



State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services

NEWSLETTER

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TO: Hospitals – **For Action**
Managed Care Organizations – **For Information Only**

SUBJECT: Diversionary Bed Update

EFFECTIVE: Immediately

PURPOSE: To Clarify the Administration of Diversionary Bed Services

BACKGROUND:

The Division of Mental Health and Addiction Services (DMHAS) contracts with inpatient providers to purchase bed-days in inpatient facilities, through “Diversion Contracts.” The purpose of Diversion Contracts is to afford individuals age 18 and older who would otherwise be admitted to a state or county psychiatric hospital the opportunity to receive treatment in an inpatient setting, which may enable the individual to stabilize and be discharged to the community. The primary goal of the purchase of bed-days is to avert admissions to state hospitals by creating increased access to private psychiatric inpatient beds. Individuals who do not stabilize and require continued inpatient treatment may be transferred to a state or county hospital at the conclusion of their approved length of stay in the contracted Diversion bed.

Priority for Admission to a Diversion Bed

Admission to Diversion beds are prioritized for individuals who are in a Short Term Care Facility (STCF) and a clinical assessment concludes that following a typical length of stay in a STCF, they continue to meet the legal standard for involuntary commitment or meet the legal standard for involuntary commitment, but agree to treatment (consensual status).

In the regulations for STCFs, N.J.A.C. 10:37G-21(h) states: “When a new patient meets the admissions criteria and all STCF beds are full, *all* current [STCF] patients shall be reassessed for possible transfer to the less restrictive acute unit, to nursing facilities *or to intermediate care beds, or to State or county hospitals*, as appropriate, to allow the admission of the new patient” [emphasis added]. This regulation supports the underlying philosophical principles of STCF beds, which is to afford individuals who meet the criteria for commitment to be served in a community hospital setting. This STCF regulation applies to individuals regardless of insurance coverage. This

regulation is in place to support flow through the STCF beds, to allow beds to become available for direct screening admissions, to support the goal of affording individuals the opportunity to stabilize in a short-term admission in a community hospital setting.

What is a Consensual Patient?

For purposes of treatment in a STCF, a consensual patient is defined as an individual who meets the legal standard for commitment, but voluntarily agrees to admission and treatment in the STCF. Therefore, the individual is not on a commitment status. Again, referencing N.J.A.C. 10:37G-2.1(h), this regulation applies to individuals regardless of whether they are on a legal commitment status or consensual status, and regardless of insurance coverage. Simply, a consensual patient receives the same level-of- care as a patient on involuntary committed status.

Change in Medicaid Payment for Inpatient Care

Effective October 1, 2018, the Division of Medical Assistance and Health Services (DMAHS) transferred responsibility for all acute inpatient hospital payment to their contracted managed care plans. This means that, for all beneficiaries enrolled in a managed care plan, all psychiatric admissions are now the responsibility of the managed care plan. This change in payer status allows the state to take advantage of the Managed Care Rule, allowing managed care organizations (MCOs) to use an Institution for Mental Disease (IMD) as an “in lieu of” service. As a result of this change, it is necessary to adjust the target population eligible for payment by DMHAS contracted Diversion Contracts. In short, Medicaid beneficiaries enrolled in an MCO may have their inpatient treatment billed to the MCO, and therefore will not be paid through a DMHAS Diversion Contract.

ACTION:

Access to DMHAS Contracted Diversion Beds

DMHAS, through the Diversion Contracts, is purchasing bed-days for individuals without, or with insufficient, third party insurance (TPL) to pay for their inpatient treatment at these facilities. Individuals with certain insurance coverage are served under a DMHAS Diversion Bed Contract. However, they may be served in the same hospital, in a non-DMHAS contracted bed. The following clarifies the insurance status for admission to a Diversion bed.

Eligible for payment with the DMHAS Diversion Bed Contract:

- Individuals age 18 and older without insurance coverage;
- Individuals age 22 to 65 with traditional Medicaid coverage (AKA FFS Medicaid) only;

- Individuals with Medicare (non-FIDE SNP) and traditional Medicaid coverage (AKA FFS Medicaid);
- Individuals with TPL for which the TPL is below the contracted daily rate of the DMHAS Diversion Bed Contract.

Not eligible for payment under the DMHAS Diversion Bed Contract:

- Individuals with Medicaid managed care coverage, regardless of whether the coverage is primary or secondary.

Please note that regardless of insurance coverage, based on N.J.A.C. 10:37G-21(h), individuals who require longer-term hospitalization after inpatient treatment in a STCF may be transferred to a hospital that has a Diversion Contract. However, if they have Medicaid managed care coverage, their treatment will not be paid through the Diversion Contract. Medicaid managed care beneficiaries who are currently in a STCF should not be transferred to other facilities without approval from the MCO. Medicaid managed care beneficiaries who are transferred from a STCF to a hospital with a Diversion Contract, and who continue to meet an acute level-of-care, shall be covered as acute.

Consensual Patient

Medicaid managed care beneficiaries who are on consensual status at the STCF and are transferred to a hospital with a Diversion Contract, and who continue to meet commitment criteria and require an acute level-of-care shall be covered as acute. When the individual no longer meets commitment criteria and no longer requires acute level-of-care (using a nationally recognized set of clinical guidelines), the individual who was transferred on consensual status becomes eligible for coverage with an administrative payment for as long as the beneficiary is receiving a clinical service and the facility is working towards an acceptable discharge plan.

Beneficiaries and providers who disagree with any medical determination should follow the appeals and grievance guidelines in their Contract.

If you have any questions concerning this Newsletter, please contact the Office of Customer Service at 609-631-4642.

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