

***Presentation:***

**Medicaid and CHIP Managed Care  
Final Rule  
(CMS-2390-F)**

# Overview and Background

- The final rule is the first update to Medicaid and CHIP managed care regulations in over a decade.
- This final rule advances the agency's mission of *better care, smarter spending, and healthier people*
- The health care delivery landscape has changed and grown substantially since 2002.
  - **In 1998, 12.6 million (41%)** of Medicaid beneficiaries received Medicaid through capitation managed care plans
  - **In 2013, 45.9 million (73.5%)** of Medicaid beneficiaries received Medicaid through managed care

# Key Goals of the Final Rule

- To support State efforts to advance delivery system reform and improve the quality of care.
- To strengthen the beneficiary experience of care and key beneficiary protections.
- To strengthen program integrity by improving accountability and transparency
- To align key Medicaid and CHIP managed care requirements with other health coverage programs

# Key Dates of the Final Rule

Effective Date is  
July 5, 2016

Phased implementation  
of new provisions  
primarily over 3 years,  
starting with contracts  
on or after July 1, 2017

Compliance with CHIP  
provisions beginning  
with the state fiscal year  
starting on or after July  
1, 2018

# DMAHS Internal Review

- Mercer consultants has performed an initial review of the entire rule.
- DMAHS subject matter experts (SMEs) are reviewing in three sections
  - The first review, consisted of a review of all provisions effective 1) immediately upon publication of the rule, 2) as of May 2016 and 3) as of July 5, 2016. *(Completed)*
  - The second review consists of all provisions effective as of July 2017. *(Currently underway)*
  - The third review will commence in mid October and will cover all provisions effective as of July 2018. *(Anticipated timeframe, subject to change)*

# Areas Identified for Additional Review January 1, 2017

- §438.3(e) MCO's ability to include "in lieu of services", medically appropriate and cost effective substitutes to State Plan services/settings.
- §438.6(e) Payments to MCOs for individuals in an institution for mental disease (IMD)
- §438.54 Enrollment and Disenrollment
- §438.104 Marketing activities
- §438.228 Appeals and grievances *(Adds clarification – No substantive changes)*
- §438.702 & §438.730 Types of intermediate sanctions / Sanctions by CMS – special rules for MCOs

# Areas Identified for Additional Review July 1, 2017

- §438.3(s) Outpatient drugs
- §438.4(b)(7) & §438.4(b)(8) Actuarial soundness
- §438.5(b) Rate development
- §438.8 Medical loss ratio (MLR)
- §438.66(a)-(d) State monitoring; readiness review
- §438.70 Stakeholder engagement for LTSS thru an MCO
- §438.110 Member advisory committee

# Areas Identified for Additional Review

## *July 1, 2017 Continued*

- §438.406, §438.408, §438.410 et al, Appeals and Grievances
- §438.602(a),(c)-(h) State Responsibilities: audits, whistleblowers, transparency, & integrity.
- §438.608(a) Program Integrity; administrative & management procedures to detect and prevent fraud, waste and abuse.
  - §438.608(c) Disclosures
  - §438.608(d) Treatment of recoveries



# Areas to Be Reviewed for July 1, 2018

- §438.4(b)(3) Actuarially Sound Capitation Rates
- §438.68 Network Adequacy Standards
- §438.71 Beneficiary Support System
- §438.602(b) & §438.608(b) Credentialing Providers, requirements
- §438.340 MCO Quality Strategy
- §438.350 thru §438.364 External Quality Review (EQR)
  - §438.354 Qualifications, §438.356 State Contract Options, §438.358 Activities Related to the EQR, §438.360 Nonduplication of mandatory activities, §438.362 Exemptions, *and* §438.364 Results

# Areas to Be Considered: 2018 and Beyond

- §438.4(b)(9) Actuarial Soundness (*July 1, 2019*)
- §438.66(e) Annual Report Program (*Upon Release of Guidance from CMS*)
- §438.334 Managed Care Quality Rating System (*TBD*)
- §438.358(b)(1)(iv) Mandatory External Quality Review: Validation of Network Adequacy (*TBD*)
- §438.358(c)(6) Optional External Quality Review: Plan Rating (*TBD*)

# Next Steps

- DMAHS will continue to:
  - Review the Final Rule against the NJ FamilyCare Managed Care Contract;
  - Make the necessary changes to the MCO Contract;
  - Provide regular updates through MAAC meetings; and,
  - Post federally approved MCO Contract(s) on the DMAHS website.

**Questions can be sent to:**  
**[Julie.Cannariato@dhs.state.nj.us](mailto:Julie.Cannariato@dhs.state.nj.us)**

***Informational Update:***

**Behavioral Health Rates**

Division of Mental Health & Addiction Services  
**wellnessrecoveryprevention**

*laying the foundation for healthy communities, together*

## FEE FOR SERVICE TRANSITION UPDATE

MAAC Meeting  
October 19, 2016

# RATES AND TRANSITION TO FFS

- In 2016 Governor Christie announced that \$127 million would be invested in enhanced behavioral health service rates for providers
  - It is the largest increase to the behavioral health community in over a decade
  - Providers benefit from the increased rates
  - Providers realize increased flexibility in managing agency revenue
  - Providers avoid contract cost containment requirements
  - Creates standardization of reimbursement across providers

# IMPLEMENTATION OF RATES AND FFS

- Increased Rates for Mental Health and Substance Use Disorders became effective July 1, 2016 with Medicaid
- SUD slot-based contracts transitioned to FFS on July 1, 2016
- July 2016 Prior Authorizations for Medicaid and some state initiatives
- SUD cash advance policy implemented
- MH Providers transition to FFS January or July of 2017

# DHS/DMHAS PLANNING FOR FFS TRANSITION

- Planning for the transition started with Rate Setting Activities in 2013
- 7 internal workgroups were created to guide the FFS transition: Core group, Fiscal/Contracts group, Medicaid group, Provider/Network group, Quality Assurance group, Information/Technology group
- A Mental Health stakeholder workgroup was also created with key MH representatives participating (e.g. NJAMHAA, NJ Association of Co. MH Administrators & NAMI, etc.)
- DMHAS Office of Information Systems engaged to develop and implement a comprehensive system solution NJ Mental Health Application for Payment Processing (NJMHAPP) to facilitate Mental Health State fund reimbursement <sup>16</sup>



# KEY ASSUMPTIONS FOR FFS TRANSITION

- Medicaid members and Medicaid covered services are to be billed to Medicaid ***prior to seeking state funding.***
- Providers are required to enroll as a Medicaid provider if receiving state funds. A provider can submit an application at <http://njmmis.com> (***including SE providers***)
- All providers transitioning to FFS are encouraged to become PE (Presumptive Eligibility) certified in order to expedite Medicaid eligibility and maximize federal financial participation.

## KEY ASSUMPTIONS FOR FFS TRANSITION CONTINUED

- Where a service is Medicaid-eligible, State-Only rates are set at 90% of the Medicaid rate (except for PACT, which is now equal to the Medicaid PACT monthly rate)
- Service limits and conflicts that are applicable for Medicaid will be applied to state FFS payments
- In order to qualify for FFS reimbursement, full compliance with DMHAS Regulations and contract requirements is mandatory.

# UPDATED FFS TIMELINE FOR IMPLEMENTATION

September  
2016

- Information Session (including demonstrations of NJMHAPP) for Providers Transitioning in January and MH FFS Stakeholder Workgroup Membership

October 2016

- User Acceptance Testing of NJMHAPP system (including hands-on session of NJMHAPP)
- Cash Advance Policy and Process Disseminated to MH Providers

Nov-Dec 2016  
January 2017

- Provider Wide Testing of NJMHAPP (to include additional users identified by providers transitioning January 2017).
- Launch NJMHAPP Application

# DMHAS RESPONSE TO STAKEHOLDER FEEDBACK ON SPECIFIC FFS RATES

- PACT increased state rate
- CSS rate for licensed clinical staff
- Psychiatric evaluation without medical services - increased state and Medicaid

# DMHAS RESPONSE TO STAKEHOLDER FEEDBACK ON SPECIFIC FFS RATES

- Psychiatric evaluation with medical services- increased state and Medicaid
- Medication Management (E/M) rate – evaluated but not changed
- CSS Peer rate– evaluated but not changed

# MANAGING THE SUD SYSTEM

- IME Phase I- July 1, 2015
  - Central Call Line
  - Care Coordination
  - Review and Approval of State funded Assessments
- IME Phase II- May 24, 2016
  - Full Utilization Management (Review and Approval) of Managed Initiatives
- Contract Conversion
  - Existing Contracts converted to FFS (specialty services excluded)

# CRITERIA FOR STATE REIMBURSEMENT

- 350% of Federal Poverty Level, modeled after SUD state only and NJ Family Care
- Private insurance does not cover the service/treatment, i.e. PACT
- >5 years of age and not receiving mental health services from CSOC
- Individual meets program eligibility criteria as outlined in regulation or policy

# GUIDELINES FOR ACCESSING STATE DOLLAR REIMBURSEMENT

- Medicaid Companion Regulations for Billing of Services Apply, where applicable
- State Rate does not wrap-around Charity Care or insurance payments
- If Out-of-Network, Providers must refer to In-Network provider and not access state fund reimbursement



## COMMUNITY SUPPORT SERVICES (CSS)

- The state regulations for CSS were finalized as of August 2016.
- DMHAS and DMAHS are working to begin implementation of CSS, allowing providers to begin billing Medicaid for CSS
- Agencies that delivered supportive housing are eligible to provide CSS and have been licensed by DHS as CSS agencies.

# COMMUNITY SUPPORT SERVICES (CSS) AND FEE FOR SERVICE

- The Division of Mental Health and Addictions Services (DMHAS) is transitioning away from cost related contracts and into a Fee for Service (FFS) funding system
- Billing in FFS is a change for supportive housing providers that will now be billing for CSS as FFS in Medicaid and in state-only beginning 7/17.
- Until 7/1/2017, CSS (former supportive housing providers) will remain in cost related contracts allowing DMHAS to provide funding during this transition.

# BENEFITS OF FEE FOR SERVICE

- **Goal of creating equity across the DMHAS system**
  - Potential for Increased system/service capacity
  - Creates greater access to care at the level needed, when needed
  - Promotes competition, creating more choices for consumers
  - Promotes service innovation

***Informational Update:***

**NJ FamilyCare Update**

# September 2016 Enrollment Headlines

**2<sup>nd</sup> Highest Enrollment on Record (1,763,960)**

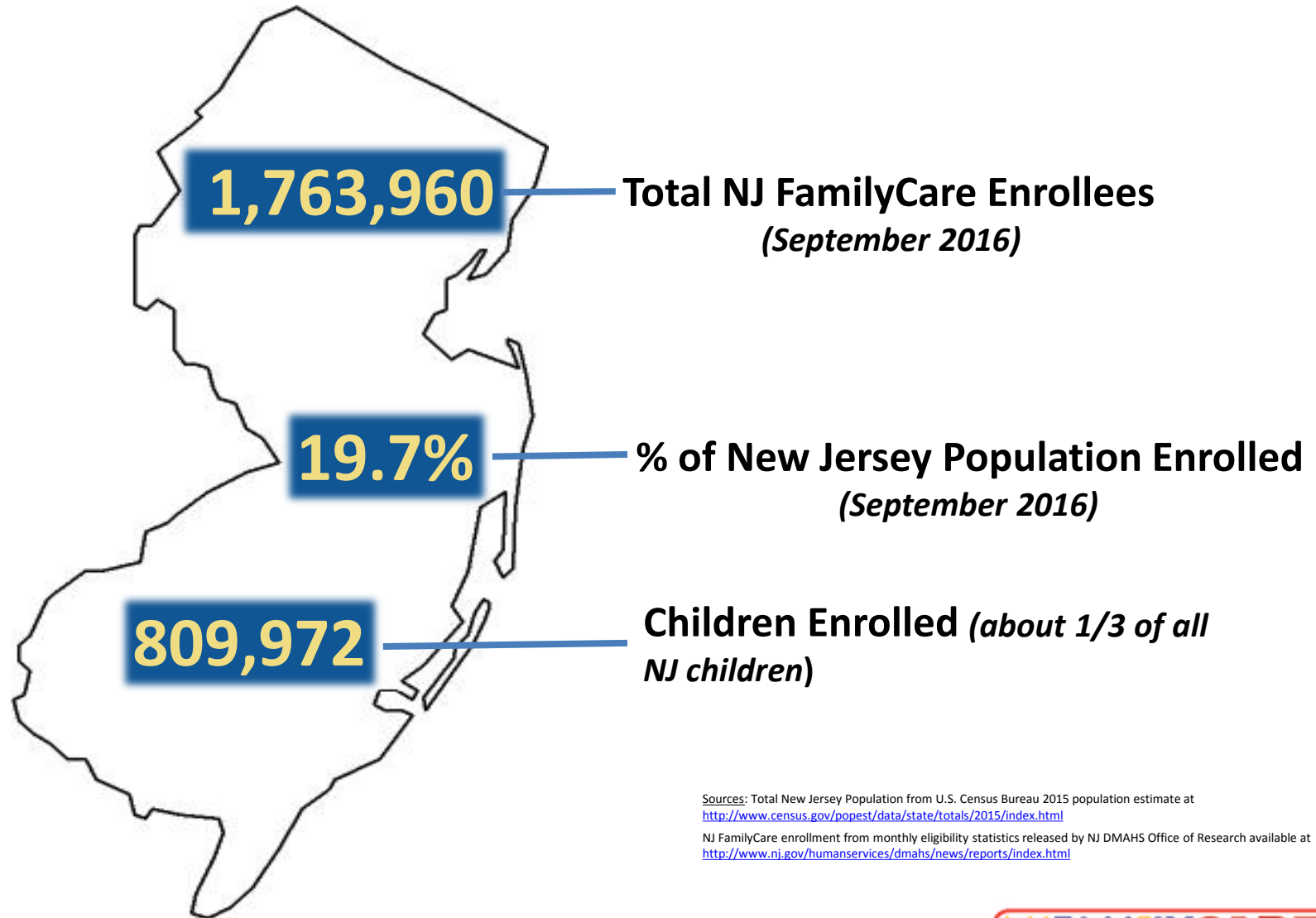
**479,479 (37.3%) Net Increase Since Dec. 2013**

**94.9% of All Recipients are Enrolled in Managed Care  
2nd Highest Managed Care Penetration Rate**

Source: Monthly eligibility statistics released by NJ DMAHS Office of Research available at <http://www.nj.gov/humanservices/dmahs/news/reports/index.html>;  
Dec. eligibility recast to reflect new public statistical report categories established in January 2014

Notes: Net change since Dec. 2013; includes individuals enrolling and leaving NJFamilyCare.

# NJ Total Population: 8,958,013

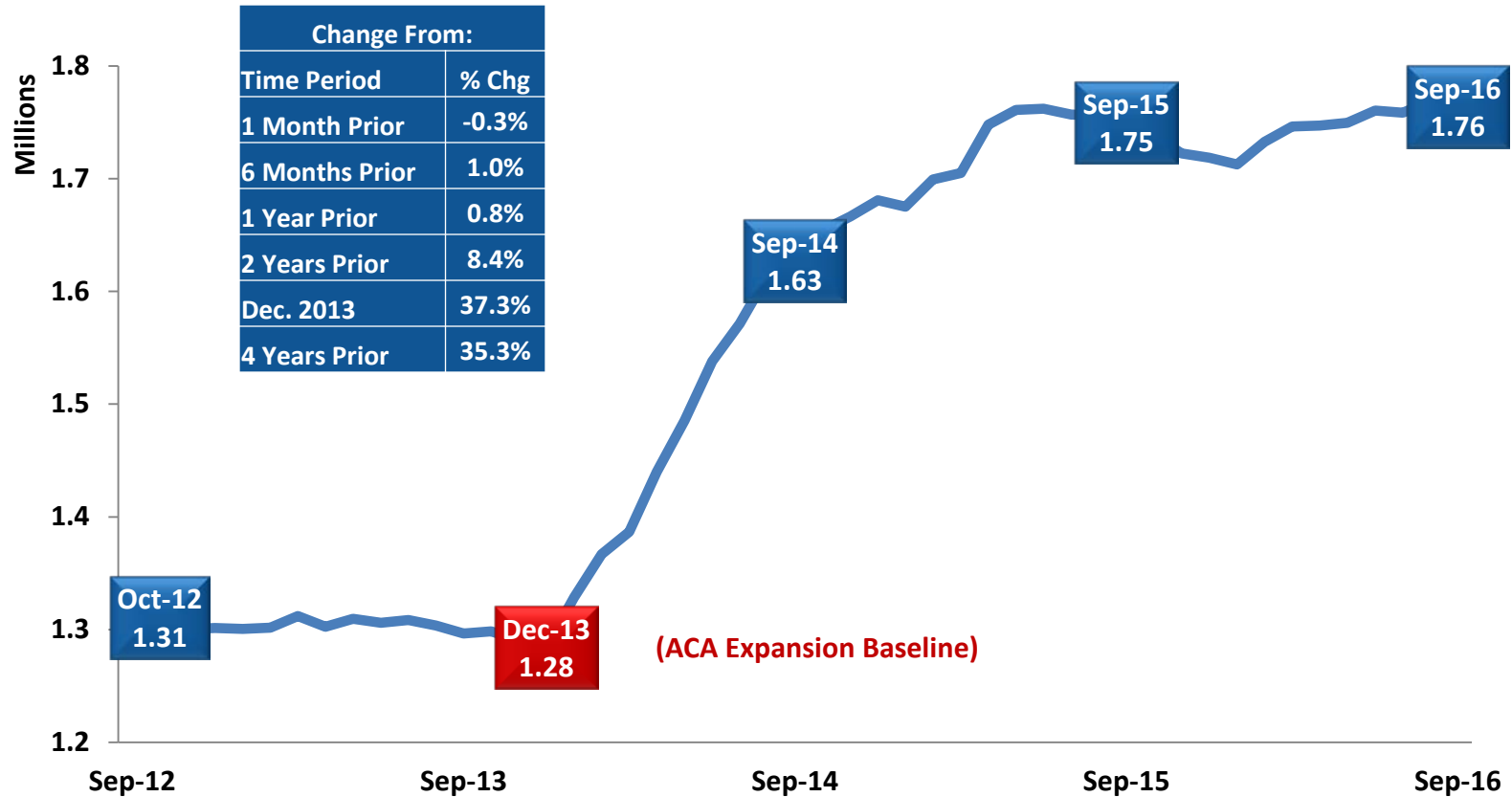


Sources: Total New Jersey Population from U.S. Census Bureau 2015 population estimate at <http://www.census.gov/popest/data/state/totals/2015/index.html>

NJ FamilyCare enrollment from monthly eligibility statistics released by NJ DMAHS Office of Research available at <http://www.nj.gov/humanservices/dmahs/news/reports/index.html>

# Overall Enrollment

## Total NJ FamilyCare Recipients, September 2012 – September 2016

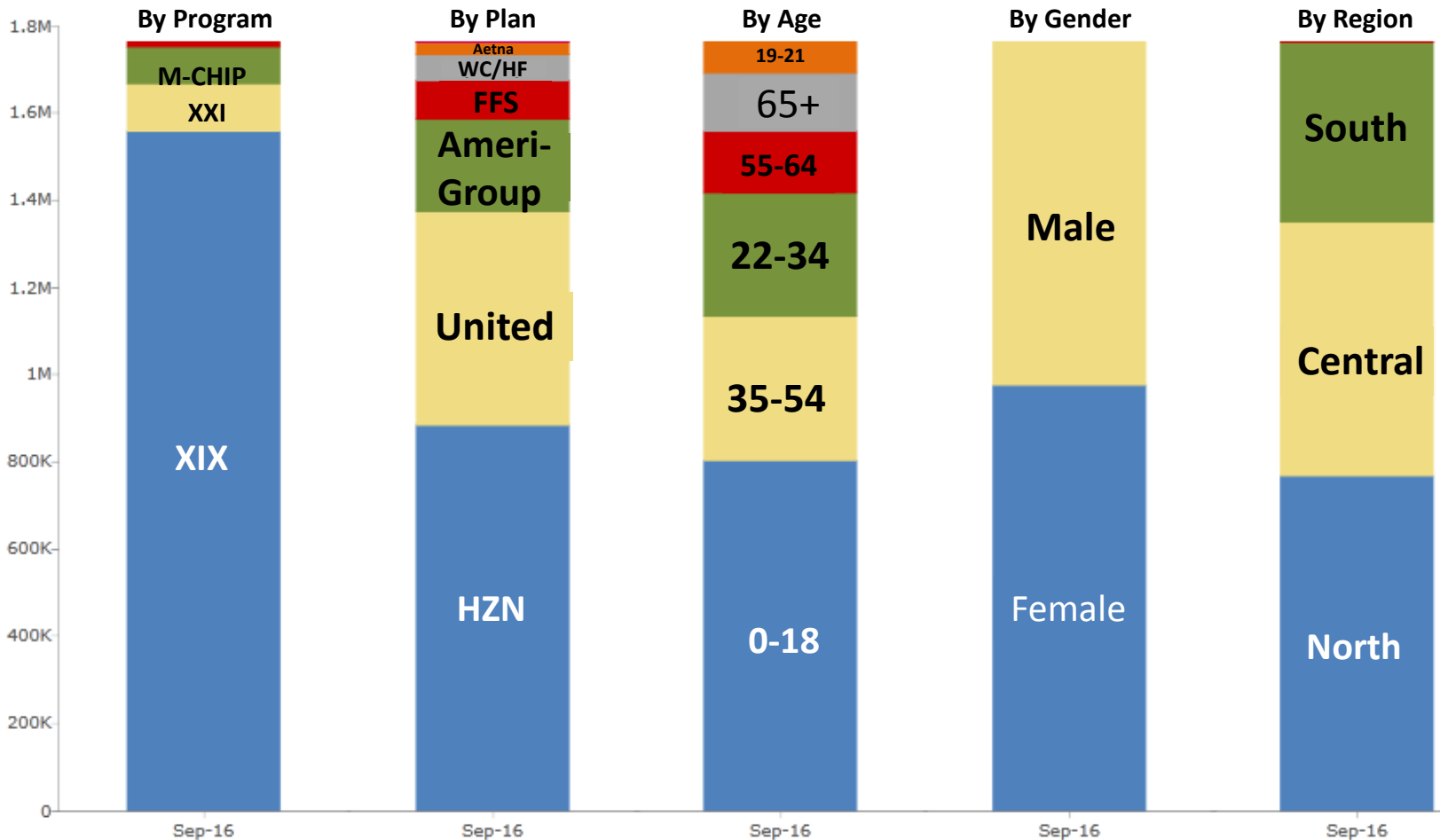


Source: SDW MMX Snapshot Universe, accessed 8/1/2016.

Notes: Includes all recipients eligible for NJ DMAHS programs at any point during the month

# NJ FamilyCare Enrollment “Breakdowns”

**Total Enrollment: 1,763,960**



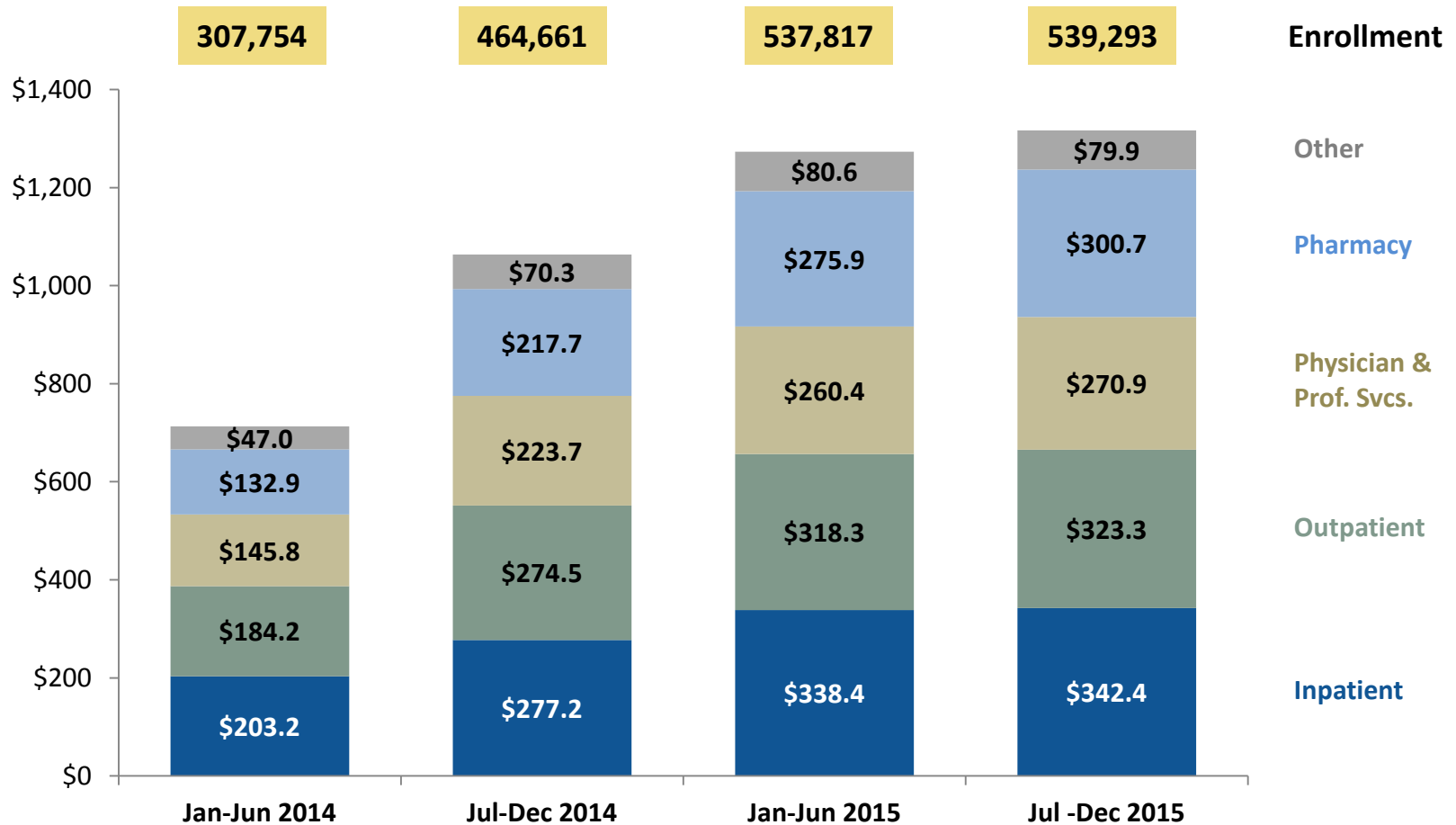
Source: NJ DMAHS Shared Data Warehouse Snapshot Eligibility Summary Universe, run for September 2016.

Notes: By Region: North= Bergen, Essex, Hudson, Morris, Passaic, Sussex & Warren. Central= Hunterdon, Mercer, Middlesex, Monmouth, Ocean, Somerset & Union. South= Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester & Salem. Region does not add up to total enrollment due to small “unknown” category that is not displayed. \*M-CHIP: Individuals eligible under Title XIX, but paid with CHIP (Title XXI) federal funds.





# Expansion Population Service Cost Detail

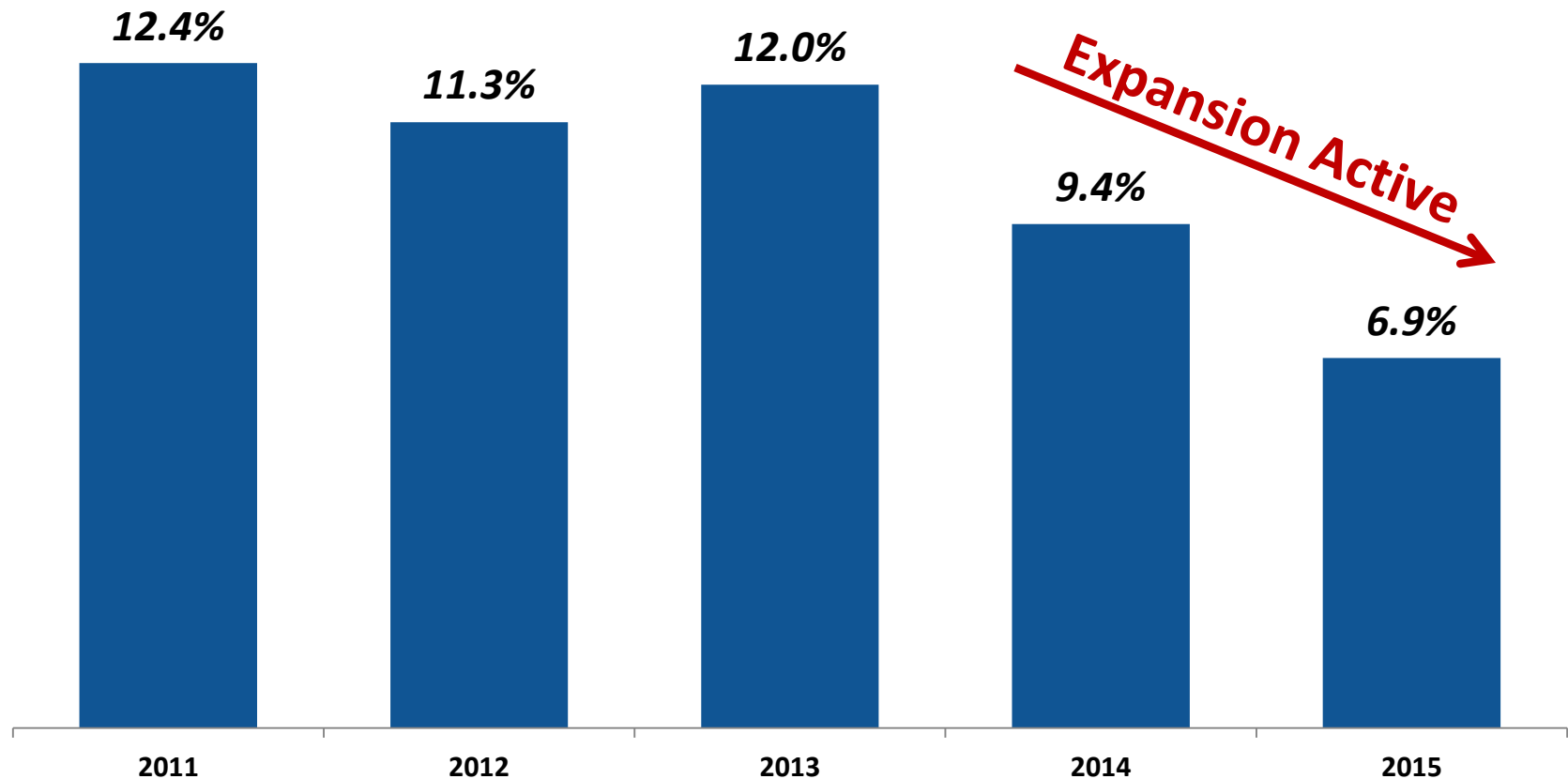


Source: NJ DMAHS Share Data Warehouse fee-for-service claim and managed care encounter information accessed 9/22/2016

Notes: Amounts shown are dollars paid by NJ FamilyCare MCOs to providers for services supplied to NJ FamilyCare members – capitation payments made by NJ FamilyCare to its managed care organizations are not included. Amounts shown include all claims paid through 12/28/15 for services provided in the time period shown. Additional service claims may have been received after this date. Subcapitations are not included in this data. In addition to traditional “physician services” claims, “Professional Services” includes orthotics, prosthetics, independent clinics, supplies, durable medical equipment, hearing aids and EPSDT, laboratory, chiropractor, podiatry, optometry, psychology, nurse practitioner, and nurse midwifery services. “Other” includes dental, transportation, home health, long term care, vision and crossover claims for duals.

# Expanded Medicaid Contributed to Large Decrease in NJ's Uninsured Population

New Jersey Uninsured Rate, 2011-2015



Source: National Health Interview Summary for years 2011-2015; produced and published by the CDC, National Center for Health Statistics: <http://www.cdc.gov/nchs/nhis/releases.htm>.

Notes: Percentages shown are for NJ only, are based on each individual's status at the time of interview and includes all ages.

# 1115 Comprehensive Waiver Renewal Application Update

# What is an 1115 Waiver and Why Does New Jersey Need to Submit a Renewal Application?

- The New Jersey 1115 Comprehensive Medicaid Waiver Demonstration is a “Research and Demonstration” waiver granted by the Centers for Medicare and Medicaid Services (CMS) under Section 1115(a) of the Social Security Act (SSA).
- Demonstrations under Section 1115 of the SSA give states flexibility to design and improve their programs using innovative ideas that are typically not allowed under Medicaid and CHIP rules.
- The Comprehensive Waiver gives NJ the authority to operate most of the NJ FamilyCare program, including:
  - Mandatory Managed Care
  - Managed Long Term Services and Supports (MLTSS)
  - Supports Program
  - Children’s Home and Community Based Services (HCBS) Programs
  - Delivery System Reform Incentive Payment (DSRIP)
- **The Comprehensive Waiver expires on June 30, 2017.**

# Concepts Included in the Waiver

- Move to an integrated, coordinated, and organized behavioral health delivery system, that includes a flexible and comprehensive substance use disorder (SUD) benefit;
- Increase access to services and supports for individuals with intellectual and developmental disabilities;
- Further streamline NJ FamilyCare eligibility and enrollment;
- Develop an uninterrupted re-entry system for incarcerated individuals;
- Include reinvestment dollars targeting housing support services for individuals who are homeless or at-risk of being homeless;
- Enhance access to critical providers and underserved areas through alternative provider development initiatives;
- Expand and enhance population health partnerships with community and faith-based organizations, public health organizations, healthcare providers, employers, and other stakeholders to improve health outcomes for Medicaid-eligible individuals.

# Stakeholder Process To Date

- The draft renewal application was published on June 10, 2016 for 60 days of public stakeholder comment.
- The Department engaged in an extensive public stakeholder process that included presentations at twelve (12) public forums over the 60 days with interested stakeholders from DMAHS, DMHAS, DoAS, DCF, and DDD.
- DMAHS received over 150 written comments on the renewal application from interested stakeholders and detailed how it addressed the comments in Attachment E of the renewal application.

# Summary of the Renewal Comments

- **Majority of the Comments**
  - Pertained to the concept of integrating care for dual eligible individuals concept
  - Supportive of the housing first and supportive housing concept
  - Applauded the work done with autism
  - Supported an integrated, organized and managed behavioral health delivery system
  - Called for continued stakeholder opportunities.
- **Based on Stakeholder Comment, Key Changes Include**
  - Removing Medicare as a condition of Medicaid eligibility.
  - Removing the Integrating Care Options for Dual Eligible Individuals concept, including both the seamless enrollment and integrated enrollment option.
  - Adding specifics around the types of models Medicaid is considering under the increased access / telehealth option.
  - A detailed population health description.

# Next Steps: CMS & DMAHS

- The amended application was submitted to CMS on Friday, September 16, 2016.
- CMS has fifteen (15) days to review the application for completeness and will then post the application to its website for a thirty (30) day federal public comment period.
- Once CMS deems the application package complete, DMAHS will post the application on the Division's website.



# Next Steps: Stakeholders

- Review the amended application
- Participate in the federal public stakeholder process
- Waiver updates will be posted on the Division's website:  
<http://www.state.nj.us/humanservices/dmahs/home/waiver.html>
  - Updates and ways of participating in workgroups will be announced through stakeholder forums like the MLTSS Steering Committee and the MAAC.

**Waiver comments can  
*always* be sent to  
[dmahs.cmwcomments@dhs.state.nj.us](mailto:dmahs.cmwcomments@dhs.state.nj.us)**

***Informational Update:***

**Managed Long Term Services  
and Supports**

# August 2016 LTC Headlines

**41.4% of the NJ FamilyCare LTC Population is in Home and Community Based Services\***

*Prior Month = 40.9%; Start of Program = 28.9%*

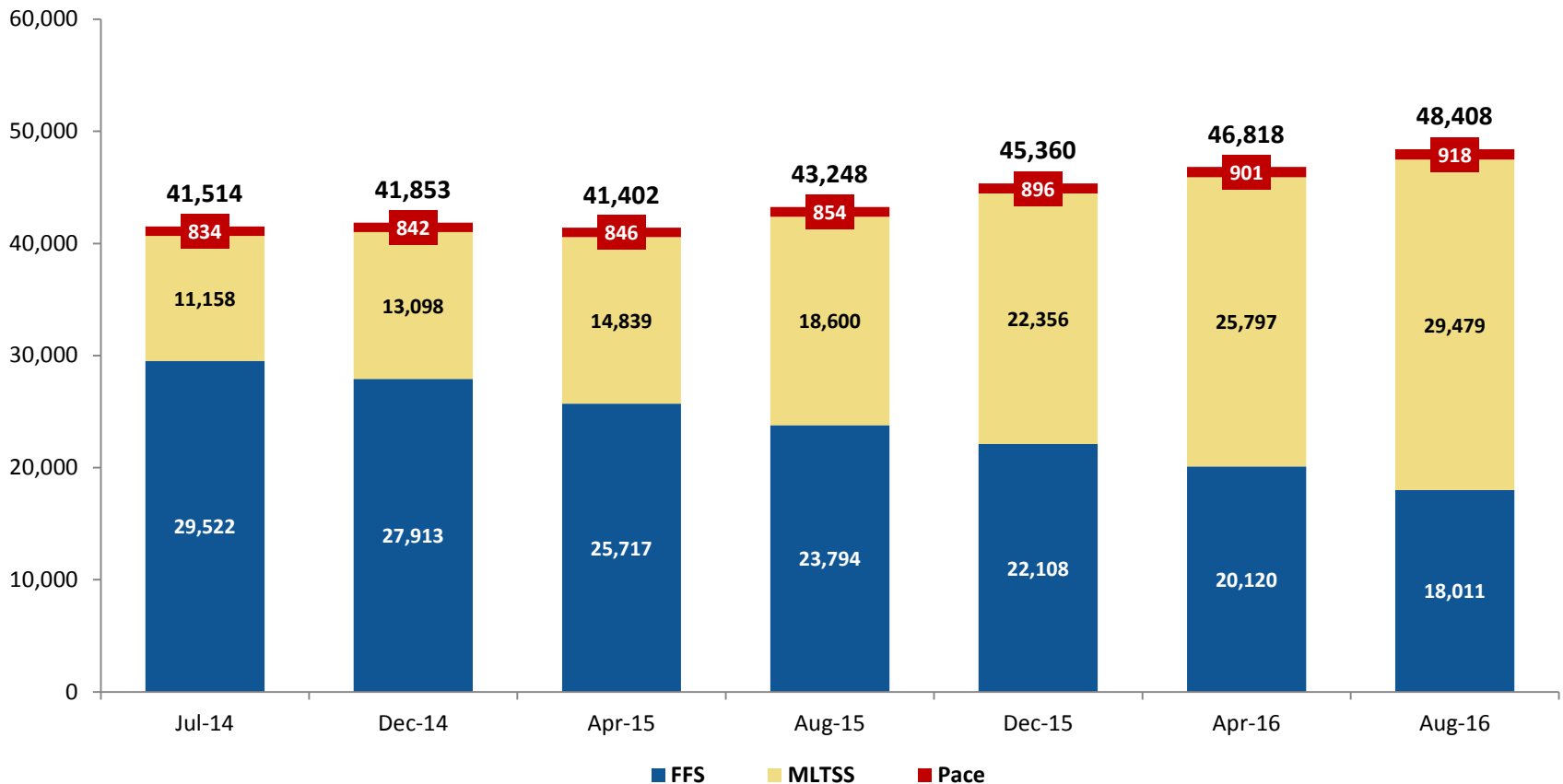
**Nursing Facility Population\*\* Down by Almost 1,000 Since the July 2014 Implementation of MLTSS**

\* Methodology used to calculate completion factor for claims lag in the 'NF FFS Other' category (which primarily consists of medically needy and rehab recipients) has been recalculated as of December 2015 to account for changes in claims lag; this population was being under-estimated.

\*\* Nursing Facility Population includes all MLTSS recipients and all FFS recipients (grandfathered, medically needy, etc.) physically residing in a nursing facility during the reporting month.

# Long Term Care Population: FFS-MLTSS Breakdown

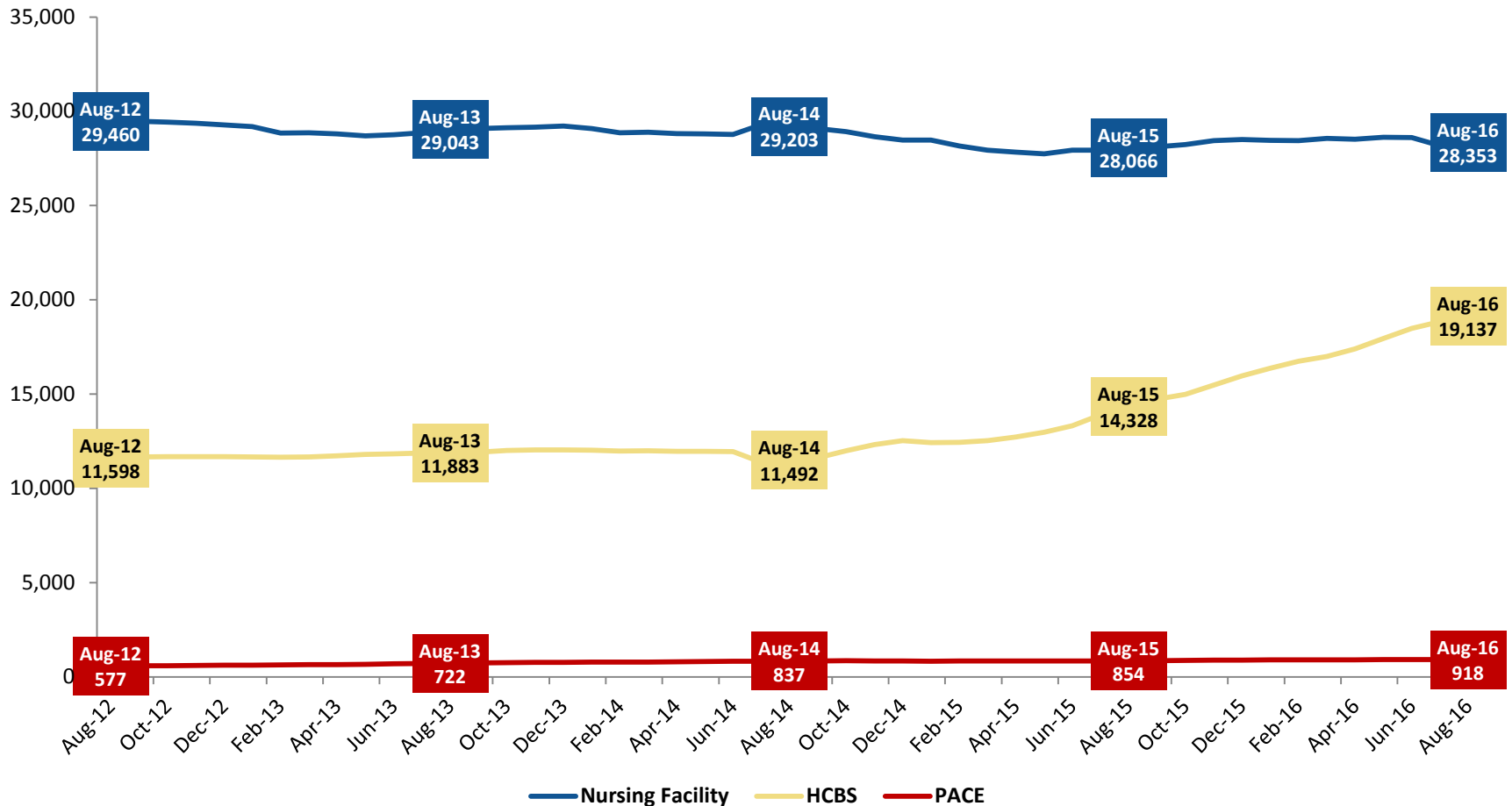
## 4-Month Intervals



Source: Monthly Eligibility Universe (MMX) in Shared Data Warehouse (SDW), accessed on 9/9/2016.

Notes: Information shown includes any person who was considered LTC at any point in a given month based on: Capitation Codes 79399, 89399, 78199, 88199, 78399, 88399, 78499 & 88499, Special Program Codes 03, 05, 06, 17, 32, 60-67, Category of Service Code 07, or MC Plan Codes 220-223 (PACE). All recipients with PACE plan codes (220-229) are categorized as PACE regardless of SPC, Capitation Code, or COS. MLTSS includes all recipients with the cap codes listed above. FFS includes SPC 65-67 and all other COS 07, which is derived using the prior month's COS 07 population with a completion factor (CF) included to estimate the impact of nursing facility claims not yet received. Historically, 90.76% of long term care nursing facility claims and encounters are received one month after the end of a given service month.

# Long Term Care Population by Setting



Source: Monthly Eligibility Universe (MMX) in Shared Data Warehouse (SDW), accessed on 9/9/2016.

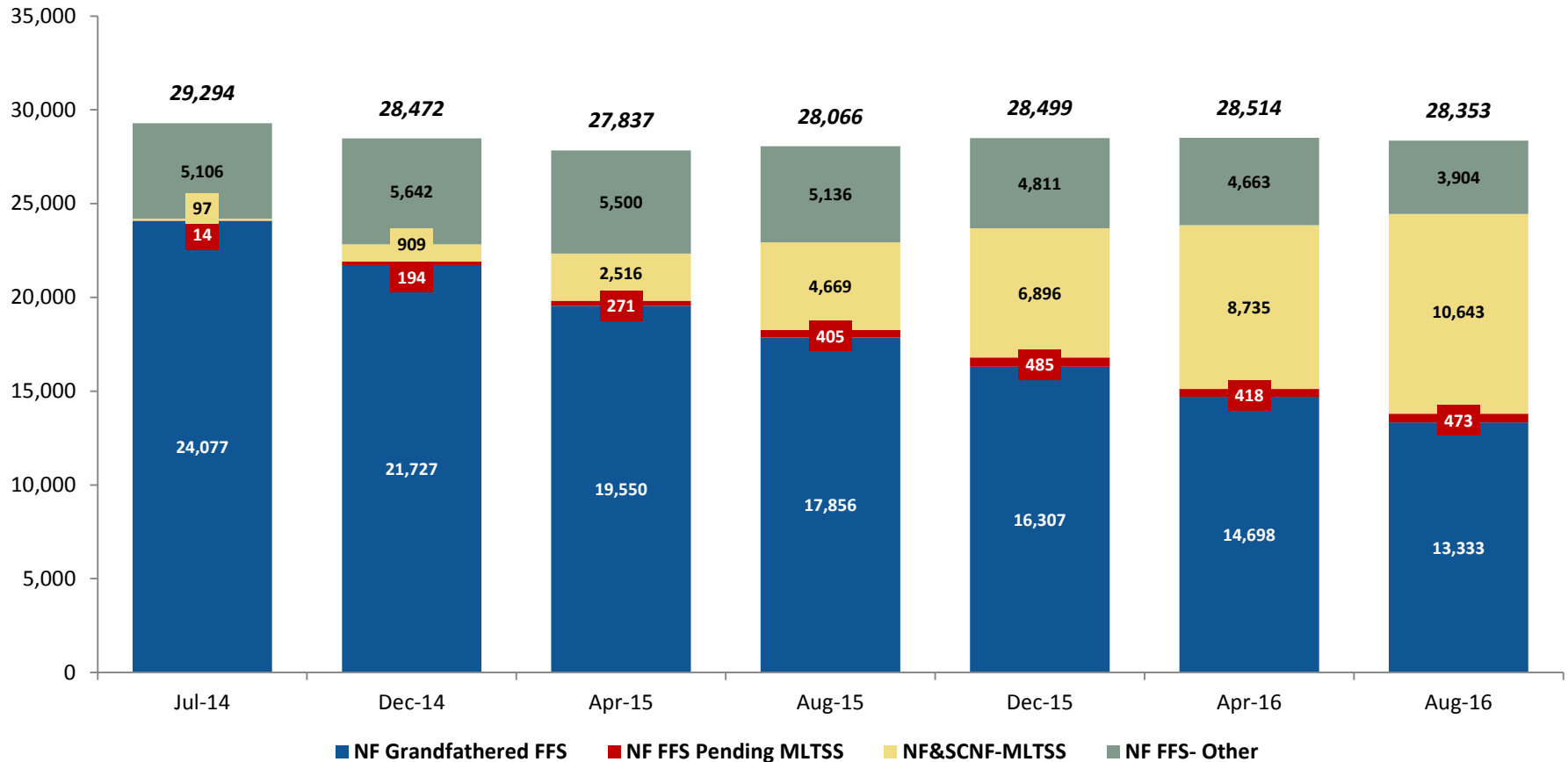
Notes: All recipients with PACE plan codes (220-229) are categorized as PACE regardless of SPC, Capitation Code, or COS.

Home & Community Based Services (HCBS) Population is defined as recipients with a special program code (SPC) of 60 (HCBS) or 62 (HCBS – Assisted Living) OR Capitation Code 79399,89399 (MLTSS HCBS) with no fee-for-service nursing facility claims in the measured month.

Nursing Facility (NF) Population is defined as recipients with a SPC 61,63,64,65,66,67 OR CAP Code 78199,88199,78399,88399,78499,88499 OR a SPC 60,62 with a COS code 07 OR a Cap Code 79399,89399 with a COS code 07 OR a COS 07 without a SPC 60-67 (Medically Needy). COS 07 count w/out a SPC 6x or one of the specified cap codes uses count for the prior month and applies a completion factor (CF) due to claims lag (majority are medically needy recipients).

# Nursing Facility Population

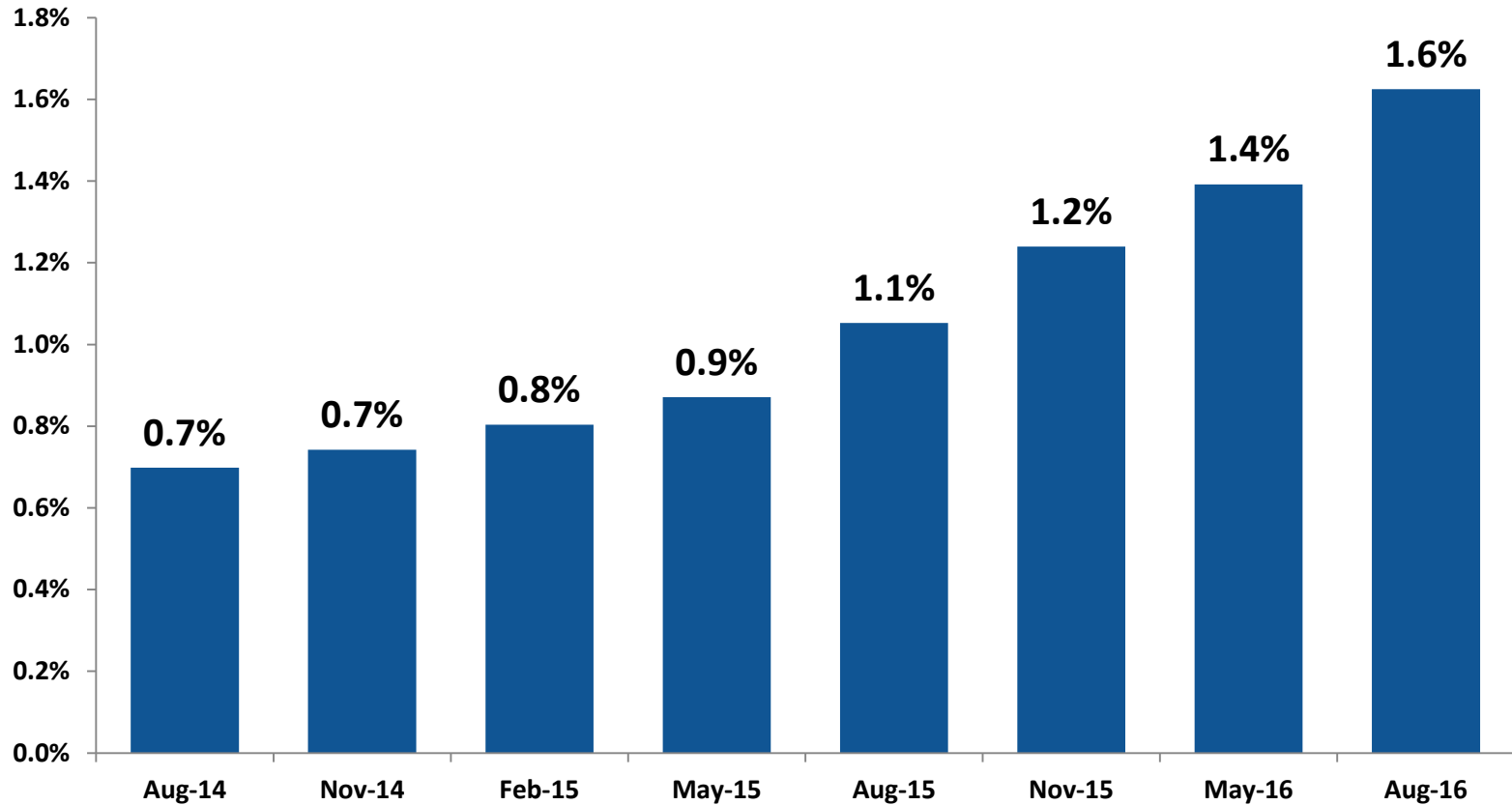
## 4-Month Intervals



Source: Monthly Eligibility Universe (MMX) in Shared Data Warehouse (SDW), accessed on 9/9/2016.

Notes: "NF (Nursing Facility) Grandfathered FFS" population is defined as recipients with Special Program Code (SPC) 65-67. "NF - MLTSS" population is defined as recipients with Capitation Code 78199, 88199, 78399, 88399, 78499 or 88499. "NF FFS Pending MLTSS" population is defined as recipients with a SPC 61,63, or 64 but not in Capitation Codes 78199, 88199, 78399, 88399, 78499 or 88499 OR recipients with SPC 60 or 62 and COS 07 but not in Capitation Codes 79399 or 89399. "NF FFS- Other" population is defined as all other recipients with COS code 07 that do not meet any of the previous criteria (most are medically needy recipients); most recent month: since claims have not been received yet, this category uses counts from the prior month with the same completion factor applied as in the prior month. "NF-PACE" is defined as recipients with a Plan Code 220-229.

# MLTSS Percentage of Overall NJ FamilyCare Enrollment

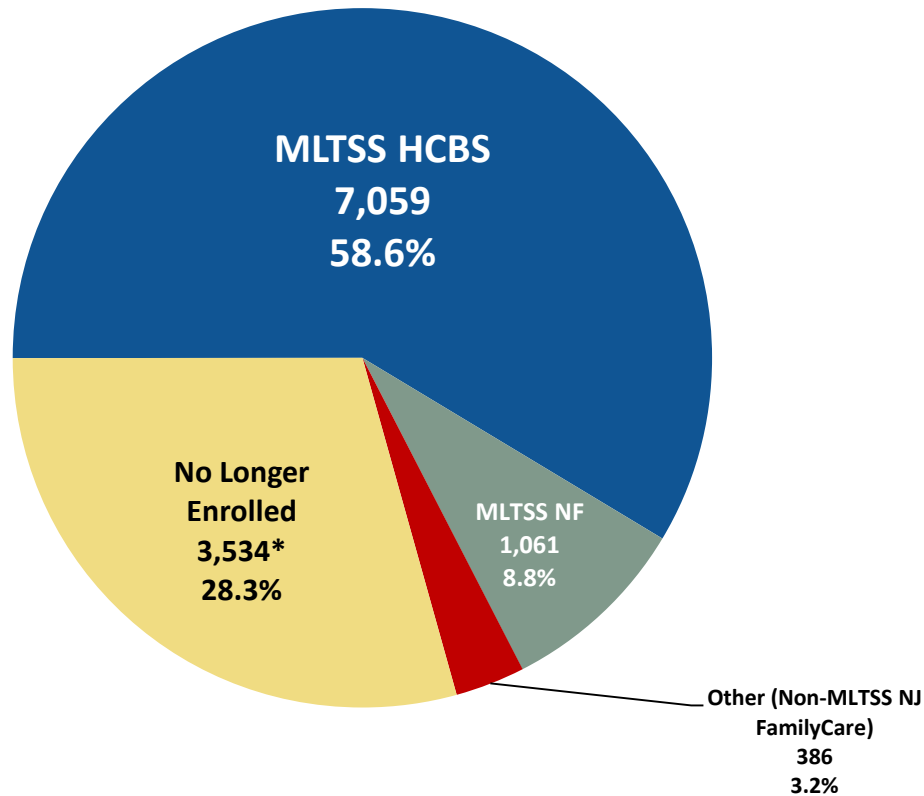


Source: Monthly Eligibility Universe (MMX) in Shared Data Warehouse (SDW), accessed on 5/13/2016.

Notes: Information shown includes any person who was considered LTC at any point in a given month based on: Capitation Codes 79399, 89399, 78199, 88199, 78399, 88399, 78499 & 88499, Special Program Codes 03, 05, 06, 17, 32, 60-67, Category of Service Code 07, or MC Plan Codes 220-223 (PACE). All recipients with PACE plan codes (220-229) are categorized as PACE regardless of SPC, Capitation Code, or COS. MLTSS includes all recipients with the cap codes listed above. FFS includes SPC 65-67 and all other COS 07, which is derived using the prior month's COS 07 population with a completion factor (CF) included to estimate the impact of nursing facility claims not yet received. Historically, 90.76% of long term care nursing facility claims and encounters are received one month after the end of a given service month.

# A Look at the June 30, 2014 Waiver Population Today

## All Waivers (6/30/14 = 12,040)



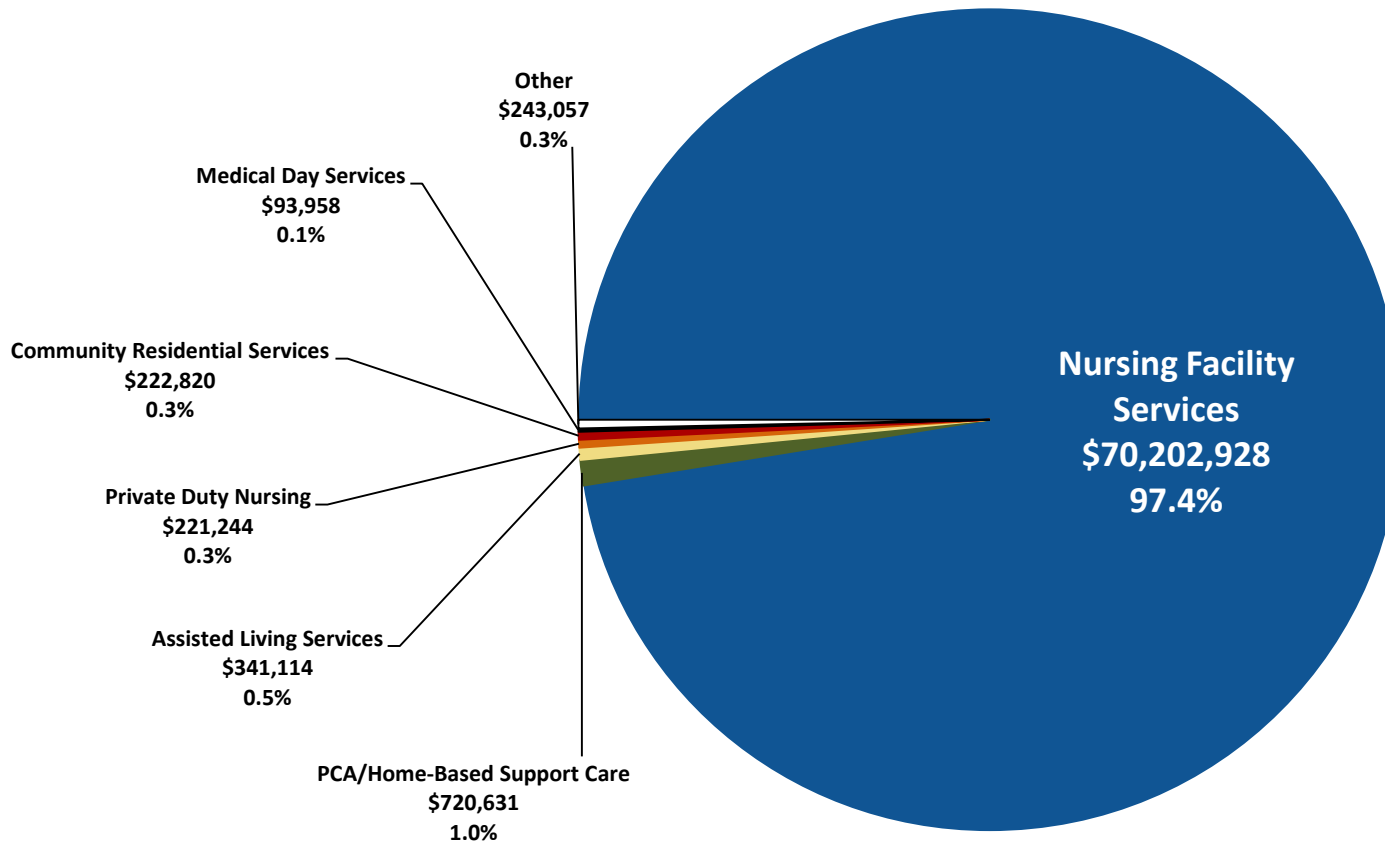
Source: DMAHS Shared Data Warehouse Monthly Eligibility Universe, accessed 9/9/16.

Notes: Includes all recipients who were in a waiver SPC (03, 05, 06, 17 or 32) on 6/30/14. Where they are now is based on capitation code or PSC. Those without a current capitation code or PSC are determined to be "No Longer Enrolled". Of the total number no longer enrolled, 93.8% (3,102) have a date of death in the system (current through 7-11-16).



# MLTSS Nursing Facility Population's LTC Services Cost

MLTSS NF Population's LTC Services Utilization, SFY15

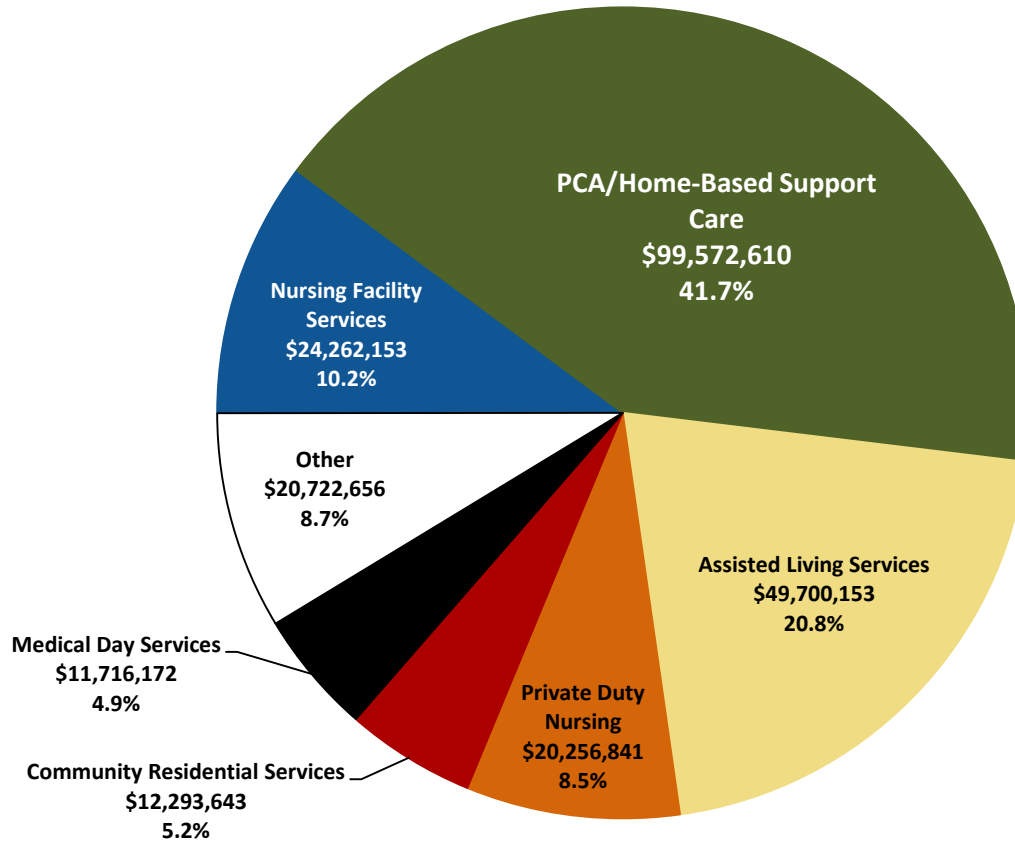


Source: NJ DMAHS Share Data Warehouse MLTSS Services Dictionary, accessed on 6/15/16.

Notes: Dollars represent encounters paid through the date that the SDW was accessed. Subcapitations are not included in this data. Other Includes: Adult Family Care, Assisted Living Program, Caregiver Training, Chore Services, Cognitive Therapy (Group/Indiv.), Community Transition Services, Home-Delivered Meals, Medication Dispensing Device (Monitoring), Medication Dispensing Device (Setup), Occupational Therapy (Group/Indiv.), PERS Monitoring, PERS Setup, Physical Therapy (Group/Indiv.), Residential Modifications, Respite (Daily/Hourly), Social Adult Day Care, Speech/Language/Hearing Therapy (Group/Indiv.), Structured Day Program, Supported Day Services, TBI Behavioral Management, and Vehicle Modifications.

# MLTSS Home & Community-Based Population's LTC Services Cost

MLTSS HCBS Population's LTC Services Utilization, SFY15



Source: NJ DMAHS Share Data Warehouse MLTSS Services Dictionary, accessed on 6/15/16.

Notes: Dollars represent encounters paid through the date that the SDW was accessed. Subcapitations are not included in this data. Other Includes: Adult Family Care, Assisted Living Program, Caregiver Training, Chore Services, Cognitive Therapy (Group/Indiv.), Community Transition Services, Home-Delivered Meals, Medication Dispensing Device (Monitoring), Medication Dispensing Device (Setup), Occupational Therapy (Group/Indiv.), PERS Monitoring, PERS Setup, Physical Therapy (Group/Indiv.), Residential Modifications, Respite (Daily/Hourly), Social Adult Day Care, Speech/Language/Hearing Therapy (Group/Indiv.), Structured Day Program, Supported Day Services, TBI Behavioral Management, and Vehicle Modifications.