

# Department of Human Services

## Senate Follow Up

### Questions & Answers

Senator Weinberg:

1. In March 2013, the department released a fact sheet indicating that the Division of Developmental Disabilities (DDD) had begun to phase out funding for services provided in sheltered workshop settings. The information indicated that the Supports Program, a new program under the approved Comprehensive Medicaid Waiver, would not provide funding for services in these settings. Additionally, funding for these services was to be phased out of DDD's Community Care Waiver over the next twelve to eighteen months.

The fact sheet also indicated that, in September 2011, the federal Centers for Medicare & Medicaid Services (CMS) had issued guidance which stated that Medicaid waiver funding may not be used for vocational services delivered in facility-based or sheltered work settings, where individuals are supervised for the primary purpose of producing goods or performing services, and that prevocational services must be time-limited, conform to specific requirements regarding clear employment goals, and may not consist of vocational services in sheltered workshops and similar settings.

During the May 1 committee hearing, Commissioner Velez indicated that the department was considering various options for addressing concerns regarding the continuation of DDD sheltered workshop services. The commissioner also indicated that the Governor's FY 2014 Budget Recommendation includes \$7 million in State funding for DDD sheltered workshop services, unchanged from FY 2013.

- **How many DDD clients currently receive sheltered workshop services? How many are expected to receive these services in FY 2014?**

Answer:

The Division has approximately \$6.9 million in contracts with providers for sheltered workshops, serving about 700 individuals. This level of service is unchanged for FY14.

- **If DDD were to continue providing its sheltered workshop services in FY 2014 and beyond to approximately the same number of clients who are currently being served, and without federal Medicaid funding, what would be the annual State cost and total cost of providing those services? How does that compare to the State cost in previous fiscal years, prior to the phase out of federal Medicaid funding for these services?**

Answer:

The annual State cost would remain at \$6.9 million, which is similar to the cost in prior years. Federal Medicaid revenue on Division services is generated through waiver programs for Home and Community-Based Services (HCBS). The federal government specifically excludes sheltered workshops from inclusion in these waivers.

Federal Medicaid funds are available for supported employment programs. Although the programs identified in the first question are listed as sheltered workshops in the Division's contract inventory, some may qualify as supported employment programs, and thus 50% of eligible costs would be matched. The Division is reviewing each program individually to determine if costs can be matched, or if the program would need to be modified to meet federal match requirements.

- **Could any subset of the DDD sheltered workshop services, in their current form, continue to qualify for federal Medicaid funds in future years? Under what conditions?**

**Answer:**

As noted above, the federal government specifically excludes sheltered workshops from inclusion in HCBS waivers. Existing programs would qualify for federal Medicaid funds under both the Community Care Waiver and the Comprehensive Medicaid Waiver's Supports Program if they operate as supported employment programs.

- **What other State or non-State funding might be available to support sheltered workshop services for DDD clients -- such as funding through the Division of Vocational Rehabilitation Services (DVRS) in the Department of Labor and Workforce Development, which also currently funds sheltered workshop services?**

**Answer:**

The vast majority of the sheltered workshop providers who hold contracts with the Division also hold contracts with DVRS. The Department is not aware of other State or non-State funding to support these services.

- **How do the sheltered workshop services currently funded by DDD and DVRS differ, in terms of client eligibility, providers, service models, and other critical features?**

**Answer:**

Currently, DVRS programs require individuals to meet the 20% production rate set in N.J.A.C. 12:51-8 (i.e., individual completes tasks in at least 20% of the time needed for an individual without a disability). Individuals that do not meet this standard are referred to DDD.

- **How would the provision of sheltered workshop services to DDD clients through DVRS, or with the support of DVRS funds, affect the annual State cost of providing those services? (Please quantify any potential fiscal impact.) What offsetting non-State funds might be available through DVRS?**

**Answer:**

The State cost for sheltered workshops would remain the same. If, however, DDD workshops can be converted to supported employment programs, 50% of eligible costs would be matched.

- **What administrative changes might be required to provide sheltered workshop services to DDD clients through DVRS, or with the support of DVRS funds? What potential obstacles, challenges, or risks to DDD clients or service providers might need to be considered in making this change?**

**Answer:**

As noted above, the production rate requirement for DVRS workshops would need to be modified or eliminated. With implementation of the Supports Program in FY14, some individuals and families may prefer to access supported employment services, rather than DVRS workshops.

**Senator Beck:**

2. The federal Affordable Care Act (ACA) provides enhanced federal matching funds for those states that participate in the Medicaid expansion of coverage to non-elderly adults with incomes below 133 percent of the federal poverty level (FPL). Under ACA provisions, the federal match for State funds expended on newly eligible persons under this Medicaid expansion will: be 100 percent from 2014 through 2016; phase down to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020; and remain at 90 percent in subsequent years.

- **Please provide year-by-year estimates of the State cost, for FY 2017 through FY 2020, of expanding Medicaid coverage to newly eligible adults with incomes below 133 percent of the FPL. Please also provide the year-by-year enrollment assumptions and any other critical assumptions underlying each year's cost estimate.**

**Answer:**

The provision of the ACA that permits states to cover non-elderly adults with income below 133% percent of federal poverty level at 100% federal match allows the state to cover a significant number of eligibles with no additional state costs through SFY 2016.

Additionally, by choosing to opt into Medicaid expansion, the state is able to claim 100% federal match on some of its existing populations which, prior to 1/1/14, was at 50% federal match. This results in additional SFY14 savings which is reflected in the SFY14 Governors Recommended Budget.

The State cost to cover newly eligible Medicaid recipients in the years after 2016 will depend on a number of variables including the number of individuals that actually enroll, the health status of these individuals, and medical inflation rates over the next several years. However, if assuming the Rutgers study estimate of 104,000 newly eligible individuals, the State costs may fall within the following ranges:

FY17: \$5-15 million

FY18: \$15-25 million

FY19: \$20-30 million

FY20: \$30-40 million

The savings realized through the enhanced match for the existing populations will more than offset the cost estimates reflected above.

Senator Pou:

3. Pursuant to P.L.2009, c.181, health care service firms are required to file annual cost reports with the Division of Disability Services as a condition of receiving Medicaid reimbursement for personal care assistant services. Medicaid personal care assistant services were shifted from a fee-for-service delivery system to managed care, effective July 1, 2011.

- **Please provide a history of the Medicaid fee-for-service reimbursement rates for personal care assistant services, beginning with fiscal year 1998. For any fiscal year in which there was more than one rate, please provide the different rates, the reason for the differentiated rates, and the average rate paid in that year.**
- **Since the transition of personal care assistant services to managed care, how have the cost reports been used? Are the reimbursement rates currently paid to providers sufficient to cover their costs?**

Answer:

Since 1998, budget language has stipulated that weekend rates shall not exceed \$16 per hour. Weekday rates were historically lower. In FY2009 weekday and weekend rates were both set at \$16.15. This rate continued until FY2011 when the rate was lowered to \$15.50, where it has remained for fee for service reimbursements.

The transition to managed care now provides the agencies the opportunity to negotiate rates with the managed care organization. The required cost reports provide information on expenditures and revenues of the agencies. While the Department of Human Services is no longer a participant in the establishment of rates, it is still involved in ensuring quality of care and adequate access to services. Also, clients have the right to appeal service levels recommended by the managed care organization.

Senator Sarlo:

4. The department currently anticipates shifting nursing facility services from fee-for-service to managed care, effective July 1, 2014. Commissioner Velez indicated that there may be a transition period in which the State's contract with Medicaid managed care organizations

(MCOs) would include “any willing provider” provisions, but a decision on the duration of the transition period has not been finalized.

The meaning of the phrase “any willing provider” was not clearly established during the committee meeting. Traditionally, the phrase means that a managed care organization would not be permitted to exclude from its network “any willing provider”; that is, any nursing facility that is willing to meet the terms and conditions of a managed care organization contract and is willing to accept the MCO rate of reimbursement. The commissioner’s testimony seemed to focus on a guarantee that a resident of a nursing facility would not be affected by contract negotiations between the facility and a managed care organization.

- **Please elaborate on the commissioner’s testimony in regard to the relationship between “any willing provider” and the protection of current nursing facility residents’ ability to remain living in the same facility. What would the “any willing provider” provisions under discussion mean for managed care organizations, nursing facilities, and residents?**
- **Please clarify the department’s current plans to shift nursing facility services from fee-for-service to managed care. What steps and timeframes are anticipated, from now until nursing facility services are first shifted into the State’s Medicaid managed care contracts? What additional steps and timeframes are anticipated following the shift? What is currently planned regarding nursing facility reimbursement rates, “any willing provider” policies, and the nature and duration of any transition period(s)?**
- **What other critical issues remain unresolved regarding the shift of nursing facility services into managed care, and the nature of any transition period(s)? When are those issues likely to be resolved?**

**Answer:**

From March, 2012 to June, 2012, the Department convened a Managed Long Term Services and Supports (MLTSS) Steering Committee of 25 members including consumer advocates, provider groups and MCO and PACE representatives. The Steering Committee broke into 4 workgroups with over 125 stakeholders who met weekly. When planning for the transition of nursing home residents from a Medicaid fee-for-service reimbursement system to MLTSS, the concern of the Department and the stakeholders on the MLTSS Steering Committee was to ensure that current nursing home residents can stay in the nursing home which they now consider their home.

In June, 2012 the MLTSS Steering Committee submitted to the Department their final recommendations which included, among other recommendations, an Any Willing Provider Provision and a recommendation to maintain the existing state case-mix reimbursement methodology for nursing homes for two years. Since the release of these recommendations in June, 2012, implementation of MLTSS for nursing home patients was pushed back to July, 2014. The State is exploring the Steering Committee’s recommendation in light of the new implementation date. The welfare of nursing home residents will be at the forefront when the Department makes its’ final decision regarding Any Willing Provider and nursing home

reimbursement rates. The MLTSS Steering Committee will reconvene to provide final decisions on these matters.

5. Current Department of Health regulations (N.J.A.C.8:33H-1.15) generally require nursing facilities to reserve 45 percent of their beds for Medicaid-eligible individuals. Without a requirement that Medicaid managed care organizations open their networks to any willing provider, a nursing facility could be excluded from managed care networks, effectively excluding it from the Medicaid program and causing it to be unable to meet its licensure requirements. This may give MCOs a significant advantage in contract negotiations with nursing facilities. Commissioner Velez suggested that nursing facilities begin negotiations with MCOs in anticipation of the July 1, 2014 transition to managed care, but uncertainty over the rules that will govern the contracts may impede these negotiations.

- **Have the discussions regarding the transition to managed care addressed nursing facilities' licensure requirements? Will any provisions be made, either for a transition period or on a permanent basis, to ensure that nursing homes do not lose their licenses as a result of unsuccessful contract negotiations with managed care organizations?**

**Answer:**

The Department is aware of the licensing regulation at the Department of Health requiring nursing homes to reserve 45 percent of their beds for Medicaid eligible patients. As the Department plans for Managed Long Term Services and Supports (MLTSS), the Department has discussed the implications of this requirement with the Department of Health. The average percentage of Medicaid occupancy in nursing homes in the State is 68%. The Department will ensure that all current nursing home residents will be able to stay in the nursing home which they consider their home now. The Department will continue to monitor Medicaid occupancy and network adequacy for nursing homes. The Department will consult with the Department of Health in determining if any changes are needed in (N.J.A.C.8:33H-1.15) as we move forward with implementation.

**Senator Greenstein:**

6. Some individuals with severe developmental disabilities are unable to make decisions for themselves, and in these cases a court may appoint a guardian to represent the person's interests and make critical decisions on the person's behalf. In some cases, no family member can be found that is able and willing to serve as a guardian, and a court may appoint a State agency, typically the Bureau of Guardianship Services, to serve as the individual's guardian.

- **Please provide a breakdown of current residents of developmental centers with court-appointed guardians by the type of guardian (i.e. a family member, another individual who is not a family member, the Bureau of Guardianship Services, another government agency, or a private agency). Please provide a similar breakdown for residents of group homes or other community placements.**

**Answer:**

There are approximately 2,242 clients in Developmental Centers (as of May, 2013). Of the individuals residing at developmental centers, 1,364 have private guardians and 718 have a

guardian assigned through the Bureau of Guardianship services. For individuals residing in the community, 1,298 clients are assigned through the Bureau of Guardianship services

7. In response to an FY 2014 OLS Discussion Point, DHS indicated that, for individuals placed in the community from FY 2009 through January of 2013, 92.4 percent of individuals remain in the community, 3.4 percent are in developmental centers or psychiatric hospitals, 1 percent are in skilled nursing facilities, 2.9 percent are deceased, and 0.3 percent are in correctional facilities.

- **Please provide a list of standards used to assess the well-being of individuals transitioned from developmental centers to group homes and other community placements. Please also provide detailed information regarding: circumstances under which an individual might be transitioned back to a developmental center after being placed in a community setting; and the criteria that guide such a decision.**
- **How many individuals have been transitioned from community placements to developmental centers since FY 2009?**

**Answer:**

Following community placement, the Division conducts reviews at the following intervals: 30 days, 60 days, 90 days, 180 days, 1 year, 2 years and 3 years. These reviews are in addition to regular case management monitoring, and they include qualitative and quantitative assessments. For example, individuals are asked about their new homes, family interactions and ability to access the surrounding community. The person performing this review corroborates these responses through a related set of observations, evaluating things such as engagement with staff, achievement of plan goals, interaction with friends and family, and evidence of community involvement (including routine medical appointments). This information is supplemented by quantitative data related to the number and frequency of family contacts and community activities. Any issues that have developed are specifically noted and addressed.

Because individuals and their families chose to live in the community, the Division makes every effort to ensure the success of placements. Division staff actively work with individuals, families and providers to develop and implement necessary supports, including staffing and medical equipment. As with anyone in the community, the support needs of individuals with disabilities change over time, and the placement planning process takes account of this. For example, new housing development is primarily focused on single-floor, accessible residences to ensure that individuals can continue to be supported in their homes throughout their lives. Since the start of FY09, 428 individuals have been moved from developmental centers to community residential placements.

8. Beginning in FY 2012, prescription drug coverage for aged, blind, and disabled Medicaid recipients was transitioned from fee-for-service to managed care. Under the Affordable Care Act, the State is now authorized to collect rebates from pharmaceutical manufacturers for drugs provided through a managed care organization (MCO).

- **Please clarify: how many aged, blind, and disabled Medicaid recipients had their prescription drug coverage transitioned to managed care in FY 2012?**

**Answer:**

After the complete 'carve-in' of aged, blind and disabled (ABD) clients and services into managed care, there were approximately 234,000 ABD clients receiving prescription services through managed care.

- **After the transition to managed care, what have been the pharmaceutical rebates recovered for drugs provided through managed care organizations to these aged, blind, and disabled Medicaid recipients in FY 2012 and FY 2013 (estimated)? How does this amount compare to the rebates received when drugs were provided under the fee-for-service system, in FY 2011?**

**Answer:**

Passage of the Affordable Care Act allowed New Jersey to collect rebates on all recipients enrolled in managed care retro-active to March 2010. New Jersey's overall collected amount increased due to the additional populations and an additional 8%-10% that was being collected for the federal government due to ACA. The aggregate fiscal year totals listed below include these additional amounts.

FY 2011 - \$206 million

FY 2012 - \$468 million (increase reflected ACA impact)

FY 2013 - \$322 million (GBM estimate)

- **The New Jersey Drug Utilization Review Board (DURB) has asked in the past for a breakdown of the pharmaceutical rebates for drugs provided through the managed care organizations (following the shift of Medicaid prescription drug coverage from fee-for-service to managed care). Is this information being provided to the DURB? What is the time lag in getting this information to the DURB, and what accounts for that time lag?**

**Answer:**

The Division of Medical Assistance and Health Services never received a formal request from the DURB regarding the breakdown of the pharmaceutical rebates for drugs provided through the managed care organizations (following the shift of Medicaid prescription drug coverage from fee-for-service to managed care). We continue to cooperate with the DURB to ensure that our clients are receiving the highest level of care.

- **Since the transition of prescription drug coverage to managed care, what procedures have been adopted to verify drug utilization data, drug rebate recovery data, and dollar amounts from the managed care organizations (MCOs), for Medicaid managed care prescription claims? How does the department verify that these data are complete?**

**Answer:**

No rebates are collected from the MCOs (the drug manufacturers are invoiced for the prescriptions used by the Medicaid population). The manufacturers are invoiced based on MCO encounter data and Fee-for-Service (FFS) claim data. The basic rebate process has not changed

due to the move into managed care since New Jersey has been operating a FFS rebate program since 1991.

- **A September 2012 report by the U.S. Department of Health and Human Services Inspector General on state collections of drug rebates paid through Medicaid MCOs (OEI-03-11-00480) showed that, between April 2010 and June 2011, 10 of the 22 states that provided prescription drugs through managed care organizations had not collected any drug rebates, in some cases because they had not collected all utilization data from the MCOs. (The period studied for the report precedes New Jersey's transition to managed care). Has New Jersey's Medicaid program experienced similar problems with obtaining these data and rebates?**

**Answer:**

After passage of the Affordable Care Act, which allowed New Jersey (and all other states) to begin collecting rebates from Managed Care Organizations (MCO) encounters, New Jersey did have some initial, minor data issues with the managed care encounter claims, but they have been resolved and New Jersey is able to collect the appropriate rebates.