STATE OF NEW JERSEY
SECTION 1115 DEMONSTRATION "COMPREHENSIVE WAIVER"
CONCEPT PAPER

I. Overview of the comprehensive waiver

The State of New Jersey (State), Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) is seeking a Medicaid and Children's Health Insurance Program (CHIP) Section 1115 research and demonstration waiver that encompasses all services and eligible populations served under a single authority that provides broad flexibility to manage all programs more efficiently. The waiver will allow New Jersey flexibility to define who is eligible for services, the benefits they receive and the most cost-effective service delivery and purchasing strategy. The comprehensive waiver will:

- Consolidate New Jersey Medicaid and CHIP under a single-waiver authority
- Commit New Jersey to making key improvements to the Medicaid eligibility system (both processes and technology) going forward
- Promote increased utilization of home-and-community based services for individuals in need of long-term care
- Integrate primary, acute, long-term care and behavioral health care
- Promote efficient and value-added health care through Medicaid accountable care organization pilots
- Provide flexibility to promote primary and preventive care access by balancing eligibility and enrollment for services, the benefits received and the rate of payment for services
- Provide flexibility in administration of the program to implement management efficiencies and purchasing strategies
- Promote healthy behaviors and member responsibility for their health care

This concept paper describes the specific actions New Jersey will undertake to improve management of its programs and manage within available funds if it is successful in obtaining the flexibility it seeks.

The initiatives that ultimately are included in the formal comprehensive waiver submission will be driven by in-depth analyses and informed by public input.

II. Streamlined and efficient program administration

<u>Consolidation of New Jersey Medicaid under a single waiver with administrative flexibility</u>

Currently, New Jersey DMAHS and its sister agencies (including Divisions within DHS, Department of Health and Senior Services (DHSS) and the Department of Children and Families (DCF)) administer Title XIX and XXI programs under multiple authorities including:

- A Medicaid State Plan
- A Title XXI CHIP State Plan

- Two Section 1115 demonstration waivers (one that covers parents and a second recently approved that offers the formerly State-funded general assistance population an ambulatory benefit package under Title XIX)
- A Section 1915(b) waiver that allows mandatory managed care for certain populations
- Five 1915(c) home-and-community based services based waivers
- 1915(j) State Plan authority for cash and counseling
- Multiple contracts with managed care organizations

The comprehensive waiver replaces these disparate authorities and seeks a single, unified federal authority that specifies the types of changes that New Jersey can make with streamlined Centers for Medicare & Medicaid Services (CMS) approval and limits the changes that require more extensive and lengthy CMS review. New Jersey seeks CMS partnership in responding to changes quickly, which may be necessary to administer the most efficient Medicaid and CHIP programs possible in a time of limited budget resources. New Jersey requests the following CMS approval process:

- Level 1 changes – Administrative changes such as contract requirements for managed care organizations or administrative services only organizations and processes and procedures under the waiver (e.g., new performance measures, network requirements, care coordination requirements, quality indicators and/or reporting requirements) – *CMS approval would not be required.*
- Level 2 changes – Changes in the service delivery system, cost-sharing, services covered and/or rate changes not otherwise approved through the waiver and amendments to budget neutrality terms and conditions – *CMS questions and Requests for Information in 30 days and approval within 45 days or the change would be deemed approved.*
- Level 3 changes – Eligibility changes not otherwise approved through the waiver and amendments to budget neutrality terms and conditions – New Jersey would seek public input, submit these changes 120 days prior to the implementation date and *CMS would have 60 days to request additional information or pose questions, 60 additional days to review and approve or the change would be deemed approved.*

As part of this proposal, New Jersey intends to streamline its internal program administration. For example, New Jersey intends to demonstrate streamlined, effective procurement processes for Medicaid contracts. DMAHS will seek State authority to pursue competitive bidding of managed care contracts during the demonstration and relief from lengthy State procurement requirements in order to implement the various components of this demonstration along the described timeframes.

Consolidation of programs under the comprehensive waiver also means that the nature of the relationship and roles of DMAHS and its sister agencies will be redefined and memorialized in interagency agreements.

III. Eligibility and enrollment

Under New Jersey's current Medicaid program, eligibility and enrollment policies, benefit packages and provider payment rates are in need of rebalancing. While the current program has

expansive eligibility levels and enrollment policies and relatively generous benefits, it nonetheless pays rates to some providers that may serve as a disincentive to participation in the program and limit the accessibility of primary care. The goal would be to ensure that hospital emergency departments, outpatient hospital clinics and inpatient beds are utilized only when appropriate.

In order to correct this imbalance, New Jersey will request broad flexibility for managing eligibility, enrollment and benefits.

Eligibility and enrollment flexibility

New Jersey is committed to continue serving individuals presently receiving services under New Jersey Medicaid and CHIP programs today (NJ FamilyCare is New Jersey's CHIP program). New Jersey will not terminate the eligibility and enrollment of any individual (child or adult) now served under its State Plan and/or waiver programs. Further, there will be no impact on eligibility criteria for children.

While New Jersey has chosen not to eliminate coverage for anyone now served by the program to avoid the turmoil to these individuals and the providers who serve them, there are three eligibility processes that New Jersey proposes to change for Medicaid and CHIP applicants:

- Freeze enrollment for all adult parents in the expansion population currently authorized under the Section 1115 waiver for parents with incomes up to 200% of the Federal Poverty Level (FPL). Enrollment of higher income parents (those with incomes above 133% of the FPL) in NJ FamilyCare (NJFC) was already frozen in March 2010. New Jersey seeks to freeze enrollment for the remaining NJFC parents by eliminating the enhanced earned income disregard for new applicants under Aid to Families with Dependent Children (AFDC)-related Medicaid (the difference between the AFDC income level and 133% of FPL).

- Eliminate the requirement that New Jersey provide coverage prior to the date of a Medicaid application for certain groups of new applicants. New Jersey will continue to provide prior-quarter coverage for individuals who are retroactively determined eligible for Supplemental Security Income (SSI) and certain individuals at the institutional level of care including home-and-community based services waivers. New Jersey believes this request is consistent with similar requests that CMS has granted in other states under 1115 demonstration authority, preserves retroactive eligibility for those most in need, and is consistent with New Jersey's belief that care should be managed at the earliest point possible.

- Require new managed care enrollees to choose a Medicaid health maintenance organization (HMO) upon eligibility application (or within 10 days of the application) or be auto-assigned. Members will be allowed a 90-day period to change HMOs without cause. After the 90-day period, plan changes for cause will be allowed, changing HMOs will be possible thereafter once a year during an open enrollment period.

New Jersey continues to migrate its Medicaid and CHIP programs towards coordinated care provided in comprehensive managed care delivery systems. Each of the provisions above are consistent with this philosophy: A person's care should be managed from the earliest point in time.

In return for the requested Medicaid eligibility flexibility, New Jersey is committed to improving its performance throughout the Medicaid eligibility determination process. To this end, the State will endeavor to:

- Significantly reduce the time for processing long-term care applications.
- Obtain authority to use preadmission screening instruments for the elderly, physically disabled, those with developmental disabilities, and those with mental illness as the disability determination for social security income from the Social Security Administration which will allow the individual to be eligible for long-term care services under 42 CFR 435.210 (would be eligible for SSI if they applied) well before the regular SSI eligibility determination is completed.
- Automate the redetermination process using IRS, State tax, child support and all other sources of income, residency and eligibility information. In order for New Jersey to accomplish this task the Social Security Number (SSN) of beneficiaries will be mandatory and maintained electronically for all programs.

New Jersey understands that these performance improvement steps will require a significant investment of time and resources on its part, but believes that the benefits to members and potential cost savings to the State are significant. These proposals reflect New Jersey's commitment to a Medicaid program that operates more efficiently and under a cohesive vision of eligibility and coverage.

<u>Medicaid as payer of last resort</u>

Under Title XIX of the Social Security Act, Medicaid is intended to be the payer of last resort with few exceptions. Medicaid continues to be available, however, to individuals who are insured through commercial and employer-based insurance and/or Medicare. On the other hand, Title XXI which authorizes the State CHIP, is explicitly available only to the uninsured. Both Medicare and private insurers have avoided payment of millions of dollars in claims they should have rightfully paid.

Commercial insurance

States depend on beneficiaries to provide third-party insurance information. When so informed, third-party liability can be identified and Medicaid payments avoided. HMOs are also required to inform states of the availability of third-party liability. This does not occur as often as it should, however, and Medicaid programs are asked to pay bills that should have been the responsibility of a commercial plan through employer-based coverage or coverage purchased directly by individuals.

Today, states are permitted to have Health Insurance Premium Payment (HIPP) programs to determine if the commercial coverage is cost effective and allow Medicaid to subsidize the premiums in lieu of direct payment under Medicaid for services covered by the commercial plan. Under Section 1906 of the Social Security Act, however, HIPP programs must evaluate each individual's or family's commercial policy, thereby creating a significant administrative burden.

Additionally, under the HIPP program, states are required to offer wraparound benefits: those that Medicaid covers but the commercial plan does not. The cost of wraparound benefits is significant (two states reported that savings would increase by 72% if wraparound coverage were eliminated). In spite of these current HIPP requirements, states report significant savings for HIPP under both fee-for-service (FFS) and managed care. Savings would be higher if administrative costs associated with determining cost effectiveness were reduced and wraparound benefits were controlled. Pennsylvania, Iowa and Texas operate aggressive HIPP programs under both their FFS and managed care programs. All three programs have significant enrollment today and report that savings increased over time.

Under the comprehensive waiver, New Jersey requests authority to enhance the opportunities under HIPP in three ways:

- Determine cost effectiveness in the aggregate by eligibility category and managed care rate code
- Eliminate wraparound coverage for adults excluding the aged, blind and disabled and children
- Improve reporting and follow-up to identify availability of employer-based coverage, particularly for members with chronic conditions and high medical cost

Retroactive Medicare Part B

For well over 30 years, state Medicaid programs provided health care services to individuals who were eligible for Medicare but because of an error in eligibility determination by the Social Security Administration were categorized as eligible for SSI rather than Social Security Disability Insurance. The error is reflected in the eligibility category known by states as SSI without Medicare. States had observed that the SSI without Medicare population was growing at a rate far in excess of the elderly and disabled with Medicare. The error is acknowledged by CMS and the Social Security Administration.

The total amount paid by states was originally estimated at $4.8 billion (state funds only). This figure is expected to increase. New Jersey's share is estimated at $107.3 million. In response to the error, CMS originally stated that it could not pay the states because the Medicare program only pays providers. States were asked to recoup payments from providers and then ask providers to bill Medicare. Most of the Medicare claims submitted by providers would no longer be considered timely filed and would be denied, aside from the significant administrative burden it would place on providers and the states.

As an alternative, several states, including NJ, have proposed that CMS allow states to pursue a solution through a 1115 waiver, and to use the amount owed (using the Medicare 222(b)

authority) as the non-federal share of expenditures in their current programs. New Jersey is incorporating this proposal into this comprehensive waiver, understanding the final disposition will be negotiated on behalf of a number of states.

At the same time, this Medicare Part B error points to the difficulty states have in keeping the statutory philosophy of "payer of last resort."

IV. Benefits and provider payments

Benefit and cost-sharing flexibility

New Jersey is requesting flexibility in defining covered services and adopting limits on the amount, duration and scope of services as well as imposing copayments and other cost sharing.

The comprehensive waiver will also seek authority to engage the population the State serves in using health care services appropriately. New Jersey will implement enhanced cost sharing including both premiums and copayments. Premiums for parents with incomes over 100% of FPL may be adopted but will not exceed 5% of family income as required under 1916(f) of the Social Security Act. In addition, New Jersey believes that copayments beyond those allowed under current federal rules for inappropriate use of services will change behavior. The primary target is non-emergency use of hospital emergency departments where New Jersey is seeking to impose a $25.00 copayment with the intent of redirecting care to primary care settings. Section 1915(f) of the Social Security Act provides authority to the Secretary of Health and Human Services to approve copayments directed at inappropriate emergency department use.

Payment rates to providers

The comprehensive waiver includes components that revise payment rates to providers that are designed to achieve four objectives:

- Rebalance the service delivery system toward primary care
- Provide equity in payments to in-state and out-of-state hospitals
- Incentivize payment reforms between HMOs and hospitals
- Participate in the Affordable Care Act provider payment reform demonstrations testing global payments and bundled payments

Rebalancing. As noted above, the New Jersey Medicaid program is in need of rebalancing with regard to the rates paid to primary care providers and other providers in specialty settings. Physician FFS rates are approximately 47% of Medicare rates and are estimated to be less than 25% of usual and customary charges.

At this time, New Jersey wants to shift the focus of payment to promote primary care and improve network adequacy and quality. Toward that end, the State will:

- Invest some of the savings achieved through other measures for an early implementation of increased payments to primary care providers up to 100% of Medicare rates. New Jersey proposes to phase this in up to full implementation in 2013 when an enhanced federal match will be available. (Phase-in based on what New Jersey can afford.)
- Encourage participation of those specialists in ambulatory settings that primary care physicians need for referrals through implementation of an enhanced consult fee.
- Through its HMOs implement payments to health care homes as described in Section V below.

Fairness in payments to in-state and out-of-state providers. In addition to rebalancing, New Jersey will also seek changes in payment rates that are designed to achieve fairness specifically when making payments to out-of-state providers. Most states limit payments to out-of-state hospitals to the lesser of the average rate paid to in-state hospitals or the rates paid the hospital by the Medicaid program in their resident state. New Jersey will adopt a similar policy as follows:

- Pay out-of-state providers the lesser of the New Jersey Medicaid rate or the servicing state's Medicaid rate when the service is available and the member has access to an in-state provider
- Coordinate with neighboring states and establish uniform payment rates for select facilities that provide specialty services

Incentivize payment reform between HMOs and hospitals. While Medicaid is continuing to encourage HMOs to delink themselves from the FFS rates, it is still clear that FFS rates continue to influence HMO and hospital behavior. As Medicaid moves more of its population to managed care, at some point the FFS rates will no longer be maintained. For this reason, the State is proposing:

- Require that non-contracted hospitals providing emergency services to Medicaid or New Jersey FamilyCare members enrolled in the managed care program shall accept, as payment in full, 95% of the amount that the non-contracted hospital would receive from Medicaid for the emergency services and/or any related hospitalization if the beneficiary were enrolled in Medicaid FFS. This is consistent with the New Jersey Appropriations Act which, for many years, has included the following provision: "Non-contracted hospitals providing emergency services to Medicaid or New Jersey FamilyCare members enrolled in the managed care program shall accept, as payment in full, the amounts that the non-contracted hospital would receive from Medicaid for the emergency services and/or any related hospitalization if the beneficiary were enrolled in Medicaid FFS." Similar language appears in a Medicaid statute at N.J.S. 30:4D-6i.

- Continue setting Medicaid managed care capitation rates that reflect costs associated with an efficient/effective HMO as compared to rate development as a cost-plus calculation. Specifically, capitation rates will continue to include a low acuity non-emergent analysis,

which is a clinical-supported approach that targets inefficient/unnecessary emergency department utilization. New Jersey Medicaid managed care data shows that about 62% of all ED services were deemed low acuity non-emergent visits in SFY 2010 with 24% determined to be preventable, accounting for 9.6% of the SFY10 emergency department expenditures. Prospectively, Medicaid managed care capitation rates will be reduced to reflect the expectation that HMOs must further reduce unnecessary emergency department utilization of its members.

Participate in provider payment reforms under the Affordable Care Act to pursue episodic pricing and linkages to outcomes. There are two payment reform opportunities under the Affordable Care Act in which New Jersey will seek participation with its HMOs and hospitals:

- Integrated Care Around Hospitalization – Section 2704 establishes a demonstration project, in up to eight states, to study the use of bundled payments for hospital and physician services under Medicaid. The demonstration is effective on January 1, 2012, and ends December 31, 2016.

- Medicaid Global Payment System – Section 2705 establishes a demonstration project, in coordination with the CMS Innovation Center, in up to five states that would allow participating states to adjust their current payment structure for safety net hospitals from a FFS model to a global capitated payment structure. The demonstration shall operate through 2012. The Affordable Care Act authorizes this program but does not appropriate any funding.

V. Delivery system innovations

New Jersey will take steps under the comprehensive waiver that are specifically designed to provide integrated health care services, promote competition, support health homes for members, and pilot the Accountable Care Organization model.

<u>Integrated primary, acute, long-term care and behavioral health care: Managing long-term care for seniors and persons with physical disabilities</u>

New Jersey is in the process of transitioning most Medicaid and CHIP enrollees into capitated managed care for most services. This comprehensive waiver continues the evolution in the delivery system by supporting cost-effective managed primary, acute, long-term and behavioral health care.

Beginning July 1, 2011, and into the fall, the primary and acute care needs of most Medicaid populations, including dual eligibles and the aged, blind and disabled, will be met through amendments to the current Medicaid HMOs. In so doing, New Jersey will also include services, such as pharmacy for the aged, blind and disabled, that have historically been carved out of managed care. The only population that will remain FFS for primary care but still under the comprehensive waiver will be General Assistance, who will receive an ambulatory benefit under Medicaid. (Some *services* for other populations will also be FFS such as behavioral health) for certain adults and children as described below in this section.) The General Assistance benefit

excludes inpatient and outpatient hospital care which will continue to be funded through New Jersey's Charity Care Program funded with disproportionate share dollars.

A principle objective of the comprehensive waiver is to rebalance or shift away from the reliance on institutional and acute emergency services toward preventive and home and community-based care where an individual's health is improved and they can remain an active member of their community.

Effective July 1, 2012, New Jersey will further amend its existing HMO contracts to manage all long-term care services including home-and-community based services and nursing facilities for the elderly and physically disabled. In order to ensure that the HMOs can meet the needs of these populations, the State will ask for each HMO to describe how they will meet specified requirements, their experience elsewhere, describe their network completely and will not be allowed to enroll individuals with long-term care needs until a readiness review is successfully completed. HMOs must also submit plans for delaying and/or preventing their aged, blind, and disabled members who do not currently meet at risk-of-institutionalization criteria from reaching that level of care criteria. Managed long-term care will include:

- Those at risk of long-term care (meet the level of care criteria administered by the State) will have integrated home-and-community based services, behavioral health and acute care
- The continuum of home-and-community based services will be expanded beyond current 1915(c) authority
- Cost-sharing, home maintenance of needs allowances and post-eligibility treatment of income will be standardized across populations
- Cash and counseling services now authorized under Section 1915(j) of the State Plan will be included under managed long-term care (HMOs will be required to continue participation of members already participating in cash and counseling and/or self-direction upon implementation of managed long-term care for a transition period)
- Self-direction will be offered through the HMO along with fiscal intermediary services for independent providers (the State will secure fiscal intermediary services through a competitive bid and make the fiscal intermediary available to HMOs to provide members the most cost-effective service that results from larger volumes of participants)
- Existing PACE programs will be blended with managed long-term care as possible participants in the HMO long-term care network
- HMOs will provide case management and support coordination either directly or through contracts with organizations such as Area Agencies on Aging
- HMOs will have authority to mandate the cost-effective placement whether home-and- or nursing facility; home-and-community based services can be more expensive for a short-term transition period post discharge from a nursing facility (this authority must be requested and approved by CMS)
- HMOs will be required to implement information systems to automate care planning and tracking functions and predictive modeling

While New Jersey has made significant progress in rebalancing its long-term care programs to move more of its seniors and disabled into home and community-based settings, New Jersey

anticipates qualifying for the enhanced federal matching share under the Balancing Incentive Payments to be available under the Affordable Care Act and will submit a competitive and successful proposal when the opportunity is announced by CMS. This has the potential to provide New Jersey with an increased federal match from two percentage points up to five percentage points on non-institutional expenditures between October 1, 2011, and September 30, 2015.

In implementing managed long-term care, New Jersey is committed to building the infrastructure required to monitor quality and HMO performance in managing long-term care. Defining quality measures in the home-and-community based services framework is a major undertaking. In addition, New Jersey will examine and consider legislation that maximizes the role of self-directed care givers. As part of this proposal, the State will also seek a waiver of the Preadmission Screening and Resident Review requirements. HMOs will make placement decisions depending on the most appropriate setting for care.

Additional managed care improvements and pilots

In addition to the changes described in the previous section, New Jersey will take steps under the comprehensive waiver that are specifically designed to promote competition, support health homes for members, pilot the accountable care organization model and take steps to integrate behavioral health and physical health care.

In order to accomplish the changes necessary and have the programs in place between July 1, 2011 and July 1, 2012, New Jersey will amend current HMO contracts initially for these changes. However, the State will seek necessary authority to streamline its contracts and competitively bid managed care in two to three years. The managed care changes for acute/medical services include:

- Pilot accountable care organizations within a managed care framework and share savings for these initiatives with the State, federal government, HMOs, the accountable care organizations and providers
- Require HMOs to implement, at least on a pilot basis, health care homes (and accountable care organizations) to obtain 90% federal matching available under the Affordable Care Act
- Implement a member rewards and responsibility program based on a partnership between Federally Qualified Healthcare Centers and HMOs, supported by program funding from the Medicaid Grants for Prevention of Chronic Disease
- Effective January 1, 2012, behavioral health services for adults assessed to have low mental health and/or substance abuse symptoms/needs will have their care managed by a HMO to ensure:
    - Integrated care coordination
    - Integrated predictive modeling
    - Promotion of co-located service delivery
    - Integrated medical record and electronic medical record initiatives
- Provide incentives for integrating physical health and behavioral health for adults with major mental health and substance abuse disorders and/or serious mental illness served

outside of the HMOs under an administrative services organization) (See *Managing behavioral health* below)
- Work with DHS to develop a framework for access to Applied Behavioral Analysis for children with autism
- Provide incentives for integrating physical health and behavioral health for children served outside of the HMOs under the Children's Initiative (See *Managing behavioral health* below).

New Jersey will also conduct a pilot of an accountable care organization for the General Assistance population who will not be under managed care. New Jersey will seek authority to use disproportionate share dollars to fund shared savings with the accountable care organizations, HMOs, and the State for reduced emergency department and inpatient use by General Assistance members. In addition, the State will seek Safe Harbor protection from penalties under the Stark Anti-Kickback requirements for providers participating in accountable care organization programs under the comprehensive waiver.

Managing services for the dual eligibles

Under the comprehensive waiver, New Jersey will enroll dual eligibles into Medicaid managed care on or about September 1, 2011 for primary and acute care. Effective January 1, 2012, New Jersey will contract with Medicare special needs plans that are also Medicaid managed care plans (HMOs). New Jersey seeks $1 million in grant funding as a component of the comprehensive waiver for planning the redesign of the current system of fragmented care for individuals who are dually eligible for Medicare and Medicaid.

Through the comprehensive waiver, New Jersey will require that dual eligibles enroll in a single Medicaid HMO/Medicare Advantage Special Needs Plans for receipt of both Medicaid and Medicare benefits. However, it appears that CMS does not have the authority to waive freedom of choice under Medicare. In the absence of such authority, New Jersey requests the ability to auto-assign a member to the same Medicare and Medicaid plan with an opt out for Medicare and the authority to limit Medicaid payment of Medicare cost-sharing to only those Medicare providers that are within the Medicaid HMO's network, with the goal of encouraging dual eligibles to enroll in the same plan for the Medicaid and Medicare benefits.

The Department has long recognized that the dual eligibles have been a cost driver for New Jersey. CMS has also recognized this issue and has offered states the opportunity to support states' ability to make data driven decisions. To that end, New Jersey will take advantage of the recently announced US Department of Health and Human Services series of initiatives to facilitate access to Medicare data in order to help coordinate care, improve quality, and control costs for these high risk and high cost beneficiaries.

Finally, New Jersey seeks to streamline oversight requirements, and as such, will seek a single appeals process rather than the two processes – one under Medicare and one under Medicaid.

Managing behavioral health

The comprehensive waiver proposes different approaches for managing behavioral health services (inclusive of mental health and substance abuse services unless otherwise specified) for adults and children.

Adults. Adults with moderate and intensive behavioral health needs will be supported through a non-risk model of managed care under contract with an Administrative Services Organization contract beginning January 1, 2013. Adults with less severe needs will be carved in to managed care beginning January 1, 2012, as described in a previous section as will all adults requiring long-term care services. DHS will develop and issue a request for proposals in SFY 2012. DHS will work with the New Jersey Division of Purchase and Property to accomplish this procurement in a short time frame. Otherwise, an exemption from the existing procurement process will be required so that DHS and DMAHS can quickly conduct necessary procurements to make use of the flexibility granted the State under the comprehensive waiver.

Before the administrative services organization is operational, the Division of Mental Health and Addiction Services within DHS will undertake a series of tasks in addition to developing the Administrative Services Organization Request for Proposal including:

- Work with DMAHS to promote integration of services with HMOs for the highest-cost members (top 5%) across the two systems including data sharing
- Work with health homes and accountable care organizations to promote integration
- Fully integrate addiction and MH services within a single division
- Complete a state hospital closure and transition residents to the community consistent with the Division's Olmstead plan. DMHAS will seek to utilize Money Follows the Person for patients leaving the State and county hospital system
- Engage stakeholders in improving the community infrastructure including the network of providers and emergency department triage
- Develop screening tools to identify adults that will be served through the HMOs
- Seek enhanced federal matching funds for integration of physical and behavioral health at community behavioral health provider sites allowed under Section 2703 of the Accountable Care Act
- Rebalance behavioral health provider rates to incentivize more cost effective care

Once the contract is in place, the administrative services organizations will perform a number of tasks on a non-risk basis. These tasks include:

- Develop and conduct a uniform assessment of all adults seeking treatment that includes diagnosis and functional status to identify the most "at-risk" population for long-term behavioral health service needs
- Conduct predictive modeling
- Manage inpatient admissions for private and public psychiatric care and perform continuing-stay review
- Recommend and implement prior authorization requirements approved by DHS
- Build a provider network focused on network adequacy for community-based care

- Perform all utilization management functions
- Assist residents' transition to the community from State hospitals that are closed
- Identify individuals meeting the State's definition of serious mental illness
- Recommend rate revisions to promote community behavioral health capacity
- Pay claims
- Provide member access services including on-line and toll free numbers with appropriate languages available
- Design and recommend a member rewards program
- Provide behavioral health supports for individuals with intellectual and developmental disabilities and provide training for direct care workers who must manage behavioral health issues
- Implement the following to promote integration of behavioral health and physical health (most requirements apply to the administrative services organization and the HMO):
    - Establish a formal process for administrative services organizations communication with HMOs and primary care physicians regarding their members in care
    - Share all behavioral health claims/encounters with HMOs allowed by federal regulations and vice versa
    - Streamline access into behavioral health services
    - Accept performance measures for integration steps taken by administrative services organization (and conversely the HMO)
    - Develop a joint focus with HMOs to integrate care for top 5% most expensive across the two systems including integrated medical records
    - Educate members and providers in both systems
    - Participate in electronic medical record initiatives
    - Develop care coordination protocols for integration with HMOs
    - Promote integrated service delivery (e.g., co-located behavioral health and physical health services)
    - Promote integrated service delivery through accountable care organizations
    - Implement hospital emergency department triage
    - Educate members regarding the formulary

Children. Most of the behavioral health services for children with moderate and intense behavioral health needs are currently supported through a non-risk model of managed care under the DCF – Division of Child Behavioral Health Services' contract with an administrative services organization provider. The administrative services organization provides many functions including utilization management, prior authorizations, a single point-of-entry and coordinates a behavioral health needs assessment process for children. This administrative services organization model will be utilized to support all children accessing behavioral health (mental health and substance abuse) services for all levels of need. Children, more than adults, often move more rapidly back and forth from low-intensity need to high-intensity need. Therefore, a single management system through the established administrative services organization model will be utilized as the best model for ensuring coordinated, integrated care in an efficient and cost-effective manner. This transition will take effect in July 2012.

Managing supports for individuals with intellectual and developmental disabilities

Consistent with the requirements of the Olmstead decision, a key objective of the comprehensive waiver is to reduce the use of institutional placement to care for people with intellectual and developmental disabilities and increase community placement and support for those individuals.

All developmental disabilities services under the supports waiver (which will be submitted to CMS) and the community care waiver, as well as State Intermediate Care Facility for People with Mental Retardation services for adults will be incorporated under the comprehensive waiver.

Before this occurs, New Jersey will seek enhanced federal match and aggressively pursue initiatives to:

- Obtain enhanced federal match under Balancing Incentive Payments to be available under the Affordable Care Act (two to five percentage points as described above)
- Implement the supports waiver to increase in-home supports and obtain federal match for Medicaid-eligible people for Medicaid-eligible services currently funded with State-only dollars
- Replace cost-based reimbursement with prospective rates
- Eliminate the process of intake applications for children who will not enter the waiver system for three or more years
- Expand the resource allocation levels for supports to include all adults served by home and community-based programs
- Expand the continuum of health-and-community based services and cost-effective residential alternatives
- Build the health-and-community based services provider network through reinvestments and incentives for community based services
- Integrate financial reporting systems
- Close a State developmental center and transition residents to the community using the Money Follows the Person grant support and using a portion of savings both to support individuals transitioned to the community and to reinvest in the home-and-community based services infrastructure

The Developmental Disabilities agency within DHS and DMAHS will also undertake initiatives designed to reduce the general fund dollars that are unmatched in the program but appear to be covered services for eligible adults and children under Title XIX. These initiatives include:

- Require a denial of Medicaid eligibility before State-funded programs are made available to both new and existing members
- Require SSN and adopt a common identifier for Medicaid and State-funded services to allow retroactive claiming for individuals determined eligible for Medicaid and submit a retroactive claim for services paid with state funds within the last 24 months (July 1, 2009-June 30, 2011)
- Enhance claiming federal match for out-of-state placements

- Streamline eligibility policies and processes to reduce the amount of time before an adult is placed on the home-and-community based services waivers avoiding the use of state-funded services
- Develop policies to manage the waiting list and ensure that individuals with greater needs are prioritized on the waiver to avoid serving them with State funds
- Convert State-funded programs serving children to Title XIX

These initiatives taken as a whole also have a significant impact on New Jersey's ability to resolve the list of adults waiting to receive services. Once the supports waiver is implemented and reinvestments are made, New Jersey will be able to serve the majority of adults now on the waiting list.

Serving individuals with intellectual and development disabilities with dual diagnoses of mental illness and substance abuse disorders

New Jersey will implement an initiative that is specifically targeted to adults and children with a dual diagnosis of behavioral health and intellectual or developmental disability. New Jersey recognizes that some services currently funded largely through State funds (e.g., crisis intervention and advanced behavioral analysis) could be covered under Medicaid, and also recognizes that most if not all of the adults and children served are Title XIX or XXI eligible. As the initiative is designed, the State will maximize federal participation under Title XIX and XXI.

The potential savings to the State needs to be further refined, but the final proposal will be reliant upon the Dual Diagnosis Task Force Report as guidance. New Jersey proposes to examine mental health screening, in-home services, emergency and crisis intervention now provided with State-only dollars and develop a plan to incorporate the services into Medicaid. These services include:

- Adult mental health screening and emergency services
- Adult off-site crisis intervention
- Short-term emergency treatment
- Crisis stabilization/respite beds
- Specialist screening staff that work in conjunction with the Crisis Response System serving individuals with developmental disabilities and mental illness
- Supportive services that would allow for identification of needs at assessment and prior to the need for crisis intervention
- Applied Behavioral Analysis for children and young adults with autism spectrum disorder particularly those without mental retardation

In addition to screening, there are other mental health and substance abuse services such as individual and group therapy and medication administration that are provided through the community behavioral health system under contract with the Division of Mental Health and Addiction Services where rates of reimbursement are materially below cost. Payment rates for providers not under contract are higher. New Jersey recognizes that community behavioral health services are cost effective and will resolve the payment inequity as a component of the

intellectual and developmental disabilities/mental illness dual initiative. This initiative results in provider reimbursement rates that are prospective and not cost reconciled.

VI. Rewarding member responsibility and healthy behaviors

Through the comprehensive waiver, New Jersey will also encourage all individuals receiving Medicaid to engage in healthy behaviors and accept additional responsibility for their health. New Jersey will engage its HMOs and the behavioral health administrative services organizations to develop a member reward initiative for healthy behaviors and/or compliance with a needed plan of treatment. HMOs would be given flexibility in the design of rewards programs and dollar incentives. The use of financial rewards would be restricted to health-related purchases through designated pharmacies. For example, members could be rewarded if they:

- Reduced or eliminated inappropriate emergency department use in favor of timely access to primary care
- Obtained age and condition-appropriate immunizations and preventive screenings
- Completed an outpatient substance abuse treatment program
- Participated in telemonitoring for diabetes, high blood pressure
- Quit smoking
- Had zero no-shows for scheduled appointments
- Completed follow-up appointments
- Were on time to appointments
- Lost weight according to a nutrition plan
- Exercised according to a treatment plan

As a complement to and funding source for the member rewards program, New Jersey has submitted a grant request under the Affordable Care Act Medicaid Incentives for Prevention of Chronic Disease. The Affordable Care Act authorizes grants of $5 million to $10 million to states to provide incentives to Medicaid beneficiaries of all ages who participate in prevention programs and demonstrate changes in health risk and outcomes, including the adoption of healthy behaviors. DMAHS has partnered with Federally Qualified Health Centers and HMOs in its grant proposal.

VII. Program integrity

New Jersey will also include in its comprehensive waiver initiatives to promote the integrity of the program. These initiatives include:

- Refocus program integrity investigations to the managed care environment including managed care entities themselves and development of strategies for program integrity for managed long-term care
- Implementation of the Medicaid Recovery Audit Contractor specific to managed care
- Revision of managed care contracts to place additional responsibilities on HMOs for reporting of potential fraud and abuse to DMAHS and the Medicaid Fraud Division for investigation, including:

  - Redefining the Special Investigations Unit required within each HMO as a data mining function staffed by analysts not investigators that monitors claims and encounter data for potential provider and member fraud or abuse such as billing for services not rendered, billing for services not medically necessary, up-coding, misrepresenting clinical information, duplicate billing, using a Medicaid card belonging to someone else, lending or altering a Medicaid ID including duplication and altering or forging prescriptions
  - Reporting of suspected fraud and abuse identified through data mining for investigation by the Medicaid Fraud Division thereby providing the potential for greater recoveries through extrapolation from sample data which HMOs are not permitted to do, the tripling of overpayments and the imposition of sanctions;
  - Imposition of sanctions if an HMO fails to report potential fraud and abuse
  - Strengthening internal audit and compliance functions within HMOs for fraud and abuse and third-party liability identification
  - Requiring routine criminal background checks of high-risk providers and excluded individuals and entities
  - Strengthening reporting and collection from liable third parties by requiring third-party liability data matches within the same corporate entity
- Enhanced focus for targeted services on explanations of member benefits sent by HMOs to engage members in making sure they receive the services for which the State has paid
- More sophisticated data matches for redetermination of Medicaid eligibility which will be possible through the SSN of Medicaid applicants and enrollees that New Jersey proposes to require
- Development of a package of amendments to Medicaid, New Jersey FamilyCare and General Assistance statutes and regulations, with input from the Medicaid Fraud Division of the Office of the State Comptroller; amendments to other DHS, DHSS and Department of Banking and Insurance and State probate statutes, with input from relevant State agencies and amendments to the Rules of the Court to accomplish the following:
  - Clarify and enhance the ability of DMAHS, the Medicaid Fraud Division and/or the Medicaid Fraud Section in the Division of Criminal Justice to address fraud, waste and abuse; save and recover funds when third-party liability exists and obtain reimbursement of Medicaid funds from estates and special needs trusts
  - Provide DMAHS the authority to file liens against the property of living permanently institutionalized individuals and to issue "cease and desist" orders, with penalties for failure to comply
  - Provide DMAHS greater authority and flexibility to address fraud and abuse by beneficiaries

VIII. Budget neutrality

Consolidation of programs under Section 1115 necessitates the negotiation of a “budget neutrality” agreement with CMS for most of the Medicaid and CHIP dollars and programs New Jersey administers. The concept of “budget neutrality” is that a 1115 demonstration program will not cost the federal government more than it would under existing Medicaid program rules

over the term of the demonstration. There continues to be a State/federal matching requirement and a state is "at risk" for the costs of continuing to serve populations and services if expenditures under the budget neutrality agreement are exceeded.

Under this proposal, there are just a few expenditures that would not operate under the demonstration:

- Services for individuals who are eligible for Medicare but do not receive a "full" Medicaid benefit because their income or assets are too high. These groups include Qualified Medicare Beneficiaries (QMB) Only, Supplemental Low Income Beneficiaries, Qualified Individuals (QI1s) and additional Qualified Individuals (QI2s). (The QMB Plus group does receive a full Medicaid benefit and are included in the comprehensive waiver.)
- Medicaid administrative expenditures claimed by schools.
- Medicaid administrative costs for DHS and its sister agencies. (Administrative costs are excluded from the tests of budget neutrality under Section 1115 waivers because CMS wants to ensure that the State has the infrastructure to administer the waiver.)
- FFS expenditures for emergency services-only populations.

All other program dollars and the disproportionate share hospitals allotment are proposed to be subsumed under the waiver. Disproportionate share dollars are to be included in this waiver for the following reasons:

- To redirect a portion of DSH dollars to incentivize hospitals and other providers for reduced emergency department and inpatient hospital use in the accountable care organization pilots.
- As a protection should it be needed to ensure that the state does not exceed budget neutrality. New Jersey will continue to pay disproportionate share hospitals under its current plan (with the three exceptions noted for General Assistance and health in this paper and the Affordable Care Act), unless it needs the DSH allotment to meet budget neutrality.

Most Section 1115 waivers are for a five-year period, which would encompass the Affordable Care Act 2014 implementation of new populations under Medicaid and a myriad of other changes. New Jersey could either shorten the waiver period or negotiate the terms under the Affordable Care Act.