



STATE OF NEW JERSEY

DEPARTMENT OF HUMAN SERVICES  
DIVISION OF DEVELOPMENTAL DISABILITIES

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## Standard Fee Rating Setting: Frequently Asked Questions (FAQ)

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### 1. Who is setting the rates?

The Department of Human Services (DHS) has contracted with Myers and Stauffer, LC (M&S) to set rates for the Division of Developmental Disabilities (Division) and the Division of Mental Health and Addiction Services (DMHAS). Myers and Stauffer is a national public accounting firm that works exclusively with state and federal agencies operating public health care programs. Currently, it has active engagements with Medicaid agencies in 45 states, and operates 18 offices located throughout the United States. Additionally, M&S previously worked in New Jersey on nursing facility and hospital reimbursement rates.

Components of the Division rate study will be completed by Johnston, Villegas-Grubbs and Associates, LLC (JVGA), a rate setting and public health firm with extensive experience in developmental disabilities rate setting. JVGA's founder, John Villegas-Grubbs, developed widely used rate architecture while serving as the CFO of Arizona's Division Waiver. After overseeing the conversion of Arizona's cost reimbursement system to fee-for-service, he worked as the DD Long Term Care Rate Finance Lead at Mercer, a global consultancy. JVGA is currently engaged in several states, including developmental disability rate setting for New York. Mr. Villegas-Grubbs also holds a Master's in Counseling and volunteers as a mental health therapist.

For additional background information and ongoing updates, please reference the Division Rate Setting webpage: <http://www.state.nj.us/humanservices/ddd/providers/ratestudy.html>.

To add your e-mail address to our mailing list, send a request to: [DDD.RateSetting@dhs.state.nj.us](mailto:DDD.RateSetting@dhs.state.nj.us).

### 2. What services are included in the rate study?

Rates will be set for all waiver-eligible services, including residential, in-home and community integration options. In addition to setting rates for the existing Community Care Waiver (CCW), rates will also be established for the new Comprehensive Medicaid Waiver's Supports Program. The Division is working to align service definitions and provider qualifications across both waiver programs as much as possible.

### 3. How many rates will there be for each service category?

Once JVGA completes their general ledger analysis, results of individual's assessment scores (based on the Developmental Disabilities Resource Tool – DDRT) will be used to model the rate impact. The impact analysis will determine how many rates are necessary for any given category.

The rate study and resulting standard fee schedule must be complex enough to address the needs of all individuals while being simple enough to be administratively feasible.

### 4. What is the timeline for rate setting and implementation?

Rates for all services under the Community Care Waiver and Supports Program are expected to be published in September 2013. At that point, JVGA will perform a budget impact analysis at both the provider and the State level. The results of this analysis will be used to craft an overall implementation plan.

### 5. What opportunities are available for stakeholder input?

The Division has established several workgroups to participate directly in the process of crafting and analyzing rate models. These workgroups include an Advisory Workgroup, Financial Workgroup, and a Family and Self Advocate Workgroup. In addition, throughout the process, the Division and JVGA will be holding status update conference calls and/or webinars. These

sessions will discuss rate architecture and methodology, the project's timeline and progress, and implementation issues. All stakeholders are also invited to send questions, information and concerns related to the rate study to the Rate Setting e-mail address: [DDD.RateSetting@dhs.state.nj.us](mailto:DDD.RateSetting@dhs.state.nj.us).

**6. Will there be service-specific working groups (e.g., transportation)?**

The Division anticipates that the existing workgroups, along with the cost analysis sample group, will provide sufficient information needed to set rates for each covered service. If additional information on specific services is required, the Division will solicit stakeholder input through the workgroups and the e-mail list.

**7. Historically, contracts have not reflected increasing costs for expenses such as staff wages and benefits, supplies, utilities, etc. Because of this, inflationary pressures are not necessarily included in the budget or cost data reported to the Division – what data sources will JVGA use to set the rates?**

JVGA will set the rates based on a cost analysis of agency accounts. Approximately 60 agencies have been selected for participation in the sample. It is important to note that rates are not being set based on absolute costs reflected in agency budgets or cost reports. Rather, the rate architecture is based on relationships between cost components and a base direct care staff wage. Although cost components can vary between states and services, those common to all rate models are the Direct Care Staff Wage, Employment Related Expenditures, Program Support, and General and Administrative Expenses.

Although expenditures may be depressed in comparison to prevailing wages and costs, the ratios between cost components will still be similar. Alternatively, if wages have been depressed to make up for rising benefit or program costs, these ratios will be elevated with respect to the direct care staff wages, resulting in a higher rate when applied to the new reference wage. For additional information on the rate architecture, please view the June 12<sup>th</sup> Status Update Webinar available on the Division's Rate Setting webpage: <http://www.state.nj.us/humanservices/ddd/providers/ratestudy.html>.

In the event that the direct care worker for a particular service is distinct from that of other services, the rate will be built on a different wage. If, however, the direct care worker is the same, but ancillary supports (e.g., nursing) are provided, that additional cost would be reflected as a higher program support percentage.

**8. How will the Direct Care Staff Wage be determined?**

The base wage is typically determined by using Bureau of Labor Statistics data for the position, or a blend of positions, that matches the required job qualifications, adjusted for the Medicaid CPI (approximately 2%).

**9. How will the additional federal match from the new Comprehensive Medicaid Waiver's Supports Program impact the rates?**

Rates will be set based on JVGA's cost analysis rather than an analysis of available budget authority. Federal match will be used to expand services to existing and new individuals. In particular, this match allows the Division to increase the budgets available for support services, and to provide in-home services to a larger number of individuals on the Community Care Waiver Waiting List (Waiting List).

**10. Will a cost-of-living-adjustment (COLA) be factored into the rate?**

No, the Division does not have authority to provide a COLA. Third-party COLAs are authorized on a statewide basis through the legislative appropriations process. The rate architecture does, however, provide a transparent way to explain and understand agency compensation to advocates and legislators.

**11. Will the rate incorporate an absentee factor?**

Under Medicaid rules, rates can incorporate an absence factor (typically 2-5%) for when an individual is assigned to a program but does not attend. In contrast, a vacancy factor (i.e., no individual assigned to the program) is not permitted. Over-enrollment (particularly in the area of day habilitation) will be an acceptable practice to help negate the impact of absent, unbillable units/days.

**12. How will retained earnings be handled in the fee for service system?**

One of the benefits to the provider community as a result of the shift to a Medicaid based, fee for service model is the ability to accumulate retained earnings for use by the agency (something the current cost reimbursement model does not allow). Accumulation of retained earnings resulting from efficient use of a standard fee structure will provide the provider community with fiscal flexibility to proactively address planned capital expenditures in areas such as new hardware or software, vehicle replacement or major maintenance.

**13. Will agencies be able to bill for support staff during a hospital stay?**

No, this is not a billable service; physicians have the authority to order appropriate care when an individual is hospitalized.

- 14. It will be difficult to manage cash flow if there is no guarantee an individual will attend on a program on a given day – how will agencies be able to manage attendance?**  
Agencies are encouraged to evaluate their cost and attendance patterns to ensure that their business models align with service delivery. Although attendance may vary significantly day-to-day, there is some level of predictability when analyzed in the aggregate. The results of this analysis will identify ways to adjust operating costs or program policy (e.g., minimum attendance requirements for enrollees and over-enrollment) to ensure that the business is financially viable.
- 15. Will there be a procedure to authorize exception rates for the needs of “unique” individuals?**  
The Division anticipates that the rate structure will be robust enough to accommodate the full range of service needs presented by individuals.
- 16. Will the rate for center-based habilitation services include facility cost?**  
Facility costs will be factored into the rate analysis.
- 17. Are training costs being incorporated into the rates?**  
Yes, anticipated costs associated with training will be considered in building the program support component of each applicable rate.
- 18. What is the financing mechanism for vehicles?**  
Vehicle purchases and associated maintenance costs will be financed through the rates, rather than as one-time Division-funded purchases (currently for vehicle acquisitions) or within the cost reimbursement structure (currently for maintenance). Agencies are encouraged to explore alternative means of providing transportation, particularly those that better align payment with fee-based revenue streams. Some options include leasing, arrangements with fleet management companies, and subcontracting from transport-specific providers.
- 19. Will there be a differential for wheelchair van transport to special needs day programs?**  
The need for transportation rate differentials will be evaluated as part of the rate study.
- 20. Will existing DHS Contract Guidelines, such as the Executive Director salary cap, still apply?**  
It is too early to give definitive answers on contract policy changes, but the Division continues to actively evaluate policy in light of upcoming system reforms and anticipates making substantial changes in order to align Division oversight with the quality assurance role required by CMS.
- 21. How will agency cash flow during implementation be maintained (e.g., cash advances, rate phase in)?**  
The Division does not have the budget authority to incur advance expenses. Advances or other transition payment mechanisms can only be funded if offset by corresponding savings.
- Due to differentials between the new rates and existing reimbursement arrangements, rate changes will be phased in over time, in a budget neutral manner, based on the budget impact analysis. For this analysis, JVGA will compare revenue for existing contract ceilings and utilization with expected revenue under the new rates for all agencies and programs. Agencies will know the impact of the new rates in advance and can plan for changes in revenue over the implementation period.
- Based on the rate setting experience of JVGA, the implementation period typically lasts between 12-24 months with 12 months viewed as the ideal result. This time frame will allow for the budget neutral phase-in of the rate structure while limiting the providers’ administrative burden of having to operate simultaneously in two distinct funding models (cost reimbursement and fee for service).
- 22. Will funds be provided in advance of implementation, or in the rate, for the following:**
- a) **Operation of dual systems?**
  - b) **IT hardware and software upgrades for intake, records management, billing and compliance?**
  - c) **Need for more sophisticated staff (e.g., accounting, compliance)?**
- The rate will not account for transition costs, as reimbursement is limited to the delivery of disability services. The Division does anticipate, however, that existing staff, IT and other resources will be redirected to fee-for-service operations as existing cost reimbursement administrative requirements are phased-out.
- 23. What is the process for rate adjustment in future years?**  
At the conclusion of the project, JVGA will make recommendations on inflation factors, rate monitoring and indicators that rates need to be rebased or refreshed. Increases to reimbursement rates, however, are subject to legislative appropriation. JVGA will also make financial reporting recommendations to agencies so that costs can be monitored in a way that corresponds to the components of the rate architecture.
- 24. Will there be a system to apply for reassessment of an individual as they age, or as their needs change?**

As with the current system, individuals or their guardians can request a reassessment if their needs change.

**25. If staff qualifications change, will there be a hold harmless period?**

No, staff qualifications are a component of the waiver service definitions and must be met in order for an agency or a person to serve an individual enrolled on the CCW or the Supports Program.

**26. Will the Division still make referrals? If so, how will the process change? If not, how will families become aware of and access services?**

The current process for referral of individuals moving from one of the Division's centers (Olmstead) and the Return Home New Jersey initiative will continue in their current capacity for the foreseeable future. The Division will still be in charge of administering any capital funding appropriated for the purpose of increasing community capacity and facilitating closure. Additionally, all waiver participants will have a Support Coordinator or a case manager who will help them to identify possible service providers from which they can choose to receive their services. Individuals receiving services will not be assigned/referred to any particular program, and there will not be "program slots." In order to advertise services and garner business, providers are encouraged to share marketing tools with Support Coordinators to highlight their services and identify the locations they serve, attend or become vendors at community events, and/or advertise in their local newspaper or other publications throughout the areas they serve. Providers will likely get their business through "word of mouth" referrals from other individuals and families.

**27. What will DDD's role be in the new Fee for Service system?**

As the waiver administrator for the Community Care Waiver and the lead Division governing the Supports Program under the Medicaid Comprehensive Wavier, DDD's primary function on most levels will switch to one of oversight, quality assurance and compliance.

The six specific Centers for Medicare and Medicaid assurances the Division will be responsible for include:

- a. Administrative Authority
- b. Level of Care
- c. Qualified Providers
- d. Service Plan
- e. Health and Welfare
- f. Financial Accountability

**28. What are the fiscal and programmatic requirements for billing and auditing?**

Agencies must adhere to all Medicaid standards and Division policies regarding cost data collection and program outcomes. The Division will have an oversight role to ensure the six assurances and monitor the appropriateness of the rates. Information on new Division policies will be distributed as implementation moves forward.

**29. When will the Fiscal Intermediary (FI) be chosen?**

DHS is procuring a Department-wide fiscal intermediary (FI) through the Department of Treasury's Division of Purchase and Property (DPP). Because this is State contract procurement, updates, to the extent available, will be made through DPP. Service providers that do not fall within a Medicaid provider category will bill the FI for services they deliver.

**30. Room and board is not an allowable Medicaid cost – how will this funding be provided?**

The Division is a disability services organization and cannot provide reimbursement through its Medicaid waiver programs for items such as food, clothing and shelter, as these are not disability related. In addition to utilizing their income - including employment, disability benefits and other earned and unearned income - individuals can access mainstream housing and food benefits such as rental vouchers and food stamps to offset room and board costs. The Division recognizes, however, that these resources may not be sufficient to cover room and board costs in many cases. As a result, the State is working to identify mechanisms to cover the gap between individuals' SSI and other income and the total cost of room and board.

**31. How will funding for capital development repairs be provided?**

Given the State's current institutional population and the large number of State-owned group homes, the Division does not anticipate substantial changes to capital policy over the next few years. Issues of repair and maintenance (whether capital or vehicle) will be addressed through usage of the rates in a fee for service model as providers will be able to accumulate retained earnings.