

Division of Mental Health & Addiction Services
wellnessrecoveryprevention

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TRANSITION TO FEE FOR
SERVICE

OVERVIEW FOR PROVIDER
MEETINGS

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INTRODUCTION

During his 2016 State of the State and Budget Addresses, Governor Chris Christie announced that \$127 million would be invested in enhanced behavioral health services rates for providers. It is the largest overall increase to this community in over a decade and it's designed to strengthen the organizations that provide critical programs for some of New Jersey's most vulnerable residents.

BACKGROUND

The rate study and rate setting processes had been underway for several months. Augmented with stakeholder input, a professional accounting firm and budget experts, the rates were determined and providers are being notified. DHS' Division of Mental Health and Addiction Services has several meetings scheduled to detail the rates and explain the process. This PPT is part of the presentation. Without context, some information may not be clear so the Division will post one of the information sessions online. Any questions should be directed to the Division by emailing MBHOInput@dhs.state.nj.us. Thank you.

FEE FOR SERVICE (FFS) RATE SETTING GENERAL OVERVIEW

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

FEE FOR SERVICE (FFS) RATE DEVELOPMENT

- **Overall objective was to build rates “from the ground up” that are reflective of full costs to provide services.**
- Key assumptions on the inputs for each service were provided to consultants Myers and Stauffer (M&S) by DMHAS program and policy staff, as well as through extensive discussions with providers (practice groups).
 - 7-8 meetings were held with providers to get their perspectives on key inputs that should be considered (e.g., staffing make-up, non-salary costs)

FEE FOR SERVICE (FFS) RATE SETTING CONSIDERATIONS

- Unifying disparate reimbursement methodologies between MH service contracts and SUD service contracts.
- Consideration of shift to Medicaid-reimbursed services as a result of Medicaid Expansion and changes in eligibility and benefit.
- DMHAS also conducted its own research into non-salary costs, wage rates and inflation.
- Subsequent to initial rate development by M&S, significant discussions were held between DHS/DMHAS Fiscal staff and program staff to review assumptions and make adjustments as appropriate.

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STAFFING AND FINANCIAL DATA CONSIDERATIONS

- For each service, rates build in assumptions on:
 - **Staffing make-up and credentials**, e.g., for Partial Care, Direct Staffing was comprised of a) Medical Director, b) Program Director (LSW), c) Supervisor (MA level), d) Case Coordinator and e) Service Worker.
 - Rates also built in the relative weight that each staff member comprises of the total Direct Staff cost.
 - **Financial Data** included review of contract database and expenditure reports, provider cost and time studies and Medicaid claims.
 - **Wage rates** for Direct Care staff were taken from the most recent Bureau of Labor Statistics (BLS) data specific to NJ. An inflation factor was applied to bring those wage rates to more current levels.
 - BLS wage categories were consistent with the functional titles for each service (i.e., considering required credentials)
 - **Fringe benefit** rates were applied based on available contract data and, to a lesser extent, data from a cost study of several providers that was conducted by M&S.

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WHAT WENT INTO THE RATES – PRODUCTIVITY FACTOR

- **Productivity factor** was applied to the Direct Care wage/fringe benefit cost for each service. This factor was designed to “gross up” the costs to reflect the fact that staff are paid for more than just “face to face” time. Examples of the factors that drove each service’s unique productivity adjustment were:
 - Time required each day for documentation
 - Required meeting time (consultations with other staff)
 - Training/supervision
 - Paid Time Off (holiday, vacation, sick)
 - In cases where more than one staff member is required for site visits, travel time and the increased staff requirement were also considered in the productivity factor.

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REGULATORY REQUIREMENTS AND G&A CONSIDERATIONS

- If applicable (e.g., if regulation prescribed), a **client-staff ratio** was applied. In other words, if a certain service involves a group of clients receiving treatment delivered by staff simultaneously, the hourly wage cost was allocated to the client/service unit consistent with that ratio.
- Factors were applied to the wage/fringe benefit rates calculated with above data to account for estimated **General and Administrative costs, capital, supplies and infrastructure/overhead**. In general, rates were applied based on available contract data.
- In general, DMHAS gave significant weight to existing regulations and compliance requirements in determining the cost inputs into each service.

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WHAT WENT INTO THE RATES

- Support of co-occurring system and ability to hire staff with credential necessary to provide co-occurring capable service
 - The expectation will be that providers of mental health and substance use disorder outpatient treatment services will be capable of serving individuals with a co-occurring mental illness and substance use disorder (MI/SUD).
 - Providers of methadone treatment (opioid treatment providers) will be capable of serving individuals with a co-occurring MI/SUD
 - **Medicare capping** – where applicable, rates were set at 100% of the prevailing Medicare rate (for New Jersey)

MEDICATION ASSISTED TREATMENT (MAT)

- The Division recognizes that medication coupled with counseling is effective in treating opioid and alcohol addiction. Consequently, the following is available:
 - MAT delivered in an OTP – New rates are *weekly bundled rates, specific to Methadone and Buprenorphine delivered in an OTP, are designed to cover the drug and the following services:* case management, medication, dispensing, counseling and medication monitoring. The bundled rate does not include transportation, intensive outpatient, intake or psychiatric evaluation. The rate is standard across all phases of treatment, i.e., same rate applied to clients in Phases I – VI.
 - **Naltrexone, Revia (Vivitrol®)** continues to be reimbursed by Medicaid and through the state FFS initiatives. Case management, the physician visit, urine pregnancy test and liver functioning tests are reimbursed as separate and distinct services in the state FFS initiatives.

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RATES FOR SERVICES NOT REIMBURSED BY MEDICAID

○ Other Considerations:

- **Room and Board** components for Residential services reflect prevailing Fair Market Rents in New Jersey and then adding a factor for food costs per day. Medicaid does not cover room and board.
- **Medicaid vs. State Only**
 - Where a service is Medicaid-eligible, State-Only rates set at 90% of the Medicaid rate
- Since new reimbursement rates reflect providers' gross costs, we have assumed that the provider will continue to bill certain third party entities (e.g., Medicare, private insurance, client fees), which are *currently* credited to DMHAS deficit-funded contracts.
 - However, we did NOT assume State recoupment of providers' county or other government grants, or other fundraising revenues.

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CONSIDERATIONS IN RATE DEVELOPMENT

- Impacts in DMHAS, Medicaid and other State agencies that invest in behavioral health programs (e.g., Administrative Office of the Courts, State Parole Board, Department of Corrections).
- Movement of Medicaid clients off DMHAS contracts and into Medicaid billing driven by the Affordable Care Act.
- Analysis of impact of phasing in Mental Health State only clients in January 2017

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RATES – MENTAL HEALTH TREATMENT

<u>Service</u>	<u>Current Medicaid</u>	<u>New Medicaid</u>	<u>New State</u>
Partial Care, Co-Occurring Capable (hour)	\$14.55	\$17.92	\$16.13
Partial Hospital (hour)	\$33.08	\$17.92	\$16.13
Outpatient			
Psychiatric Evaluation without Medical Service	\$54.39-\$72.75	\$157.94	\$142.15
Psychiatric Evaluation with Medical Service	\$82.17	\$325.00	\$292.50
<u>Co-Occurring Capable Outpatient</u>			
Individual Therapy Co-Occurring (30 minutes)	\$8.00-\$34.48	\$68.21	\$61.39
Individual Therapy Co-Occurring (45-50 minutes)	\$16.00-\$44.63	\$90.26	\$81.23
Group Therapy Co-Occurring (90 minutes)	\$8.00-\$23.00	\$27.50	\$24.75
Family Therapy (60 minutes)	\$24.70-\$46.00	\$113.94	\$102.55
Family Conference (30 minutes)	\$12.40-\$19.00	\$22.91	\$20.62
Group Psychoeducational Services (90 minutes)	n/a	n/a	\$5.95
Supported Education/Employment (15 minutes)	n/a	n/a	\$19.19
Medication Monitoring – State only (15 minutes)	n/a	n/a	\$40.88
Targeted Case Management (15 minutes)	\$31.10	\$38.12	\$34.31
Program for Assertive Community Treatment (month)	\$1,377.00	\$1,487.81	\$1,487.81
Residential			
A+ Services (daily)	\$179.23	\$268.85	\$241.97
A Services (daily)	\$143.16	\$214.74	\$193.27
B Group Home Services (daily)	\$111.48	\$167.22	\$150.50
B Apartment Services (15 minutes)	\$4.10	\$13.33	\$12.00
D Family Care Services (daily)	\$43.71	\$17.55	\$15.80
<i>Room & Board (except apartments)</i>	<i>n/a</i>	<i>n/a</i>	<i>\$27.47</i>

*Co-occurring rates enable organizations to hire staff who are credentialed to serve individuals who have a mental illness and substance use disorder.

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RATES – SUBSTANCE USE DISORDER

TREATMENT

Service	Current Medicaid	New Medicaid	New State
Partial Care, Co-Occurring Capable (daily, 4 hours)	\$83.80	\$78.31	\$70.48
Outpatient			
Psychiatric Evaluation without Medical Service	\$54.39-\$72.75	\$157.94	\$142.15
Psychiatric Evaluation with Medical Service	\$82.17	\$325.00	\$292.50
<u>Co-Occurring Capable Outpatient</u>			
Individual Therapy (30 minutes)	\$8.00-\$34.48	\$68.21	\$61.39
Individual Therapy (45-50 minutes)	\$16.00-\$44.63	\$90.26	\$81.23
Group Therapy Co-Occurring (90 minutes)	\$8.00-\$23.00	\$27.50	\$24.75
Family Therapy Co-Occurring (60 minutes)	\$24.70-\$46.00	\$113.94	\$102.55
Family Conference (30 minutes)	\$12.40-\$19.00	\$22.91	\$20.62
Group Psychoeducational Services (90 minutes)	n/a	n/a	\$5.95
Medication Monitoring (State-only)	n/a	n/a	\$40.88
Intensive Outpatient Co-Occurring Capable (daily, 3 hours)	\$71.00	\$109.48	\$98.53
<u>Co-Occurring Capable Methadone/Buprenorphine</u>			
Methadone (weekly)	\$4.25 (dispensing)	\$91.15	\$82.04
Buprenorphine (weekly)	n/a	\$189.71	\$170.74
Residential			
Short-Term – Services	\$147.00	\$201.60	\$201.60
<i>Room & Board</i>	<i>n/a</i>	<i>n/a</i>	<i>\$18.90</i>
Long-Term – Services	\$68.00 (non-Medicaid)	n/a	\$84.40
<i>Room & Board</i>	<i>incl. in above rate</i>	<i>n/a</i>	<i>\$17.60</i>
Halfway House – Services	\$57.00 (non-Medicaid)	n/a	\$67.90
<i>Room & Board</i>	<i>incl. in above rate</i>	<i>n/a</i>	<i>\$17.60</i>
Detox – Services	\$204.00	\$408.08	\$408.08
<i>Room & Board</i>	<i>n/a</i>	<i>n/a – paid</i>	<i>\$20.20</i>

*Co-occurring rates enable organizations to hire staff who are credentialed to serve individuals who have a mental illness and substance use disorder.

FFS RATES – BUDGET IMPACT

- Behavioral Health Rate Increase: **\$127.8 million**
 - Enhanced federal match and third-party liability: **\$107.8 million**
 - Net State investment = **\$20 million**
 - State funds rate increase: \$49.5 million
 - State funds offset by enhanced federal match and third-party liabilities: (\$29.5 million)

FFS MEDICAID

- The appropriate Medicaid members and Medicaid covered services are to be billed to Medicaid prior to seeking state funding.
- Providers are required to enroll as a Medicaid provider if receiving state funds. A provider can submit application at <http://njmmis.com>
- SUD and CSS services funded through Medicaid and State dollars will be prior authorized by the IME.
- The rates require CMS approval.
- True Up: The alternative benefit plan includes SUD treatment services: intensive outpatient, outpatient, partial care, short term residential (non-IMDs), detox (non-IMD), IOP and opioid treatment. Currently the NJ FamilyCare Plan A only includes methadone. As of 7/1/2016, the *True Up* expands these services to all Plan A members.“
- Medicaid is to be billed for individuals 21 years old and younger as well as individuals 65 years of age and older for individuals in IMDs in short term residential and detox level of care as of 7/1/2016.

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CONTRACT TRANSITION

- Division approval for cost containments (Social Service Contract Requirements) is no longer required when a provider moves to FFS
 - p/t and f/t salary compensation limitation
 - Salary compensation limitations for physicians and APNs
 - Employee severance agreement
 - Travel expenses
 - Tuition reimbursement
 - Restriction for provider-agency sponsored meetings, conferences and special events
 - Vehicle requests

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CONTRACT TRANSITION – CASH FLOW

- Cash flow considerations upon implementation
 - Upon FFS implementation, DMHAS will allow providers the opportunity to request up to two months of contract payments as an advanced payment against future FFS revenue
 - Amount advanced must be paid back to the Division within the same State Fiscal Year
 - Proposed criteria under consideration for advanced funding:
 - Attestation of commitment to be a participating provider for 24 months
 - Provider must be in “good standing”
 - Provider must submit a 24 month cash flow analysis
 - Financial stability review
 - Final policy and procedures will be distributed June 2016.

FFS TIMELINE FOR IMPLEMENTATION

July 2016

- Medicaid rates for MH and SUD become effective
- Medicaid True-Up* for SUD becomes effective
- State rates for SUD becomes effective
- SUD state rates become fully FFS
- IME Prior Authorization for SUD

January 2017

- State rates for MH becomes effective
- MH providers may move to FFS

July 2017

- All MH providers move to FFS

Next

- Managing BH services

DHS - DMHAS (06/29/16 ver.)

*The alternative benefit plan includes SUD treatment services: intensive outpatient, outpatient, partial care, short term residential (non-IMDs), detox (non-IMD) and opioid treatment. NJ FamilyCare Plan A only includes methadone. The *True Up* expands Plan A coverage to mirror the ABP.

FFS - CONCLUSIONS

- Providers should be assured that DHS/DMHAS staff have worked diligently to develop rates that are reflective of expected provider costs and that will ensure access to needed behavioral health services.
- Success – from a State affordability and Budget perspective – hinges on fully leveraging federal Medicaid resources.
 - Providers will need to enroll as Medicaid providers if they are not already. All Medicaid-eligible clients will need to be billed appropriately to Medicaid.
- Success at provider level hinges on ability of agencies to truly understand their unique costs to deliver each service so that they may develop “P&L’s” (Profit/Loss) for each of their business segments.