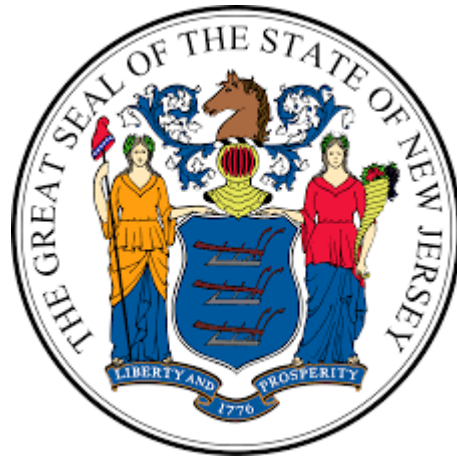


Access Monitoring Review Plan – 2016

State of New Jersey



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Overview

- The NJ FamilyCare Program, the state's Medicaid Agency, provides healthcare coverage for residents with low-income, including children, pregnant women, individuals with disabilities, seniors and other adults.
- The Division of Medical Assistance and Health Services (DMAHS), which falls under the auspices of the Department of Human Services (DHS), is the single state agency that administers the Medicaid program. In 2015, the New Jersey Medicaid program provided coverage to approximately 1.7 million residents. In total, the NJ FamilyCare program expended approximately \$15 billion dollars in State Fiscal Year 2015.
- For 93% of the NJ FamilyCare beneficiaries, care is coordinated by one of five managed care organizations contracting with DMAHS, including Aetna Better Health of New Jersey, Amerigroup New Jersey, Horizon NJ Health, UnitedHealthcare Community Plan and WellCare.
- New Jersey is the 4th smallest state in the United States, and is comprised of 21 counties and 566 municipalities¹, however, it is ranked first in terms of overall population density, with 1,210 residents per square mile². The state is approximately 150 miles long and 70 miles wide. It is comprised of nearly 8,723 square miles, almost 700 square miles larger than Connecticut and Delaware combined, with a total estimate population of approximately 8.96 million³.
- The State of New Jersey has no federally recognized tribal organizations or rural areas.
- New Jersey measures and monitors indicators of health care access to ensure that its Medicaid beneficiaries have access to care that is comparable to the general population.
- In accordance with 42 CFR 447.203, New Jersey developed an access review monitoring plan for the following service categories provided under a fee-for-service (FFS) arrangement:
 - Primary Care services;
 - Physician Specialist services;
 - Behavioral health services;
 - Pre-and post-natal obstetric services, including labor and delivery; and,
 - Home health services.
- The plan describes data that will be used to measure access to care for beneficiaries in FFS. The plan considers: the availability of Medicaid providers,

¹ <http://nj.gov/nj/about/facts/fastfacts/>

²² https://simple.wikipedia.org/wiki/List_of_U.S._states_by_population_density

³ <https://www.census.gov/quickfacts/table/PST045215/34>

utilization of Medicaid services and the extent to which Medicaid beneficiaries' healthcare needs are fully met.

- The plan was developed during the summer of 2016 and posted on the state Medicaid agency's website from October 31, 2016 thru December 1, 2016 to allow for public comment and feedback.
- Analysis of the data and information contained in this report show that New Jersey Medicaid beneficiaries, receiving service under FFS, have access to health care that is similar to that of the general population in New Jersey.

New Jersey's Managed Care and Fee-For-Service Programs

New Jersey is a mandatory managed care state. It began by enrolling children through the NJ KidCare program and later expanded to parent and some childless adults under NJ FamilyCare. In 2011, a single NJ FamilyCare program enrolled most Medicaid population groups on a mandatory basis, with the exception of some dual eligibles, and covered acute, primary and specialty care, as well as behavioral health services. Long-term services and supports (LTSS) were provided through the fee-for-service system.

In October 2012, New Jersey was granted federal approval to reform many elements of its current managed care system through a new Section 1115 comprehensive demonstration. From 2013-2014, the state expanded existing managed care programs to include LTSS, some behavioral health services for certain populations, and extended home and community-based services to additional populations, such as to people with developmental disabilities, many of which were transitioned from fee-for-service into managed care. New Jersey also operates a PACE program in seven counties.⁴ In 2014 New Jersey expanded Medicaid. The new federal health care law requires that parents, single adults and childless couples, ages 19 to 64, with incomes under 133% FPL receive an Alternate Benefit Plan (ABP). Single adults, childless couples and parents received the Alternative Benefit Plan (NJ FamilyCare Plan ABP) package effective January 2014. The ABP must include 10 essential health benefits: 1.) Ambulatory patient services; 2.) Emergency services; 3.) Hospitalization; 4.) Maternity and new born; 5.) Mental health and substance abuse; 6.) Prescription drugs; 7.) Rehabilitation and habilitation services; 8.) Lab services; 9.) Preventive services; and 10.) Pediatric services including vision and dental.

Beneficiary Population

In 2015, the New Jersey Medicaid program provided coverage to about 1.7 million enrolled beneficiaries. Approximately 93% of these beneficiaries are enrolled in

⁴ <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/new-jersey-mcp.pdf>

managed care. The remaining 7% receive care through FFS. Figure 1 below shows that over the last three years NJ FamilyCare has consistently seen a decrease in recipients receiving services through FFS, 0.9% between calendar years (CY) 2013 and 2014 and 1.8% between CYs 2014 and 2015. The 1.8% decrease largely can be attributed to Medicaid Expansion, the implementation of a Managed Long Term Services and Supports program (MLTSS) and the carve-in of behavioral health benefits for the MLTSS and developmental disability (DD) populations.

Figure 1: Percentage of NJ FamilyCare Recipients who are FFS⁵

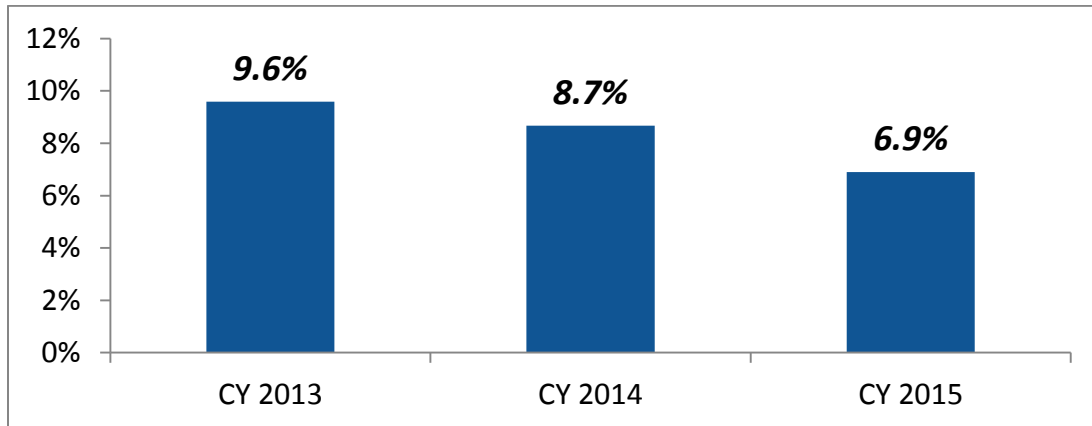
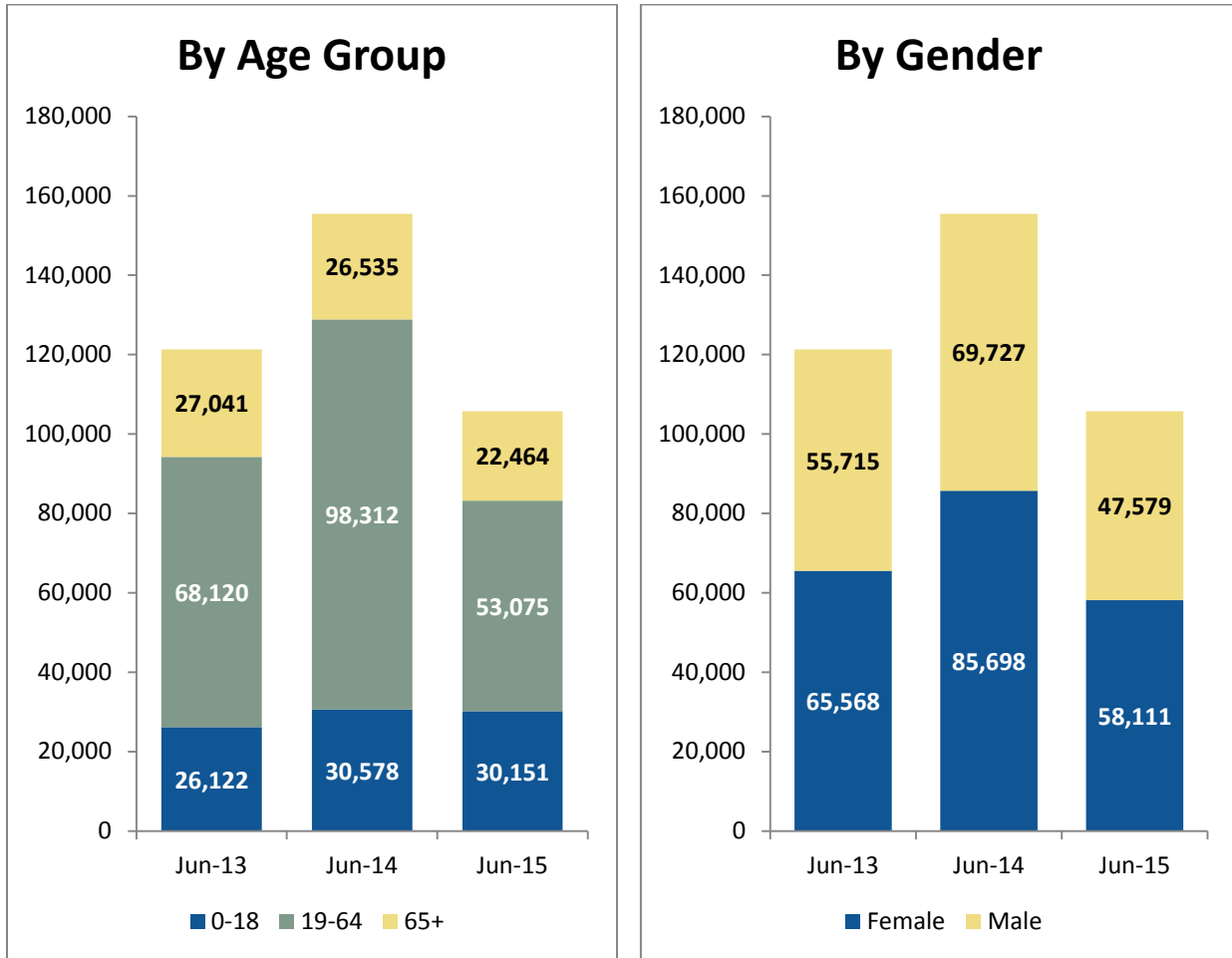


Figure 2 highlights the age and gender composition of the NJ FamilyCare program's FFS population from State Fiscal Year 2013 thru State Fiscal Year 2015. As of June of 2015, the majority of NJ FamilyCare's FFS population (7% of the total NJ FamilyCare Enrollment) are male between the ages of 19-64. It is also important to note that the decrease of nearly 50,000 FFS individuals aged 19-64 between the years 2014 and 2015 is in direct correlation with Medicaid Expansion, through which these beneficiaries were transitioned to managed care.

⁵ Source: NJ DMAHS Shared Data Warehouse (Snapshot) MMX Eligibility Summary Universe, accessed 6/30/2016.
Notes: Information shown is a ratio of member months totaled over the calendar year shown.

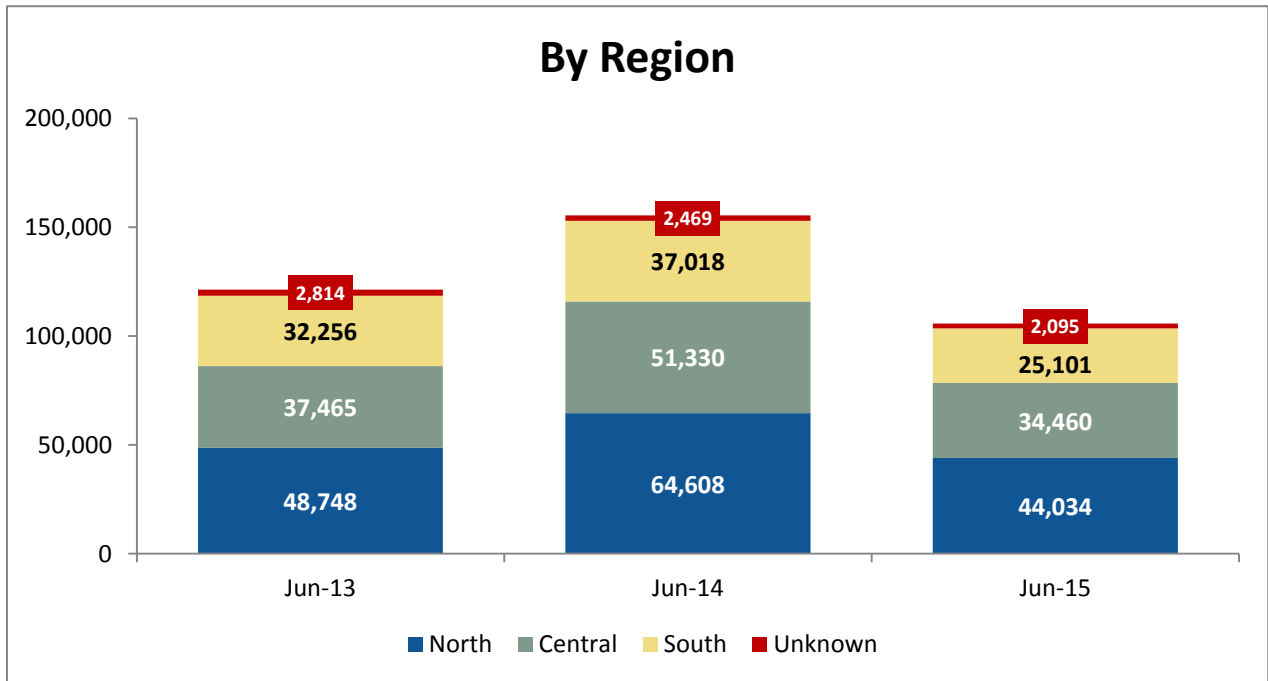
Figure #2A: NJ FamilyCare FFS Recipients by Age Group and by Gender⁶.



Fifty-percent (50%) of the total NJ FamilyCare Medicaid FFS population was between the ages of 19 and 64.

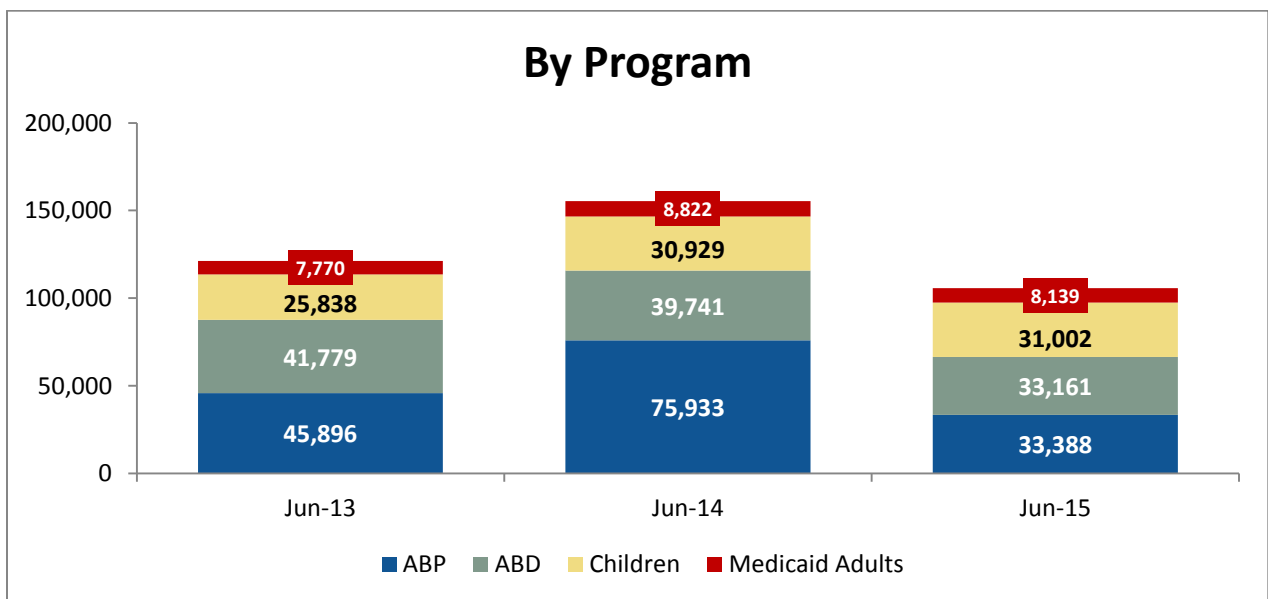
⁶ Source: NJ DMAHS Shared Data Warehouse (Snapshot) MMX Eligibility Summary Universe, accessed 9/20/2016.
 Notes: Information shown includes any person who was not enrolled in a managed care organization during the given time period.

Figure #2B: Number of NJ FamilyCare Recipients who are FFS by Region⁷



Approximately 42% of NJ FamilyCare FFS beneficiaries reside in the northern part of the state, while 33% live in Central New Jersey and 24% live in the Southern part of the state.

Figure #2C: Number of NJ FamilyCare Recipients who are FFS by Program⁸



^{7 8} , Source: NJ DMAHS Shared Data Warehouse (Snapshot) MMX Eligibility Summary Universe, accessed 6/30/2016.
 Notes: Information shown is a ratio of member months totaled over the calendar year shown.

As of June 2015, the percentages of NJ FamilyCare recipients receiving services are spread almost equally among the following three programs: ABP (32%), ABD (31%) and Children (29%).

Access concerns raised by beneficiaries and providers

New Jersey operates a call center (The Hotline) for beneficiaries and providers. The call center serves as a way to engage beneficiaries/providers and assist them with their Medicaid related needs. All beneficiaries have a Medicaid card that includes the number for the Hotline. The call center operates daily (Monday – Friday) from 8:30 a.m. to 4:30 p.m. The Hotline calls are mostly from beneficiaries with eligibility questions, but they also get a number of calls relating to assistance needed with other social services, such as “How do I get food stamps?” or “I have a relative that died, and I need assistance with a burial.” Staff is able to provide an array of referral materials. Beneficiaries also can call the Medicaid Director’s Office or the Office of Customer Service from 9:00 a.m. to 5:00 p.m. daily with any Medicaid questions or feedback. Individuals calling after hours have the option of leaving a voice mail message which is then routed to the appropriate staff to address. At present, there is a mailbox on the Division’s website where anyone can leave feedback, send questions or submit an inquiry. This mailbox is checked daily and the mail is routed to the appropriate offices within the Division.

Beneficiaries and providers also have the option of calling or visiting any of the State’s four Medical Assistance Customer Centers (MACCs) between the hours of 8:30 a.m. to 4:30 p.m. Monday thru Friday. MACC’s are available to answer any Medicaid questions, but typically assist with local issues, like “I need a doctor in my area.” The MACC offices are fully staffed with bi-lingual staff and access to a clinical medical director. Beneficiaries have the option to visit the office and are able to meet with a customer service representative in-person that same day.

As of January 2015, beneficiaries needing assistance with addiction services can call the Medicaid Addiction Services Hotline 24 hours a day. The Interim Managing Entity (IME) serves as a single point of entry for those seeking treatment for substance use disorders. The IME ensures that individuals are receiving the right level of care, for the right duration of time, at the right intensity. It can provide information on the availability of programs, i.e. where there is an open bed, on a daily basis, as well as determine the type of service a beneficiary may need.

The Hotline, MACCs and the IME all do simple call tracking. As DMAHS transitions a new Medicaid Management Information System (MMIS), it anticipates the ability to track and monitor beneficiary calls by payment source (FFS vs. managed care), by type of

call, and by caller demographics. The new NJ MMIS is expected to be implemented by 2018.

Comparison Analysis of Medicaid Payment Rates to Medicare and Other Payers

NJ FamilyCare will analyze the prescribed service categories in comparison to the payment rate of other insurers:

- Primary Care services;
- Physician Specialist services;
- Behavioral health services;
- Pre-and post-natal obstetric services, including labor and delivery; and,
- Home health services.

Additional future analysis may include any services for which DMAHS reduces payment rates or restructures rates that could result in diminished access. In accordance with the Access Monitoring Review Plan, DMAHS will monitor access to the services affected by this change for a period of at least three years after the effective date of the change. Further, if CMS or the State becomes aware of a significantly larger volume of beneficiary, provider, or other stakeholder access complaints regarding a particular type of care or service within a specific geographic area, the state will add those services to its access monitoring review plan protocol.

A comparison to the New Jersey State Health Benefits Program (SHBP) will be made when the SHBP provides coverage for same or similar services. DHS has made a request to the State of New Jersey Department of Treasury and will update the Access Monitoring Review Plan accordingly when that information is received and analyzed by the DMAHS fiscal office. Rate comparisons may be made to other contiguous states (New York, Pennsylvania, or Delaware) when those states make their rates publicly available or to other states, as they are demographically similar to New Jersey.