) encounter data and FFS claims data on an incurred basis for MLTSS and non-MLTSS populations for the applicable services. Expenditures under the DDD waiver spend were not included in this analysis.

- Values in the graph have been adjusted to include member cost-sharing expenditures.
- Average monthly cost per user = annual service expenditures/number of user months. If a member used a service for 10 months, they contributed 10 user months.

Appendix F

Disclaimers and Caveats

This report is prepared on behalf of the New Jersey Department of Human Services, and is intended to be relied upon by the New Jersey Department of Human Services, the New Jersey Legislature and other audiences deemed appropriate. It should be read in its entirety.

To the best of Mercer's knowledge, there are no conflicts of interest in performing this work.

The suppliers of data are solely responsible for its validity and completeness. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit it. All estimates are based upon the information and data available at a point in time and are subject to unforeseen and random events, and actual experience will vary from estimates.

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Mercer Health & Benefits LLC
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
www.mercer-government.mercer.com