

Discussion Points

DEPARTMENT OF HUMAN SERVICES (GENERAL)

1. Following Hurricane Sandy in late October 2012, the Department of Human Services (DHS) has been providing a wide range of services to individuals and communities affected by the storm. For instance, the Division of Mental Health and Addiction Services (DMHAS) coordinated Disaster Mental Health Teams to offer crisis counseling at Federal Emergency Management Agency (FEMA) Disaster Recovery Centers. The Division of Family Development administered federal disaster-related Supplemental Nutrition Assistance Program (D-SNAP) benefits and was awarded \$11.6 million in federal funding by FEMA to operate a Disaster Case Management Program (DCMP) providing a single point of contact to assist individuals with accessing recovery-related services.

In addition, individuals and families affected by the storm could be expected to utilize a number of DHS' ongoing assistance programs and services. For instance, Emergency Assistance, available under the State's General Assistance and Temporary Assistance for Needy Families programs, provides benefits to eligible persons who are homeless or at immediate risk of becoming homeless, and to those who have experienced a substantial loss of housing, food, clothing or household furnishings due to fire, flood, or similar disaster.

Many disaster-related services are supported by existing, increased, or anticipated federal funding, but significant increases in expenditures of State funds may be possible.

- **Questions:** Which DHS programs were most affected by Hurricane Sandy? What are the anticipated total storm-related expenditures, by program, by funding source, thus far and projected in FY 2013? projected in FY 2014? In which programs will federal or other non-State resources, either received or anticipated, be insufficient to cover increased, storm-related utilization and expenditures? What additional expenditures of FY 2013 State funds are anticipated in these programs? Which programs are anticipated to have a continuing need for additional State funds in FY 2014, and where is this specifically reflected in the FY 2014 Budget?

Answer: The impact regarding Super Storm Sandy is still being assessed but the Department has been proactive in its response to constituents impacted by Sandy. For example, the Office of Disaster and Terrorism in DMHAS was immediately involved and took a place at the State's Command headquarters at the State Police ROIC. An Immediate Services Program (ISP) was pre-approved by FEMA for \$1.9M to provide crisis counseling, hotline services and other assistance to the victims and 1st responders of Super Storm Sandy. The total ISP grant was for \$3.5M. A Regular Services Program (RSP) has also been applied for and is anticipated to bring an additional \$11.5M in aid to the 10 affected counties and victims. The \$11.6M highlighted above for Disaster Case Management was recently awarded after going through the RFP process. This program will directly assist individuals who are still in needs of an array of services as a result of Sandy. With some of the recent funding streams made available to the State, DHS is pursuing funding for clinical services of

Discussion Points (Cont'd)

dually diagnosed patients with mental illness and substance abuse disorders, an Early Intervention Support Services (EISS) program to establish rapid access to short-term recovery oriented crisis intervention and stabilization services, sheltering programs for the needy like the Social Services for the Homeless and Programs for Assistance in Transition from Homelessness (PATH) which assist those with the increased costs of temporary rentals and subsidy housing for the mentally ill who are homeless, or imminently homeless.

2. The federal Budget Control Act of 2011 (Pub.L.112-25) and the American Taxpayer Relief Act of 2012 (Pub.L.112-240) provided for the sequestration of federal funds effective March 1, 2013. The sequestration is expected to affect federal funding in areas related to programs operated by DHS, including mental health and substance abuse services, child care assistance, and other services. However, certain programs providing significant federal funding to DHS are exempt from sequestration, such as Medicaid, the Children's Health Insurance Program (CHIP), and the Temporary Assistance for Needy Families (TANF) Block Grant.

- **Questions:** What specific State-administered programs does DHS expect to be most significantly affected by the sequestration, and by what amounts? Will any programs require contingency State funding if Congress does not override the sequestration? Are any reductions of federal funds reflected in the Governor's Budget Recommendation in the adjusted appropriation levels for FY 2013 or the recommended appropriations for FY 2014?

Answer: We are still reviewing specific amounts and programs potentially impacted by the sequestration action. In some cases we are working with estimates pending the receipt of grant award notification. We are also investigating potential solutions to mitigate service reduction. Programs that are being monitored in this regard include substance abuse services, mental health services, senior services, services to the blind and visually impaired and child care. Due to the timing of the sequestration decision, the DHS section of the FY14 Governor's recommendation has not been adjusted to reflect federal reductions. In addition, due to uncertainties in the federal budget for FFY14, some of these reductions may still be restored.

3. Implementation of most of the health insurance provisions of the "Patient Protection and Affordable Care Act," Pub.L.111-148, as amended by the "Health Care and Education Reconciliation Act of 2010," Pub.L.111-152 (ACA), including the Medicaid expansion and the health insurance exchange, is scheduled to begin on January 1, 2014. Several programs targeted at low-income uninsured individuals, including many health care services for persons with mental illnesses or addictions, may require less direct State support if the service providers are able to achieve more revenue from private insurance and Medicaid. The Governor's FY 2014 Budget does not appear to reduce appropriations for these programs based on an assumed decrease in the number of uninsured people in New Jersey.

- **Questions:** What programs are most likely to be affected if the ACA is successful in increasing the number of people with health coverage? Will

Discussion Points (Cont'd)

providers be required to assist patients to obtain insurance through the exchange, as many currently do with Medicaid? How will the department ensure that contracted providers maximize non-State revenues?

Answer: A complete analysis of the ACA and Medicaid expansion is still on-going. We do not have enough empirical data at this time to measure the full impact on any specific DHS program as a result of these changes. We are proactively working with the federal government to encourage New Jersey residents to obtain adequate insurance coverage.

4. In October 2012, New Jersey received federal approval for its Comprehensive Medicaid Waiver. The State is now authorized to receive federal revenues for new initiatives as well as for certain existing services that were previously supported by State funds. Thus, cost-shifting to federal funds and other potential sources of State savings are now possible.

The Governor's FY 2014 Budget Recommendation anticipates specific State savings due to the Comprehensive Waiver for several areas within DHS and the Department of Children and Families (DCF). For example, \$16.5 million in combined, net State savings is anticipated from the Children with Serious Emotional Disturbances Program and the Dually Diagnosed Developmental Disability/Mental Illness Program in DCF, while \$2.1 million in savings is anticipated from the Medication Assisted Treatment Initiative in DMHAS.

In addition, at least two new programs are expected to generate increased federal revenues for adult services in the Division of Developmental Disabilities (DDD): a program providing basic support services to individuals with developmental disabilities who live with family members (Supports Program); and a program providing home- and community-based services (HCBS) to persons with intellectual developmental disabilities who live out of State but in an HCBS setting (IDD/OOS Program).

- **Questions:** For DHS, please indicate the total State savings anticipated for FY 2014 as a result of the approved Comprehensive Waiver. Please also disaggregate the anticipated savings by DHS division and major Comprehensive Waiver component (e.g., Supports Program, etc.)

Answer: For the FY14 Budget, there are various initiatives in DHS and DCF where anticipated costs are offset as a result of obtaining a federal match on existing clients that are being paid for with State only dollars. As a result of the waiver authority, we are in the process of drawing down the federal matching dollars for the Medication Assisted Treatment Initiative and on behalf of adults without dependent children. Total savings from the other initiatives for which we received waiver authority will be dependent upon the start date and population enrollment during FY14.

Discussion Points (Cont'd)**DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES**

5a. The Governor's FY 2014 Budget Recommendation indicates that, as part of the Statewide reorganization of programs into the Department of Children and Families (DCF), addiction services for adolescents up to age 18 are being transferred to DCF from the Division of Mental Health and Addiction Services (DMHAS) during FY 2013. Although the FY 2013 Appropriations Act did not reflect any transfers of DMHAS funds, language provisions included in the act allow for transfers of funds and services during the fiscal year.

In response to a FY 2013 OLS Discussion Point, DCF indicated that the reorganization was expected to commence in January 2013 and that, on an annual basis, at least \$4.3 million previously transferred to DHS was expected to be retained by DCF for substance abuse treatment for adolescents.

- **Questions:** Please provide an update on the reorganization of adolescent addiction services from DMHAS into DCF. Please disaggregate, by program/service: the specific funding amounts that have been transferred to DCF in FY 2013; and the specific DMHAS accounts that have been affected. How many adolescents, and which specific services, do any funding transfers represent? What further transfers of funds, clients, and services are anticipated for FY 2014?

Answer: The Departments of Human Services and Children and Families have been working cooperatively to reorganize the provision of addiction services for adolescents to ensure continuity of services during the transition. An Adolescent Transition Advisory Group meets monthly to discuss the transition of adolescent services into the Children's System of Care with a transition date of July 1, 2013 for individuals under age 18. The group's overall focus is to ensure the safe and seamless transition of the adolescents as well as ensuring continuity of care during this process. The group is comprised of staff from DCF (CSOC and DHS (DMHAS) as well as community providers and other pertinent stakeholders. The group's focus has been working on integrating programs, developing and defining service array, determining business rules, developing a fiscal model and information technology/PerformCare. DMHAS and CSOC staff work weekly addressing transition issues. DMHAS staff have been identified to transfer from DHS to DCF. This staff person will serve as the adolescent coordinator of adolescent substance abuse services and works weekly with CSOC staff as well as PerformCare staff.

There was no transfer of funding or staff during Fiscal Year 2013. The transition of adolescent addiction services will be effective July 1, 2013. In the Fiscal Year 2014 Recommended Budget, approximately \$8 million of federal Substance Abuse Block Grant funds will be realigned from DHS to DCF to support adolescent addiction treatment services for youth under age 18. These funds will be available for outpatient, partial care, residential long term, residential short term and fee for service programs.

Discussion Points (Cont'd)

The DHS Division of Mental Health and Addiction Services is in the process of quantifying the funding dedicated to the 18-20 year old population so that funding and services can move during Fiscal Year 2014. Re-budgeting of these resources will occur in the Fiscal Year 2015 budget cycle.

5b. The Governor's FY 2014 Budget Recommendation also indicates that certain mental health services for adolescents up to age 18 will be transferred from DMHAS to DCF during FY 2014, as will certain mental health and addiction services for individuals ages 18-20.

- **Questions:** Please disaggregate, by program: the specific funding amounts to be transferred to DCF in FY 2014; and the specific DMHAS accounts that will be affected. How many adolescents, and which specific services, will any funding transfers represent? Which specific adolescent addiction services and mental health services are expected to remain within DMHAS, and how do those services differ (in terms of clients, settings, purpose, etc.) from the services that will be moved to DCF?

Answer: As noted in response 5a above, the Division is in the process of quantifying the funding dedicated to the 18-20 year old population so that funding and services can move during FY 14. All of the affected mental health services are in cost related contracts where the detail regarding the allocable portion of cost, revenue and Division funding for the 18-20 year old population is not routinely collected. We constructed a survey that providers are presently completing to aid in developing the allocation.

The following MH services for individuals age 18-20 are expected to move to DCF:

- Outpatient services
- Intensive Outpatient Treatment and Support Services (IOTSS)
- Early Intervention and Support Services
- Partial Care/Hospitalization
- Integrated Case Management Services (ICMS)
- Supported employment
- Justice involved services
 - Legal services

All substance abuse treatment services funded by state GIA and federal block grant dollars for the 18-20 age group except Medication Assisted Treatment are expected to move to DCF at some point during FY 14.

ALL substance abuse treatment services funded by the following initiatives/interagency agreements for the 18-20 age group will remain with DMHAS:

- Driving Under the Influence Initiative (DUII) programs
- Drug Court services

Discussion Points (Cont'd)

- State Parole Board Mutual Agreement Program (SPB-MAP) services for parolees and current inmates awaiting parole
- Department of Corrections Mutual Agreement Program (DOC-MAP) services for inmates

6a. The FY 2012 Appropriations Act provided \$2.0 million to phase in the involuntary outpatient commitment (IOC) legislation, P.L.2009, c.112, which amended the State's civil commitment laws to allow for the involuntary commitment to outpatient treatment of an individual. Five IOC contracts were awarded in April 2012 for sites in Burlington, Essex, Hudson, Union, and Warren counties. In response to a FY 2013 OLS Discussion Point, DHS indicated the full annualized FY 2012 appropriation would not be expended (and that a portion of funding would be lapsed to the General Fund). DHS also indicated that the FY 2013 appropriation would maintain IOC funding at \$2.0 million, which would be fully expended in FY 2013 under contracts with six program sites. A sixth contract was awarded (Ocean County) in fall 2012.

Available information indicates that the Governor's FY 2014 Budget provides \$2 million for the current IOC contracts within the \$265.0 million recommended appropriation for Community Care (page D-175). The FY 2014 Budget Recommendation also contains a language provision (page D-177) appropriating up to \$2.4 million in unexpended FY 2013 Community Care funds to IOC activities. There is no indication regarding: how many additional county-based IOC programs this amount would support in FY 2014; whether the additional funding would be sustained beyond FY 2014; and whether DHS anticipates funding any additional IOC programs in the future.

- **Questions:** How many additional county-based IOC programs will be supported in FY 2014 by the \$2.4 million in unexpended FY 2013 Community Care funds? In which counties? Is baseline funding for the program anticipated to increase beyond FY 2014? Are any additional IOC funds beyond this amount anticipated?

Answer: The current appropriation of \$2M supports 6 counties. Before additional RFPs are released, the Division will conduct an evaluation of current providers to inform the development of future RFPs so, at this point, we are unable to say with certainty how many more counties will participate.

6b. The IOC legislation required IOC sites in all 21 counties by August 2013. In a fiscal note for the original legislation, DMHAS had estimated that the IOC program would cost \$10.2 million annually when fully implemented in all 21 counties, for an average per-county cost of \$486,000. Based on the six current contracts totaling \$2 million, the average per-county expenditure is about \$333,000.

- **Questions:** How many clients have been served by the IOC program in each county, to date, in FY 2013? What accounts for the lower average per-county expenditure in the current contracts than what was originally estimated? What

Discussion Points (Cont'd)

accounts for the delay in full implementation to all 21 counties? What is the department's current cost estimate for full program implementation?

Answer: The following volume of individuals have been served in each county to date:

- Essex -- 24
- Warren -- 8
- Hudson --1
- Union --33
- Burlington --13
- Ocean 1 referral; no current active individuals (program just started operation)

At the time the fiscal estimate was prepared, it was based on certain assumptions regarding staffing and client volume. RFPs were developed to award programs on a competitive basis and the awarded providers had proposals for less than had been assumed when the projection was developed.

A stakeholder input process was conducted from April 2011 to July of 2011 to help assure the development of a comprehensive and complete RFP. The RFP was subsequently released in January 2012.

The program is designed to be available to provide capacity for involuntary commitments that may occur. Funding must consider the availability of service rather than focusing solely on utilization. In other programs, such as screening where we need to assure availability, we examine trends in utilization over time to assure the capacity we are making available is reasonably aligned with the evolving demand.

Although the fiscal note provided an estimate of \$10 million for the implementation of IOC services, the estimate was before any RFP's were issued and could not forecast the volume of potential consumers and the necessary coordination of services. The legislation requires us to evaluate implementation and to develop recommendations to the program moving forward. We continue to meet with stakeholders to evaluate the operation of the program and to better assess and refine treatment cost in relation to achieving the objectives of the legislation.

The legislation requires involuntary inpatient commitment for clients who pose imminent danger vs involuntary outpatient commitment for dangerousness in the foreseeable future.

Given the newness of the current programs, education of clinicians, judicial system etc., we believe that a measured phase-in of additional services following a thorough evaluation, as previously mentioned, is the most prudent course of action.

7. The Governor's FY 2014 Budget recommends \$265.0 million for Community Care (page D-175). Community Care funds contracts with community mental health agencies to provide an array of mental health services, including: early intervention and support services;

Discussion Points (Cont'd)

screening services; outpatient, partial care, and residential services; supported housing and employment; integrated case management; legal services; and family support services.

Of the \$262.6 million originally appropriated for the program in FY 2011, \$6.8 million was lapsed to the General Fund. Of the \$258.6 million appropriated for the program in FY 2012, \$2.9 million was lapsed to the General Fund. Of the \$258.9 million originally appropriated for the program in FY 2013, \$4.7 million was being held in reserve as of March 2013.

- **Questions:** What portion of the \$4.7 million in FY 2013 funds currently in reserve will be lapsed? Will \$2.4 million of the funds in reserve be appropriated to IOC programs, or will these funds be drawn from remaining, uncommitted Community Care funds?

Answer: \$2.3M of the \$4.7M reserve can be lapsed allowing the remaining \$2.4M to carry forward.

8. As of March 2013, approximately \$4.1 million in DMHAS FY 2012 Grants-in-Aid funds were still encumbered, including \$3.6 million in Community Care and \$0.5 million in Community Based Substance Abuse Treatment and Prevention – State Share.

- **Question:** How much of the encumbered funds can be lapsed?

Answer: DHS reviews all outstanding encumbrances as part of our spending plan process and these encumbrances related to contracts can not be lapsed.

9. The Governor's FY 2014 Budget recommends \$88.8 million for Olmstead Support Services (page D-175).

Olmstead Support Services provide mental health services that are similar to those supported under Community Care, but with a focus on assisting individuals discharged or diverted from the State's psychiatric hospitals, in accordance with the State's long-term efforts to reduce the number of institutionalized individuals pursuant to the U.S. Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999), which required that residents with mental illness live in the least restrictive appropriate environment.

Historically, the program has appeared to be unable to expend its entire appropriation. Of the \$55.8 million originally appropriated for the program in FY 2011, \$5.4 million was lapsed to the General Fund. Of the \$65.6 million originally appropriated for the program in FY 2012, \$3.4 million was lapsed. Of the \$79.0 million originally appropriated for the program in FY 2013, \$4.1 million was being held in reserve as of March 2013.

- **Questions:** As annual appropriations for Olmstead Support Services have consistently exceeded annual expenditures, should the \$88.8 million

Discussion Points (Cont'd)

recommendation for FY 2014 be reduced? Will the \$4.1 million in FY 2013 funds currently in reserve be lapsed?

Answer: No, the \$88.8 million recommendation should not be reduced. The growth for FY14 is more in line with how individuals were discharged; actual experience has shown that placements occur later in the fiscal year compared to what we had budgeted in previous years, which assumed that individuals would be placed earlier in the year. Yes, \$4.1 million in FY13 Olmstead funds are currently in reserve and have been identified to potentially lapse.

10. Under the approved Comprehensive Medicaid Waiver, adult behavioral health services are generally excluded from coverage under an individual's primary managed care organization (MCO) and instead will be covered through a managed behavioral health organization (MBHO).

Under the waiver, the State will continue to pay for services on a fee-for-service basis, but will contract with an MBHO as an Administrative Services Organization for coordination of services. Although the MBHO will not determine payment rates, it will be responsible for administrative functions that may limit the use of services, including prior authorizations, network management, utilization management, and quality management. Under the Comprehensive Waiver, an MBHO is to begin coordinating behavioral health services for adults on July 1, 2013, or a later date. Available information suggests that the adult MBHO will not be operational in FY 2014.

- **Questions:** Please provide an update on the anticipated timing for implementation of an adult MBHO and the rationale for any departure from the timeframe provided in the waiver. What will the expected cost of the contract be?

Answer: The Comprehensive Medicaid Waiver was approved by CMS in October 2012. The Special Terms and Conditions (STC) of the Waiver grant approval effective July 1, 2012 or a date thereafter for adults to have their behavioral health coordinated by a behavioral health ASO/MBHO. DMHAS and DMAHS have been working collaboratively and deliberately to address policy and fiscal issues related to the successful implementation of an ASO/MBHO. These include: convening a stakeholder input process, procurements of an actuarial firm to support rate rebalancing, developing business rules related to access, prior authorization, and claims payment; and collaborating with systems partners to determine how funds received from other departments and divisions will be managed by the MBHO. In December of 2012, DMHAS provided a revised timeline to stakeholders calling for the publication of the RFP in late spring 2013 with an award in the fall of 2013. Once awarded, as per the STCs, a readiness review will be conducted for 4-6 months, and the ASO/MBHO is anticipated to go live sometime after July 2014.

Discussion Points (Cont'd)

The expected cost of the contract has not been finalized as the RFP is still being written. The scope of services to be managed will materially affect the cost of the contract.

11a. Two federal audits conducted by the U.S. Department of Health and Human Services' Office of Inspector General (OIG), in November 2011 and March 2012, recommended that the State refund up to \$13.0 million and \$22.5 million, respectively, for Medicaid administrative reimbursement obtained for contracted community-based mental health agencies between 2005 – 2007. The claims in question were submitted by Maximus.

In response to a FY 2013 OLS Discussion Point, DHS stated that it can recoup incentive payments made to Maximus, and the issue of recouping from Maximus any amounts that the State refunds to the federal government was being reviewed by the Attorney General's office.

- **Questions:** In the current fiscal year, has the State recouped any incentive payments from Maximus or any amounts refunded to the federal government? What amounts? Will any amounts be recouped in FY 2014? If no funds have been recouped to date, please explain why those funds have not been received.

Answer: Upon a recommendation from DHS's outside counsel, Covington & Burling, LLC, DMHAS sought assistance from the University of Massachusetts Medical School, Center For Healthcare Financing (CHCF), to re-evaluate the audited MAC claims produced by Maximus.

On March 19, 2013, DHS submitted a response to CMS on the Final OIG audit report on Mental Health MAC. CHCF evaluated the MAC claim and provided support for our claim.

Since the State is still in the process of challenging the audit findings, DHS has not recouped any payments from Maximus related to the MAC audit.

11b. In response to a FY 2013 OLS Discussion Point, DHS stated that the State is challenging the disallowance of the entire value of the community-based mental health Medicaid administrative reimbursement claims for FY 2005 – FY 2007. DHS also indicated that, as the State had obtained administrative reimbursement for the subsequent fiscal years of FY 2008 – FY 2010, the federal disallowance for that period could be \$16.5 million. However, DHS also stated that the OIG had not yet targeted this time period.

- **Questions:** What is the current status of the disputed disallowances? Has the OIG identified any additional disallowances for subsequent fiscal years? What fiscal implications, if any, will these disallowances have for FY 2013 or FY 2014?

Answer: AS stated in 11a, upon recommendation from DHS's outside counsel, Covington & Burling, LLC, DMHAS sought assistance from the University of

Discussion Points (Cont'd)

Massachusetts Medical School, Center For Healthcare Financing (CHCF), to re-evaluate the audited MAC claims produced by Maximus.

On March 19, 2013, DHS submitted a response to CMS on the Final OIG audit report on Mental Health MAC. CHCF evaluated the MAC claim and provided support for our claim.

The OIG has not pursued additional disallowance for any years subsequent to the audit period. Until the final settlement is reached with CMS, the fiscal implications of the disallowance cannot be quantified.

12. In November 2012, an OIG audit found that New Jersey claimed Medicaid Disproportionate Share Hospital (DSH) payments totaling \$100 million (gross) for five local psychiatric hospitals that did not meet Federal requirements for DSH payments during State Fiscal Years 2003-2007. The report recommended that the State be required to refund the federal share (\$50 million) of these DSH payments. In its response, DHS disputed the findings and stated that its repayment obligation was only \$3.5 million.

- ***Questions:*** What is the current status of the disallowed DSH payments? What is the amount of the current repayment obligation? What repayment amount is incorporated in the FY 2014 Budget?

Answer: The federal government has agreed to accept a refund of approximately \$3.5 million, which will be covered by resources already set aside. The refund will not impact the FY2014 Budget.

Discussion Points (Cont'd)**DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES**

13. In his FY 2014 budget address, Governor Christie announced his decision to support New Jersey's participation in the Medicaid expansion under the Affordable Care Act, extending health coverage to an additional 104,000 adult New Jerseyans with incomes below 133 percent of the federal poverty level (FPL). Medicaid costs for newly eligible beneficiaries will be paid entirely by the federal government in calendar year (CY) 2014, with the federal matching rate phasing down to 90 percent by CY 2020.

Maximizing enrollment of newly eligible individuals in Medicaid – and thereby maximizing federal funds flowing to New Jersey – may require new or expanded outreach and enrollment efforts by the State. In the past, New Jersey has been recognized for its outreach and enrollment efforts, receiving federal bonuses of more than \$40 million in the last three years in recognition of the State's efforts directed at children.

- **Questions:** Does DHS plan to implement any new or expanded outreach and enrollment efforts targeted at newly eligible individuals? How are these initiatives to be funded, and at what amounts? What other policies (for example, presumptive eligibility – see Discussion Point 15b, below) are intended to promote and ease newly eligible individuals' enrollment into Medicaid?

Answer: The Division is planning several activities to outreach and enroll eligible individuals beginning October 2013. These activities include: the use of our Presumptive Eligibility program; contracts with existing MCOs; partnerships with existing State agencies and community based organizations; and a new automated eligibility determination system.

14. Evaluation data on pages D-179 and D-180 of the Governor's FY 2014 Budget provide estimated Medicaid and NJ FamilyCare enrollments and per-person expenses for General Medical Services, Medicaid Managed Care Title XIX, General Assistance, NJ FamilyCare Adults, and NJ FamilyCare Children. As indicated by a footnote on page D-180, all of these estimates except NJ FamilyCare Children reflect the mid-year amounts before the impact of the Affordable Care Act (ACA) and Medicaid Expansion. Although the effect of the ACA on enrollment is highly uncertain, the Governor's FY 2014 Budget Recommendation, including the \$227 million in savings and the \$42 million increased expenditure associated with the ACA indicated on page B-4, relies upon assumptions about enrollment in the second half of FY 2014.

- **Question:** Please provide the department's estimated enrollments and expenses for the second half of FY 2014 for each item on pages D-179 and D-180 referenced to footnote (b). This includes average monthly enrollment and average monthly expense in each of the following: General Medical Services, Medicaid Managed Care Title XIX (and each of the three populations that compose this group), General Assistance, and NJ FamilyCare – Adult Health Coverage Benefits.

Discussion Points (Cont'd)

Answer: The Department, with the assistance of the Rutgers Center for State Health Policy, estimates that 104,000 new enrollees will be eligible for Medicaid due to ACA. An additional 193,000 currently eligible, but yet not enrolled clients could potentially enroll due to the increased outreach and marketing efforts due to ACA. A portion of our current population, the higher income New Jersey FamilyCare parents, will shift to the ACA marketplace.

The Department calculated the estimated savings of \$227 million and potential increased expenses of \$42 million on an aggregate level.

Per footnote b on page D-180, the evaluation data is not reflective of potential enrollment resulting from the Affordable Care Act and Medicaid Expansion.

15a. The Governor's FY 2014 Budget recommends \$13.7 million for eligibility determination services, an increase of about \$0.6 million over the FY 2013 appropriation. This annual growth is much smaller than in recent years. Expenditures grew from \$8.6 million in FY 2011 to \$10.8 million in FY 2012, and to an adjusted appropriation of \$13.0 million in FY 2013.

There may be increased need for eligibility determination services due to increased Medicaid applications and enrollment associated with the Affordable Care Act. In his FY 2014 Budget Message, the Governor indicated that Medicaid enrollment would increase by 104,000 as a result of the proposed expansion of Medicaid to adults with incomes up to 133 percent of the FPL. Enrollment of individuals currently eligible for Medicaid may also increase as a result of the new individual health insurance mandate and other provisions of the Affordable Care Act (ACA). However, the federal government may cover some costs related to individuals who apply for Medicaid coverage through the health insurance exchange. (The federal government has not indicated how much of the eligibility determination process will be handled by the exchange, and how much will be left with the State. The initial open enrollment period for all exchanges will begin on October 1, 2013, and all exchanges are to begin offering coverage on January 1, 2014.)

- **Questions:** What factors have driven the growth in Eligibility Determination Services for the past several years? Will the FY 2014 appropriation be sufficient to handle the increased demand for eligibility determination services associated with the ACA?

Answer: Over the years, DHS has increased the amount we reimburse County Welfare Agencies for the determinations that they perform. This reimbursement is made on a per case basis. Beginning October 2013, applicants will have a variety of options in applying for Medicaid: Presumptive Eligibility, County Welfare Agencies, our Health Benefit Coordinator and the marketplace (the federal Health Exchange).

15b. The ACA provides states with new options to provide presumptive eligibility for several groups that could not previously be presumed eligible under federal law, such as newly eligible adults with incomes up to 133 percent of the FPL or certain low-income

Discussion Points (Cont'd)

parents currently eligible under section 1931 of the Social Security Act. Presumptive eligibility allows states to enroll these individuals for a limited period of time, before completed Medicaid applications are filed and processed, based on a preliminary determination by Medicaid providers of likely Medicaid eligibility. The State currently provides presumptive eligibility for children, pregnant women, and women with breast or cervical cancer – the only groups allowed under federal law prior to the ACA.

- **Questions:** Does the department plan to exercise any of the ACA's expanded options for presumptive eligibility? How do the current presumptive eligibility policies affect Medicaid expenditures for eligibility determination and care?

Answer: New Jersey has a long-standing Presumptive Eligibility program for pregnant women and children. Presumptive Eligibility, along with other application sites, may be utilized to enroll eligible individuals. Those detailed changes will be released in State regulation.

16. The Governor's FY 2014 Budget Summary (Budget in Brief) states that "New Jersey's Medicaid program will include an automatic trigger to roll back expansion if federal reimbursement rates promised under the Affordable Care Act change." This seems to suggest a statutory mechanism that conditions the State's participation in the Medicaid expansion (providing coverage to adults with incomes up to 133 percent of the FPL) on specified provisions of federal law. However, the Governor's FY 2014 Budget Recommendation does not include any language authorizing such a trigger.

- **Questions:** By what authority would the Executive roll back Medicaid program expansion if federal reimbursement rates under the Affordable Care Act change? What specific changes to federal law would trigger a rollback of the Medicaid expansion? If federal law is changed and the federal matching rates under the Affordable Care Act are reduced, how would the roll back of Medicaid be implemented? Would individuals terminated from Medicaid be transitioned to other health care coverage, such as in the health insurance exchange, where applicable?

Answer: CMS has advised states that they can choose whether and when to expand Medicaid and can make changes to its Medicaid program through a State Plan Amendment. Where applicable, individuals terminated from Medicaid would be transitioned to other health coverage such as the health insurance marketplace.

Discussion Points (Cont'd)

17. Effective January 1, 2014, the Affordable Care Act generally requires that income eligibility for Medicaid be determined on the basis of Modified Adjusted Gross Income (MAGI), which would align eligibility determinations with the activities of health insurance exchanges. One significant consequence of this shift is that the State will no longer be able to differentiate between earned and unearned income when determining eligibility for Medicaid. The State has limited flexibility in how it will adjust its current income standards to MAGI.

- **Questions:** **Has the State developed proposed income eligibility standards and methodologies for implementing them? Please quantify any expected effect on enrollment and expenditures attributable to the new MAGI requirements.**

Answer: The State is working with CMS to develop our MAGI eligibility standards. We will provide training for eligibility workers and application assistors on the new calculations. CMS expects enrollment to remain stable in the aggregate. Note, however, that New Jersey is electing the optional Medicaid expansion.

18a. The term "NJ FamilyCare" is sometimes used loosely to refer to both the NJ Family Care Program (as established under P.L.2005, c.156) and the State's Medicaid program (established under P.L.1968, c.413). Both programs provide health coverage to low-income parents and children. However, NJ FamilyCare and Medicaid utilize different eligibility rules and income standards.

The NJ FamilyCare Program provides medical assistance to parents with gross family incomes (combining earned and unearned income) up to 200 percent of the FPL. Effective March 1, 2010, DHS closed the NJ FamilyCare Program to new enrollments of parents.

The State's Medicaid program currently provides medical assistance to parents with earned income up to 133 percent of the federal poverty level (FPL) and unearned income up to a fixed, lower threshold established under the former Aid to Families with Dependent Children program. (This threshold was 20-30 percent of the FPL in calendar year 2012, depending on family size). Thus, any increases in either earned or unearned income may render a parent ineligible for the Medicaid program. Prior to the NJ FamilyCare parent enrollment freeze, Medicaid participants whose earned or unearned income increased above the eligibility limits for Medicaid could be transitioned into NJ FamilyCare.

Available information indicates that certain parents who: (1) were continuously enrolled in Medicaid or NJ FamilyCare from a date preceding March 1, 2010 (including parents shifting between programs); (2) were subsequently disenrolled from Medicaid after March 1, 2010 due to an increase in earned or unearned income; and (3) had gross family incomes below 200 percent of the FPL upon Medicaid disenrollment were considered "new applicants" for the NJ FamilyCare program and were denied enrollment into NJ FamilyCare.

Discussion Points (Cont'd)

- **Questions:** How many parents were: continuously enrolled in either Medicaid or NJ FamilyCare from a date preceding March 1, 2010; disenrolled from Medicaid after March 1, 2010; had gross family incomes below 200 percent of the FPL at the time of Medicaid disenrollment; and were denied enrollment into NJ FamilyCare? Of these same individuals, how many had gross family incomes below 133 percent of the FPL at the time of Medicaid disenrollment and were denied enrollment into NJ FamilyCare?

Answer: It is impossible to determine with any reasonable certainty the number of people who were not enrolled, or denied enrollment, due to NJ FamilyCare's enrollment freeze. With the passage of ACA, the new MAGI requirement will simplify the eligibility determination methodology between earned and unearned income.

18b. Proposed budget language (page D-187) provides for the transfer of several groups of current NJ FamilyCare enrollees to New Jersey's federally operated health insurance exchange, effective January 1, 2014 "or on such date established by the federal government for the Health Insurance Exchange pursuant to the Affordable Care Act." (Under the Affordable Care Act, the health insurance exchange is to be operational on October 1, 2013, and insurance policies sold there are to be effective January 1, 2014.) These groups include: (1) adults or couples without dependent children who were enrolled in the New Jersey Health ACCESS program on October 31, 2001; (2) all parents or caretakers who: (i) have gross family income that does not exceed 200 percent of the poverty level; (ii) have no health insurance, as determined by the Commissioner of Human Services; (iii) are ineligible for Medicaid, or (iv) are adult aliens lawfully admitted for permanent residence, but who have lived in the United States for less than five full years after such lawful admittance, and are enrolled in NJ FamilyCare; and (3) Essential Persons (Spouses) whose coverage is funded solely by the State.

- **Question:** Does "the date established by the federal government for the Health Insurance Exchange" refer to the date on which insurance policies sold through the exchange become effective?

Answer: It refers to the earliest date on which insurance policies sold through the marketplace can become effective starting 1/1/14.

- **Questions:** Assuming that the health insurance exchange is implemented on the schedule provided by the Affordable Care Act, will these individuals' coverage be terminated on January 1 if they are not enrolled in an exchange health plan? Will the department actively facilitate their transfer to the exchanges? What savings are anticipated by transitioning these populations off State-funded coverage? When combined with the transition of adults under 133 percent of the FPL to Medicaid, will this effectively eliminate all adult coverage (e.g., coverage of parents between 133 and 200 percent of the FPL) in the NJ FamilyCare program as of January 1?

Discussion Points (Cont'd)

Answer: The Department and its Health Benefit Coordinator will conduct eligibility redeterminations for these impacted populations to first determine whether they are newly eligible for Medicaid. If they are not eligible for Medicaid, they will be notified and efforts will be made to smoothly transition them to the federal marketplace. Approximately \$400,000 will be saved during FY 2014. Yes, this will effectively eliminate all adult coverage in the Title XXI program as of January 1.

19a. The NJ FamilyCare program provides premium assistance to individuals who are eligible for NJ FamilyCare and have access to employer-sponsored insurance, if the private insurance provides similar benefits to NJ FamilyCare and if premium assistance is more cost-effective for the State than enrolling the person in NJ FamilyCare. Historically, this program has been minimally used, as few individuals who are eligible for NJ FamilyCare have access to employer-sponsored coverage. The Affordable Care Act (ACA) may increase the availability of employer-based insurance to low-income individuals through its insurance market reforms, such as requiring employers to offer insurance and allowing small employers to obtain insurance through the health insurance exchange.

- **Questions:** Does the Governor's FY 2014 Budget anticipate greater utilization of premium assistance as a result of changes in insurance markets under the ACA? If so, please quantify the assumed fiscal impact.

Answer: New Jersey has had a premium support/employer sponsored buy-in program for years. The Department proposed through its Comprehensive Waiver to expand the number of individuals who would qualify for the premium support program by improving the program operations. We will continue to explore our premium support program as a cost effective way to implement the Medicaid expansion, including through the marketplace.

19b. The NJ FamilyCare Advantage program permits certain children under the age of 19 whose family income is greater than 350 percent of the FPL (too high to qualify for NJ FamilyCare) to buy into the program.

- **Questions:** Does the Governor's FY 2014 Budget anticipate increased participation in NJ FamilyCare Advantage as a result of the ACA? If so, please quantify the assumed fiscal impact.

Answer: Discussions regarding the future participation in the New Jersey FamilyCare Advantage program are ongoing. This is a full-cost buy-in program so there is no fiscal impact to the state.

20. The ACA provides for a one percent increase in the federal Medicaid matching rate for certain immunizations and preventive services, effective January 1, 2013, if the State does not impose any cost sharing for those services. Available information suggests that New Jersey already provides these services without cost sharing.

Discussion Points (Cont'd)

- **Questions:** Does the Governor's FY 2014 Budget account for this additional federal revenue? How much is anticipated?

Answer: Yes, New Jersey does provide these services without cost sharing. The anticipated State savings are approximately \$350,000.

21. The Governor's FY 2014 Budget recommends a new language provision (page D-187) that prohibits new provider agreements with Medicaid Managed Care Organizations (MCOs) or with primary care case managers unless the agreement is determined by the Director of the Division of Medical Assistance and Health Services to be "necessary to provide access to services for enrollees and promotes the stability and success of the managed care program." The language indicates that this provision is intended "to facilitate and maximize participant enrollment and to prevent plan inefficiencies."

- **Question:** Please explain how requiring division approval for new provider contracts will facilitate and maximize participant enrollment and prevent plan inefficiencies.

Answer: While the Department values competition and choice, it should be balanced with the financial consequences of increasing the number of health plans and provider and consumer satisfaction. This means the Department will have the ability to proactively determine the number of participating health plans. National best practices are to move toward time limited contracts under an open competitive, public procurement process.

22a. The Governor's FY 2014 Budget anticipates \$335 million in revenue from Medicaid and General Assistance prescription drug rebates. The original FY 2013 estimate of \$331 million is revised down slightly, to \$323 million. Total rebate revenues were approximately \$260 million in FY 2010, \$207 million in FY 2011, and \$468 million in FY 2012.

Final FY 2012 rebate revenues were about \$140 million higher than the FY 2012 revenues estimated in the Governor's FY 2013 Budget. According to DHS, this increase largely represented a one-time retroactive collection of rebates due to Affordable Care Act (ACA) provisions requiring an overall increase in manufacturer rebates for drugs dispensed to Medicaid patients, which is offset by increased State rebate remittances to the federal government; and collection of drug rebates for individuals enrolled in Medicaid managed care.

- **Questions:** What is the total sum of Medicaid drug rebates owed to the State but not yet paid by drug manufacturers? What accounts for the revised estimate for FY 2013? To what extent do the FY 2013 or FY 2014 estimates depend upon drawing down rebates incurred in prior periods but not yet collected?

Answer: The current amount owed to the State is approximately \$30 million, or 0.9% on \$3.3 billion invoiced to manufacturers since the program's inception. This

Discussion Points (Cont'd)

amount is subject to change (revised down) as the Division works through disputes with some manufacturers. Due to ACA, we are now allowed to collect rebates for those enrolled in managed care and this is the driver of our revised FY 2013 estimate. The FY 2013 and FY 2014 estimates do not rely on outstanding rebates.

22b. In response to a FY 2013 OLS Discussion Point, DHS indicated that \$50 million to \$60 million of the \$140 million in additional FY 2012 Medicaid drug rebate revenues was to be used to offset unrealized savings resulting from delayed approval of the Comprehensive Medicaid Waiver. Informal information from DHS also indicated that approximately \$70 million to \$80 million (50 to 60 percent) of the \$140 million was to be remitted to the federal government, pursuant to the ACA.

- **Question:** Please provide detailed, disaggregated information regarding the final disposition of the \$140 million in higher than anticipated FY 2012 Medicaid prescription drug rebate revenues.

Answer: This increase was due to ACA and the ability to begin collecting rebates for those enrolled in managed care dating back to ACA's passage in March of 2010. These retroactive collections caused the increase in the FY 2012 rebate amount. Our answer to the FY 2013 OLS Discussion Points regarding the FY 2012 supplemental included an increased State share rebate amount of \$50 million to \$60 million based on \$140 million in additional gross (State and federal) rebate collection. All collected rebates are used to offset General Medical Services expenditures.

23. The Governor's FY 2012 Budget had assumed a total of \$39.0 million (State savings) in various fraud, settlement, and other contract recoveries. The FY 2012 Appropriations Act incorporated this amount plus an additional \$18.0 million in fraud recoveries assumed by the Legislature. In response to a FY 2013 OLS Discussion Point, DHS indicated that fraud and settlement recoveries would approach \$39.0 million in FY 2012. The Governor's FY 2014 Budget anticipates \$20.0 million in additional, enhanced Medicaid fraud recoveries relative to FY 2013 (page D-182).

- **Questions:** What were the final fraud, settlement, and contract recoveries realized in FY 2012? What amounts of such recoveries are anticipated in FY 2013 and FY 2014? Why are fraud recoveries expected to increase in FY 2014?

Answer: Since FY 2012, \$40 million in base recoveries has been included in the budget. In FY 2012, the State realized \$43 million in actual recoveries. In FY 2013, the Division anticipates to collect \$55 million in recoveries, mainly due to recent large national settlements with some drug manufacturers. The FY 2014 estimate is \$60 million (including the additional \$20 million in fraud recoveries).

24. Under federal rules, states may claim federal financial participation through Medicaid for prisoners for care received in a medical institution. The Affordable Care Act extends income eligibility for Medicaid to include most prisoners, and thus may give the State and its

Discussion Points (Cont'd)

subdivisions the opportunity to bill the federal government for a significant portion of correctional health care costs. In response to an FY 2013 OLS Discussion Point, the Department of Corrections indicated that it had formed a task force with DHS to study the possibility of billing Medicaid for eligible correctional health care costs.

- **Questions:** What conclusions, if any, has the task force reached about billing Medicaid for State prisoners' health care costs? Is it feasible, given current policies and State laws and regulations, for counties and municipalities to bill Medicaid for their correctional health care costs?

Answer: Medicaid coverage is allowable for inpatient stays over twenty-four hours for those inmates that meet Medicaid eligibility requirements. DMAHS and DOC have worked out a process for taking Medicaid applications of State inmates admitted to hospitals and thereby drawing down federal dollars for inpatient hospital and inpatient physician Medicaid covered services. DMAHS will next explore working out a process with the counties to leverage federal dollars for overnight inpatient hospital stays for county inmates. With the exception of inpatient stays over twenty-four hours, federal law precludes Medicaid coverage for inmates.

25. The FY 2013 Appropriations Act passed by the Legislature included a new language provision, which was removed by the Governor's line-item veto, requiring establishment of a Medicaid supplemental payment program for services provided by physicians employed as teaching faculty by medical schools that receive State funding. As described, the program would have used State appropriations to the medical schools as the State share, effectively allowing the State to receive federal Medicaid dollars with no additional State cost. Available information is that several other states operate similar programs.

- **Questions:** Has the department studied the feasibility of such a program? How much federal revenue might be achieved under such a program?

Answer: Since this language was not included in the FY 2013 Appropriations Act, no action was taken.

26. On November 14, 2007, the United States Government Accountability Office (GAO) released a report on tax evasion by Medicaid providers (Medicaid: Thousands of Medicaid Providers Abuse the Federal Tax System, GAO-08-17). The GAO found that over 30,000 Medicaid providers in seven selected states (New Jersey was not included in the sample), or over five percent, had federal tax debts totaling over \$1 billion as of September 30, 2006. The unpaid taxes mostly consisted of individual income and payroll taxes. The GAO noted further that the federal government and the seven states surveyed had no process for screening health care providers for unpaid taxes and hence did not bar health care providers with tax debts from enrolling in or receiving payments from Medicaid.

In response to OLS Discussion Point #10 in the FY 2008-2009 Department of the Treasury Budget Analysis, the Division of Taxation indicated that it did not have a database of Medicaid providers. Consequently, it was unable to screen the providers for unpaid taxes. At the time, the Division of Taxation stated it intended to begin discussions with the Division

Discussion Points (Cont'd)

of Medical Assistance and Health Services (DMAHS) to identify and to resolve any legal issues that might impede the exchange of provider information for tax administration purposes. If successful, the Division of Taxation could provide information to the Medicaid program on medical providers who have unpaid State taxes so that the Medicaid program may terminate the providers from the program or withhold Medicaid reimbursements until resolution of the tax matter. Replying to OLS Discussion Point #16 in the FY 2012-2013 Department of the Treasury Budget Analysis, the Division of Taxation stated that it had begun ongoing discussions with DMAHS on this initiative and that the discussions led to the identification of unspecified preliminary solutions.

- ***Questions:*** Have DMAHS and the Division of Taxation concluded their discussions concerning the exchange of information on medical providers so that the Medicaid program may terminate providers with unpaid State tax liabilities from the program or withhold Medicaid reimbursements until resolution of the tax matter? If so, what has been the outcome of the discussions?

Answer: If the Division of Taxation identifies someone who might be a Medicaid provider and has a tax debt, Taxation notifies Medicaid and if they are an active Medicaid provider, Taxation sends Medicaid a lien notice that Medicaid will place against the provider. Consequently, before any payments are made to the provider, monies would be withheld and sent to Taxation or the lien holder.

Discussion Points (Cont'd)

DIVISION OF AGING SERVICES

27. The Division of Aging Services was created to implement the Governor's recommendation to transfer services for senior citizens from the former Department of Health and Senior Services to the Department of Human Services (DHS). The new division is intended to serve as a single point of access for seniors who are seeking State services. As part of the DHS, the division is intended to better link supports and services than it was able to do when it was part of the Department of Health and Senior Services.

- **Question:** How has the transfer of programs for seniors to the DHS affected access, coordination, and delivery of services?

Answer: The reorganization has allowed for a smoother transition path for long term services and supports to managed care under the Medicaid comprehensive waiver. Having both the Division of Medical Assistance and Health Services (DMAHS), which manages the State's Medicaid program and the Division of Aging Services (DoAS) in one Department has made sharing of information, resources and staff easier. For example, it has been much less problematic to coordinate the change from a system of using local community care management agencies to care management through managed care organizations under MLTSS.

Another example of the benefit of the reorganization can be seen with the Balancing Incentive Program (BIP). Working together under one organizational structure and with support from our community partners, DHS swiftly submitted and was approved for BIP. The federal initiative offers an additional 2% in federal matching funds for New Jersey in exchange for expanding Home and Community Based Services (HCBS) and decreasing reliance on institutionalization—a Medicaid reform effort to which the Administration is committed. BIP provides new ways to serve more people with HCBS and is being led by DMAHS and DoAS but with participation from the Division of Disability Services (DDS), the Division of Developmental Disabilities (DDD) and the Division of Mental Health and Addiction Services (DMHAS).

28a. The FY 2013 Appropriations Act revised proposed language in the Governor's FY 2013 Budget concerning reimbursement rates for nursing homes, effectively eliminating the recommended \$5 "corridor" and instead requiring that a nursing facility's per diem rate at least equal the rate it received in FY 2012. This condition was extended to both class I (private) and class II (county-operated) nursing facilities under the Governor's line-item veto.

- **Questions:** What is the FY 2013 fiscal impact of the current reimbursement rate compared to the rate originally proposed in the Governor's FY 2013 Budget Recommendation? What adjustments did the revised formula require to operating and administrative prices, direct care limits, or the budget adjustment factor used to determine FY 2013 rates? Will the FY 2013 appropriation be sufficient to fund the revised formula?

Discussion Points (Cont'd)

Answers: There was a positive fiscal impact on nursing home rates as a result of the FY 2013 Appropriations Act. No facility received less than the rate that it received in FY 2012 and 136 facilities received an increase over their FY 2012 rate, as a result of additional funding added to the nursing home appropriation.

There were no adjustments to the formula for operating and administrative prices or direct care limits. The FY 2013 final appropriation contained additional funding which reduced the negative impact of the budget adjustment factor.

The FY 2013 appropriation will be sufficient to fund the revised formula this fiscal year.

28b. The Governor's FY 2014 Budget maintains the FY 2013 nursing facility rate formula (page D-194). Many nursing care providers have indicated that Medicaid pays considerably less than the costs they incur in providing care to Medicaid patients. Many have suggested that they will be forced to significantly reduce their services or cease operation if their rates do not increase.

- **Questions:** How many nursing facilities have significantly curtailed operations or closed in the past year under the current rate formula? Please provide information on the number and proportion of nursing facilities, including county-operated facilities and special care nursing facilities (SCNFs), whose Medicaid reimbursement rates are less than their costs for providing care. Among these facilities, how many rely primarily on Medicaid for their operational funding? Please disaggregate the above information according to the following classes of facilities: private; county-operated; and SCNF.

Answers: There have been two "closures" of nursing facilities during FY 2013. Neither facility had indicated that the closure was due to any financial distress. In fact, the Department of Health is working on transfer of ownership applications for both of these facilities. Therefore, it appears that these closures were not a result of the funding level of the nursing facility rate setting system.

Because Medicaid does not reimburse for all costs, but only Medicaid allowable costs, virtually no facility has ever been fully reimbursed for all its costs. Unallowable costs include items such as marketing, political activity, donations, etc.

If "primary" is defined to be facilities that receive over 50% of their revenue from Medicaid, 180 of 359 nursing facilities, or 50%, reported that Medicaid is a primary source of revenue. The 180 is comprised of 141 private nursing facilities, 13 county nursing facilities and 26 special care nursing facilities. The Department normally considers facilities to be "high Medicaid" at a 75% level. Therefore, if using the 75% threshold, there are 41 of 359 nursing facilities, or 11%, at that level. The 41 is comprised of 21 private nursing facilities, six county nursing facilities and 14 special care nursing facilities.

Discussion Points (Cont'd)

28c. Evaluation data on page D-188 indicates an anticipated reduction in the gross annual cost for Nursing Home Services, from approximately \$1.753 billion in FY 2013 to \$1.751 billion estimated for FY 2014. This assumes a reduction in the number of patient days, while maintaining a consistent average per diem rate. However, the State appropriation is increased from \$671 million to \$678 million (page D-192).

- **Questions:** What accounts for the increased General Fund appropriation for nursing facilities in FY 2014? Are other sources of revenue expected to decrease?

Answers: Overall, State Nursing Home resources remain flat. The increase displayed in the Nursing Home appropriation is offset by a corresponding decrease in nursing home resources that are part of the Global Budget for Long Term Care appropriation as footnoted on page D-193, footnote b.

29. The Governor's FY 2014 Budget displays a \$17.5 million Prior Year Federal Claims Adjustment as a supplemental appropriation in FY 2013 (page D-192). No information has been provided about this supplemental appropriation.

- **Questions:** What error in prior year federal claims is the supplemental appropriation required to correct? What prior years are affected?

Answer: The Department over claimed non-Medicaid costs to the federal government in FY 2010. The Supplemental represents the repayment of the over claimed amount.

30. The Comprehensive Medicaid Waiver provides for the implementation of Managed Long-Term Services and Supports (MLTSS), which would transition community-based long-term care and nursing home care from fee-for-service to managed care, and would grant managed care organizations (MCOs) the ability to transition clients between different settings based on the client's needs and the relative cost of the different settings. Available information is that implementation of MLTSS for individuals in the community will begin in January 2014, and MLTSS for individuals in nursing facilities will begin July 2014 (i.e. in FY 2015). Recommended budget language (page D-196) provides that, in the case that nursing facility reimbursement is shifted to managed care during FY 2014, MCOs will be required to "hold harmless" the facilities' fee-for-service reimbursement rates at no lower than their FY 2013 rates through the end of the fiscal year.

- **Questions:** Does the budget anticipate any changes in spending related to the partial implementation of MLTSS expected in FY 2014? How will the transition of individuals in the community to MLTSS affect service delivery during FY 2014?

Discussion Points (Cont'd)

Answers: No changes were reflected in the budget presentation for this population

The population currently receiving home and community based services and supports (HCBS) already receive their primary and acute services through a Medicaid Managed Care Organization. Beginning January 1, 2014, these individuals will also receive their behavioral health and long term services and supports through the same MCO allowing for increased coordination of care.

31. The Comprehensive Medicaid Waiver provides for a simplified system for determining eligibility for long-term care services. Among the changes, the waiver implements a projected spend-down income calculation for potential beneficiaries and eliminates penalties for transferring assets prior to Medicaid enrollment for individuals who become eligible for long-term care services and whose income is at or below 100 percent of the FPL.

- **Questions:** What effect does the department expect the eligibility changes to have on long-term care services? What are anticipated changes to the number of clients served and gross annual costs due to the new rules? Will significant administrative savings be achieved?

Answers: The Department would like to clarify that the waiver does not eliminate penalties for transferring assets prior to Medicaid enrollment for individuals who become eligible for long-term care services and whose income is at or below 100 percent of the FPL. It allows for these individuals to provide self-attestation on this issue but does not eliminate penalties for those who falsely make the attestation.

We do not expect the eligibility changes to have an effect on the number of clients served or the gross annual costs. We do anticipate that the changes will speed up the eligibility determination process for those individuals with income below 100% FPL.

Any resulting administrative savings in this first year of implementation will not be significant for the SFY 2014 budget.

32. A recent investigative report by the Office of the State Comptroller (OSC) described a pattern of improper Medicaid billings by five Adult Medical Day Care (AMDC) providers. (See: http://www.nj.gov/comptroller/news/docs/report_mfd_investigative_adc_03_06_13.pdf)

Most notably, the report found that the investigated facilities billed Medicaid for a range of services that they could not substantiate, and that some of the patients at the facilities did not appear to be medically or clinically eligible to receive AMDC care. The report included a series of recommendations, primarily suggesting that the Medicaid managed care organizations (MCOs) work more aggressively to fulfill their oversight role in the provision of care. The OSC did not publish a formal response from the DHS.

Discussion Points (Cont'd)

- **Question:** How will DHS encourage MCOs to improve their oversight of AMDC and other health care providers?

Answer: It is important to note that the OSC report covered a period of billing practices by adult medical day care (AMDC) providers that occurred when this service was still in a Fee for Service model. AMDC was not carved into the managed care benefits until July 2011, which was after the period reviewed by OSC.

DMAHS and the Medicaid Fraud Division (MFD) shared the recommendations from this report with the four contracted managed care organizations. That meeting resulted in the following strategies to address these challenges:

- 1) Verifications: The MCOs will make unannounced site visits to determine if recipients are receiving the services being billed.
- 2) Clinical Eligibility: MFD recommended that the MCOs consider holding AMDC medical director responsibilities to a higher contractual standard than licensing regulations require. MFD has made these recommendations to the Department of Health.
- 3) Verifications and Clinical Eligibility: Two of the MCOs reported that they assess members for clinical eligibility in their homes and *not* at the AMDC. All of the MCOs offer language lines or staff members who speak the client's language to conduct assessments in a language other than English, when needed. MFD recommended having an interpreter present (not on the phone).
- 4) Over Capacity: The MCOs recommended that the Department of Health share its AMDC census reports with them so they can avoid sending members to ADMCs over census.

33. The Governor's FY 2014 Budget anticipates \$48 million in PAAD and Senior Gold manufacturer rebate revenues, the same as FY 2013. Rebate revenues totaled approximately \$43 million in FY 2011 and \$83 million in FY 2012.

- **Questions:** How much of the FY 2012 increase was a result of retroactive collections? What is the total sum of rebates currently owed to the State but not yet paid by drug manufacturers? To what extent do the FY 2013 or FY 2014 estimates depend upon drawing down rebates incurred in prior periods but not yet collected?

Answer: Approximately \$35 million of the FY12 increase was the result of one time resources earned in FY11 but collected in FY12, and approximately \$47 million were invoiced to manufacturer's and are in process for collection. The FY13 and FY14 estimates do not depend upon drawing down rebates earned in prior periods.

34. Evaluation data on page D-190 of the Governor's Budget indicates that the number of persons served by Adult Protective Services is expected to increase from 3,899 in FY 2012, to 4,700 in FY 2013 and 5,821 in FY 2014. An additional \$1 million is recommended for

Discussion Points (Cont'd)

this purpose in FY 2014 (located in the Community Based Senior Programs line item on page D-192).

The county Adult Protective Services offices investigate reports of abuse, neglect, and exploitation of vulnerable adults living in the community.

- **Questions:** What explains the rapid growth in the number of persons served by adult protective services? How will the additional \$1 million be used?

Answers: The increase in caseload has been growing over the past several years due to changing demographics but the most recent projected increases stem from new mandatory reporting requirements and a post-Sandy abuse and neglect surge. The increased funding is proposed to do the following:

- Assist with reduction of overly - intensive caseloads
- Preserve county, municipal and other public and private resources. Once an individual becomes an APS client, fewer calls to police occur, reduced emergency room visits, and less economic exploitation (that commonly results in need for public benefits) will exist.
- Increase the opportunity to provide bridge money for emergent food, utilities and medicine for the most needy clients.
- Enable APS to comply with the 2010 Mandatory Reporting Statute.
- Supplement APS's ability to seek mandated legal protective proceedings for individuals who are being financially exploited and physically abused.

35. Evaluation data on page D-190 of the Governor's Budget shows a drastic decrease in the number of clients provided health insurance counseling services, from approximately 2 million in FY 2013 to 250,000 in FY 2014.

- **Question:** Please explain the anticipated decrease in health insurance counseling services.

Answer: There was no actual decrease in services. DoAS implemented a new client tracking system that enabled the Health Insurance Counseling Program to come into compliance with the federal reporting requirement that mandates states to submit the number of unduplicated clients as opposed to total number of contacts. This resulted in the decrease in the units counted from 1,958,000 in the Revised FY13 to 250,000 for the estimated FY 14 budget.

Discussion Points (Cont'd)**DIVISION OF DISABILITY SERVICES**

36. The FY 2013 Appropriations Act included a new language provision, which is continued in the FY 2014 Budget Recommendation (page D-201), requiring that the reimbursement rates for AIDS Community Care Alternatives Program (ACCAP) and Community Resources for People with Disabilities (CRPD) Private Duty Nursing (PDN) services be increased by \$10 per hour above the FY 2008 rate, and requiring that the rate be equal to the rate for Early and Periodic Screening, Diagnostic, and Treatment PDN services of similar magnitude.

- **Questions:** How many providers were affected by this change? What has been the total increase in costs as a result of this change?

Answer: A total of 116 private duty nursing (PDN) providers were affected by the change in reimbursement rates. For the period of July 1, 2012 through December 31, 2012, a total of 306,312 units of PDN were provided, resulting in a total increase in cost for that time period of \$3.1M.

37. Medicaid personal care assistance (PCA) services provide assistance with aspects of daily living for Medicaid beneficiaries with a short-term or long-term disability. The services include assistance with: various activities of daily living (e.g., grooming, bathing, dressing, walking, eating); household duties essential to the beneficiary's health and comfort (e.g., cleaning, shopping, preparing meals); and certain health activities (e.g., assistance with exercise or physical therapy procedures, self-administered medications, use of a wheelchair or other equipment).

PCA services were shifted from fee-for-service reimbursement to managed care, effective July 2011. In the current fiscal year, Horizon NJ Health has reduced hourly reimbursement rates for PCA services by 4.5 percent, from \$15.50 (previously set by the State for fee-for-service reimbursement) to \$14.80 per hour. Available information indicates that UnitedHealthcare has proposed an 11 percent reduction in PCA reimbursement rates, from \$15.50 to \$13.80 per hour. The State's Medicaid managed care contract requires each contracting managed care organization to ensure that its provider network includes sufficient number of providers of health care to cover all services in the amount, duration, and scope included in the benefits package.

- **Questions:** To date, what effect has the rate reduction had on Horizon's network of PCA providers? In addition to Horizon and UnitedHealthcare, have the State's other Medicaid MCOs indicated plans to reduce PCA reimbursement rates in FY 2013 or in FY 2014? How many personal care assistance service providers were in the provider networks for each of the State's four Medicaid managed care organizations as of December 2012? How many Medicaid enrollees received personal care assistance services, disaggregated by each managed care organization, in December 2012?

Discussion Points (Cont'd)

Answer: The rate of reimbursement between managed care organizations and providers is generally proprietary and negotiated between those two entities. All four of the Medicaid/NJ FamilyCare participating HMOs meet the network adequacy standards for personal care attendant (PCA) and home health services as required by the State and MCO contract. As of December 2012, the total number of participating PCA/home health care providers was over 300 and the number of unduplicated recipients was over 26,000.

38a. In response to a FY 2013 OLS Discussion Point, DHS reported that the total number of personal care assistance (PCA) recipients for December 2011 was approximately 29,000, of which 25,000 were managed care and 4,000 were fee-for-service (FFS). Total units of service were 1.9 million, of which 1.854 million were managed care and 46,000 were FFS. The total cost was \$35.2 million, of which \$34.5 million was managed care and \$700,000 was FFS. DHS indicated 256 providers under both managed care and FFS.

- **Questions:** Please provide updated figures for December 2012 for PCA services delivered under managed care and FFS. How many persons received PCA services in each? What were total expenditures for PCA services in each? How many units of service were provided? How many providers of PCA services are currently in the managed care network compared to FFS?

Answer: Because DHS did not break out the number of providers or services by HMO in question 37, the response to 37 applies to this question, as well.

38b. It is noted that, based on the above data, managed care PCA expenditures in December 2011 were about \$18.61 per unit of service, while FFS expenditures were about \$15.22.

- **Question:** What accounts for the higher per-unit cost for PCA services under managed care compared to FFS?

Answer: The amounts computed above are not true per unit costs because the total cost amounts include other components, e.g. assessment costs are included in the managed care amount but not in fee for service.

39. The Affordable Care Act established a new Medicaid State Plan option, the Community First Choice (CFC) Option, to provide home and community-based attendant services and supports. This option allows states to receive a six percentage point increase in federal matching payments for Medicaid expenditures related to this option. (In New Jersey, this would equate to a 56 percent matching rate). Some specific activities currently provided under Personal Care might qualify for this higher matching rate if provided. The Centers for Medicare and Medicaid Services issued the final regulations governing the CFC Option in April 2012 and the demonstration was scheduled to begin on June 1, 2012.

A FY 2012 OLS Discussion Point noted that some specific activities currently provided under Personal Care at 50 percent federal reimbursement could qualify for the 56

Discussion Points (Cont'd)

percent matching rate if those activities were provided separately, and not as part of Personal Care. In response, DHS indicated that it was re-examining the State's definition of PCA services and researching the potential consequences to the existing PCA service package.

- ***Questions:* Has the State pursued any plans to implement the CFC Option? If so, what impacts on State and federal funding for PCA services are anticipated in FY 2014?**

Answer: Opting into the CFC would require that we provide an enhanced service package under the Home and Community Based Waiver over and above the current Medicaid benefit package. Any enhanced federal matching opportunity in PCA would be more than offset by the additional benefit package allowed under the CFC.

Discussion Points (Cont'd)**DIVISION OF DEVELOPMENTAL DISABILITIES**

40. In his budget address on February 26, 2013, the Governor announced the settlement of two lawsuits filed in 2005 and 2008 by Disability Rights New Jersey (DRNJ). The lawsuits contended that the State had failed to comply with the U.S. Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999), which required that residents with disabilities live in the least restrictive appropriate environment. The 2005 lawsuit by DRNJ sought the discharge from the developmental centers of individuals who do not oppose community placement and for whom community placements are determined to be appropriate. The 2008 lawsuit sought to reduce the length of time individuals were on the Division of Developmental Disabilities (DDD) waiting list for services.

According to information from DRNJ, the settlement agreement requires that about 600 persons currently residing at developmental centers be discharged to the community by the end of FY 2017, and that new developmental center admissions be made only if necessary for individuals' health, safety, and welfare, and only after all appropriate alternatives have been exhausted. The settlement agreement also includes funding for a consultant to assist DDD with implementing the settlement agreement and funding for DRNJ to monitor the implementation of the agreement and to represent individuals seeking discharge from, or alternatives to, residence in a developmental center.

- **Questions:** What will be the settlement's most significant operational and fiscal impacts on DDD in FY 2014? How many residents of developmental centers will be discharged in the remainder of FY 2013 pursuant to this decision? In FY 2014? What savings (annualized) may be realized from the settlement, such as from reduced legal expenses? How much annualized funding will the new consultant and DRNJ receive, respectively, for their assistance and monitoring roles?

Answer: The *Olmstead* Settlement Agreement formalizes ongoing reform efforts, including new transitional case managers and medical-behavioral support teams, to ensure the successful transition of individuals who decide to live in the community. Through FY 2017, the Division anticipates placing 600 individuals to meet the settlement targets. Legal expenses for outside counsel over the past three years have averaged \$225,000 annually. Under the terms of the settlement, annual consultant fees are limited to \$25,000, plus reasonable expenses. DRNJ will receive \$88,000 annually to cover anticipated monitoring costs

41. Approximately \$34.7 million (gross) in Direct State Services and Grants-in-Aid funding was transferred into the Department of Children and Families (DCF) from DDD as a result of the FY 2013 reorganization into DCF of services for children with developmental disabilities. The General Provisions in the FY 2013 Appropriations Act include language allowing further transfers that may be necessary to operationalize the planned restructuring.

Discussion Points (Cont'd)

The Governor's FY 2013 Budget anticipated that 6,349 children with developmental disabilities would be affected by the reorganization, and that 11 staff from DDD would be transferred into DCF.

- **Questions:** What additional funds and staff have been transferred to DCF during FY 2013, and how many children were affected? Please disaggregate, by program/service: any additional funding amounts that have been transferred to DCF in FY 2013; and specific DDD accounts that have been affected. What additional movements of children, funds, or staff are anticipated for FY 2014?

Answer: The \$34.7 million reallocated to DCF funds the annual cost of residential and family support services for approximately 6,700 children. In total, approximately 15,000 children transferred to DCF, the vast majority of which live at home and receive services funded by their local education authority, rather than DDD. No additional funds have been transferred to DCF during FY13. In FY14, an additional \$163,000 will be transferred to annualize the costs of the 11 staff transferred during FY13.

42. Pursuant to P.L. 2011, c. 143, the Task Force on the Closure of State Developmental Centers issued a binding recommendation in August 2012 instructing DHS to develop and implement a plan to close North Jersey Developmental Center followed by Woodbridge Developmental Center within the next five years in accordance with a schedule that takes into account the needs of the residents of the developmental centers to be closed and the operational concerns of the developmental centers and the community services system.

- **Questions:** What is the current status of, and anticipated timeframe for, plans to close Woodbridge and North Jersey Developmental Centers? How many patients will be relocated from these developmental centers during FY 2014 and in subsequent fiscal years? How many patients will be transferred to other developmental centers? Nursing homes? Community programs? How many patients will be placed in new residential programs to be developed? In existing residential facilities?

Answer: The Division does not anticipate closing a developmental center in FY 2014. Staff continue to work with individuals, their guardians and families to identify preferred living arrangements. The Division anticipates transitioning approximately 140 individuals to the community in FY 2014.

43. The FY 2013 Appropriations Act assumed net savings of approximately \$10.2 million relative to FY 2012 due to lower census at the developmental centers. (In response to a FY 2013 OLS Discussion Point, DHS indicated that this amount was net of \$7.4 million in anticipated costs associated with shifting Vineland Developmental Center employees to staffing group homes operated by the Parents and Friends Association.)

- **Questions:** Are the \$10.2 million in net savings likely to be realized, based on FY 2013 expenditures to date? If not, what accounts for any shortfall in

Discussion Points (Cont'd)

savings? What effect, if any, did the recommendation of the Task Force on the Closure of State Developmental Centers have on anticipated FY 2013 savings?

Answer: The Division anticipates meeting this savings target through attrition and reduced overtime expenditures.

44. The Governor's FY 2014 Budget assumes an increase in federal ICF-MR revenues of \$14 million above the FY 2013 estimate, to \$337 million in FY 2014. The Governor's FY 2014 Budget also assumes State savings of \$1.3 million due to lower census at the developmental centers.

ICF-MR revenues are federal Medicaid matching funds that support the operation of the State's seven developmental centers. Thus, a reduced developmental center census would generally correspond to a reduction in State expenditures and corresponding federal ICF-MR revenues.

- **Questions:** What accounts for the discrepancy between increasing ICF-MR revenues and a decreasing developmental center census? Are estimated FY 2014 federal ICF-MR revenues overstated?

Answer: ICF-MR revenues are determined by the cost of operating developmental centers, which has not declined in proportion to census. Absent a layoff, staff reductions have been achieved slowly through retirement and attrition. In particular, recent fringe rate increases have contributed to increased ICF-MR reimbursement rates.

45a. During calendar years 2009 – 2012, nearly 380 clients from developmental centers were placed in community programs as follows: 80 in 2009; 60 in 2010; 105 in 2011; and 129 in 2012.

In response to a FY 2013 OLS Discussion Point, DHS reported that, of the consumers transitioned to the community in CYs 2009 - 2011, 93.5 percent remain in the community, 2.5 percent are in developmental centers, 1.5 percent are in skilled nursing facilities, 1.5 percent are deceased, and 1 percent are in correctional facilities.

- **Questions:** Please provide an update to the data cited above, including CY 2012 information. How many of the clients transitioned to the community in CYs 2009 - 2012 are still in a community placement? How many clients are now in a nursing home or other type of institutional setting? How many are now deceased?

Answer: For placements from FY09 through January of FY13, 92.4% remain the community, 3.4% are in developmental centers or psychiatric hospitals, 1% are in skilled nursing facilities, 2.9% are deceased, and .3% are in correctional facilities.

Discussion Points (Cont'd)

45b. DHS-approved agencies that establish new community residences for the developmentally disabled throughout the State may weigh a number of factors when locating sites for new residences. For example, residences often need to be situated in areas that: have appropriate access to support services; are not safety hazards in terms of traffic and other safety concerns; are able to accommodate persons using wheelchairs; and have access to public transportation. New residences may also take into account the potential number of clients and families to be served.

- **Questions:** How and when does DHS work with agencies that have been approved for establishing new community residences for the developmentally disabled to identify where there is a need for such a residence in the State? What information does DHS collect and share with those approved agencies so that they serve persons who need to be transitioned to the community? What is the process for identifying which individuals will reside in which location?

Answer: New community residential development is determined by the preference of the individual, or group of individuals, that will be living in the home. The Division provides agencies with the level of care required, as well as information about geographic preference and other factors. Agencies then submit proposals, which are reviewed by the Division, the individual and, where applicable, the individual's Guardian.

46. According to the approved Comprehensive Medicaid Waiver, the State's new Supports Program is to provide a basic level of support services to Medicaid-eligible individuals with developmental disabilities who live with family members or who live in their own homes that are not licensed by the State and who are not currently receiving Community Care Waiver services.

The Community Care Waiver (CCW) provides services to individuals with developmental disabilities who require such services to live in the community. CCW services are funded through a combination of State dollars and federal Medicaid matching funds and include: case management, individual supports, day habilitation, respite care, supported employment services, transition services, assistive technology, environmental and vehicle adaptations, and transportation.

According to the Comprehensive Waiver approval documents, individuals served under the Supports Program will receive a smaller package of program services than those served under the CCW primarily because Supports Program participants have greater access to other, nonpaid supports. The documents also indicate that new Supports Program participants will be enrolled based on eligibility and availability of annual State budget allocations.

- **Questions:** How many individuals are anticipated to receive Supports Program services in FY 2014, at what State cost? Will there be any waiting list for Supports Program services at the FY 2014 Budget's recommended funding level? Of individuals to receive Supports Program services in FY 2014, how many are on the CCW waiting list? How many individuals are anticipated to

Discussion Points (Cont'd)

receive CCW services in FY 2014, and what is the current size of the CCW waiting list?

Answer: Supports Program enrollment will begin in FY 2014. Although the enrollment process will take time, there will not be a waiting list for services, and the Division anticipates serving all the adults currently on the Community Services Waiting List. Prior to the approval of this program through the Comprehensive Medicaid Waiver, family support services have been made available through 100% State funding, with a relatively modest dollar amount available to each individual (in addition to day services). The reinvestment of federal matching funds allows the Division to extend and enhance both the type and amount of services offered to individuals and their families.

47. According to the Governor's FY 2014 Budget the amount of federal CCW revenues realized in FY 2012 was \$279 million (page C-21). This amount is \$82 million less than the \$361 million that had been previously estimated in the Governor's FY 2013 Budget.

- **Question:** **What accounts for the decrease in FY 2012 CCW revenues?**

Answer: The FY12 CCW revenue projection has not decreased. The FY14 Budget reflects the amount collected to date, but due to routine rate adjustments, claiming has not yet been completed for this time period.

48. Effective January 22, 2013, DDD began requiring Medicaid eligibility as a condition of receiving DDD-funded services. As a result of this change, individuals who are new to DDD will be required to be deemed functionally eligible for DDD services and obtain Medicaid eligibility before they can begin receiving any services from the Division. Individuals already receiving DDD-funded services who are not already Medicaid eligible will have to become Medicaid eligible before receiving any new services and will have 60 days (until March 23, 2013) to become Medicaid eligible in order to ensure continuation of current services.

- **Questions:** **What amount of State savings does the Governor's FY 2014 Budget anticipate from increased federal Medicaid revenues due to this new policy? How many individuals receiving DDD services were not eligible for Medicaid as of January 2013? How many of those individuals did not obtain Medicaid eligibility by March 23, and what will be the service impact on those individuals? What are the most common reasons why these individuals might be ineligible for Medicaid?**

Answer: The FY14 Budget does not include a savings related to this regulatory change. To date, the Division has contacted approximately 4,500 individuals whose Medicaid eligibility requires further analysis. Many of these individuals have never attempted to apply for Medicaid, but will have no problem meeting eligibility requirements when they do. Staff are working through this list on a case-by-case basis to ensure that there is no interruption of necessary services while Medicaid

Discussion Points (Cont'd)

eligibility is determined. An individual may be found ineligible if residency requirements are not met, if assets and income are above the Medicaid threshold, or if the individual or his/her guardian refuses to complete the application paperwork. There will be no impact on services while an individual is working through the application process. Staff at DDD and Medicaid are working with individuals to solve income and asset issues as they arise. If an individual has assets that clearly exceed the Medicaid limits, s/he will be expected to pay privately for services until the Medicaid limit can be met, at which time DDD can begin to fund the services.

Discussion Points (Cont'd)**COMMISSION FOR THE BLIND AND VISUALLY IMPAIRED**

49. As of March 2013, \$291,000 from the Technology for the Visually Impaired account were being held in reserve. These funds provide specialized equipment and training to help blind or visually impaired individuals live safely and independently in their communities. An additional \$165,000 from the Education Services for Children account were also being held in reserve. These funds provide services designed to ensure that students who are blind or visually impaired may participate equally with other students in regular classroom activities or the appropriate, least restrictive educational placement.

- ***Questions:*** **Has the reduced budget authority in these accounts affected services? How many clients were affected? What portion of the reserved funds will lapse to the General Fund?**

Answer: The programs and amounts identified are not scored for lapse. Any unspent balances that may accrue before the end of the fiscal year in the Technology for the Visually Impaired account are the result of moving to a new RFP where two new Assistive Technology providers were chosen. In addition, any unspent resources from the Education Services account are due to the change in contract payment methodology from cost reimbursement to fee for service. In both programs, any unspent resources will not result in an adverse impact on client services.

Discussion Points (Cont'd)**DIVISION OF FAMILY DEVELOPMENT**

50. The Division of Family Development (DFD) is developing and implementing a new social service information system known as the Consolidated Assistance Support System (CASS), which will replace a system that has been in operation since the mid-1980s. CASS is intended to provide a comprehensive system for managing client information and determining eligibility for a number of programs in DFD and other DHS divisions, including: General Assistance, Temporary Assistance for Needy Families, Supplemental Nutrition Assistance Program (SNAP), child care assistance, Medicaid and NJ FamilyCare.

In FY 2013, DHS reported that the estimated date for CASS implementation was October 2013 with a total Hewlett Packard (HP) contract cost of \$107.5 million.

In May and September 2012, HP announced that it would lay off approximately 30,000 personnel, with substantial reductions occurring among staff associated with Electronic Data Systems (EDS), which was acquired by HP in 2008 and which had been originally awarded the CASS contract.

- **Questions:** What is the current status of CASS with respect to its implementation date and its total cost? Have the HP layoffs had an effect on key personnel developing CASS and progress toward project completion?

Answer: The current status of CASS is as follows:

- Phases 1 through 5.5 have been completed.
- Phase 6 (Testing and Conversion) is expected to be completed by August 30, 2013.
- The implementation of CASS is scheduled for October 2013.
- The total contract cost for CASS is currently \$107.5 million.

With respect to the HP layoffs, we have been assured by HP that the corporate action will not have any effect on the CASS project.

51. According to an Office of the State Comptroller report, 8,000 eligible children were on the waiting list for WorkFirst New Jersey (WFNJ) Child Care services as of October 2011 (see: http://www.nj.gov/comptroller/news/docs/dhs_childcare_assistance_audit_report.pdf). DHS indicated that about 7,000 children were on the waiting list as of June 15, 2012. Information reported by the National Women's Law Center indicated that the waiting list had decreased to about 3,600 children in August 2012.

The FY 2013 Appropriations Act included an additional \$2 million above the recommended level in the Governor's FY 2013 Budget for WFNJ Child Care services for the purpose of waiting list reduction.

Discussion Points (Cont'd)

- **Questions:** Approximately how many additional children received child care due to the \$2 million in waiting list reduction funds? How many children are currently on the waiting list for WFNJ Child Care services?

Answer: The Division has been successful in reducing the waiting list from over 8,000 cited above in the OSC report to approximately 100 children today who are pending placements. These 100 children are projected to be placed within the next two months. The \$2 million in waiting list reduction funding was sufficient to cover the costs for approximately 475 children.

52. The FY 2013 Appropriations Act included a language provision prohibiting the General Assistance (GA) and GA Emergency Assistance programs from providing benefits to recipients who are enrolled in college, which is defined pursuant to N.J.A.C.9A:1-1.2 and includes both four-year colleges and community colleges.

In response to a FY 2013 OLS Discussion Point, DHS indicated that these language provisions were anticipated to generate approximately \$6.9 million in cost avoidance and involve the elimination of GA eligibility for an estimated 1,900 college students as of June 2012.

- **Questions:** By how much has the average monthly GA caseload changed due to this provision? Is the \$6.9 million in projected savings for FY 2013 still valid?

Answer: There have been several different policy changes and/or initiatives implemented within the GA program since July 2011 (GA/college students, 30-day eligibility, directed GA compliance teams, etc.) therefore, it is difficult to determine the effect of any one provision. An analysis of the GA program indicates that the average annual GA/GA-EA caseload decreased 25.9% from SFY 2011 (64,215) through SFY 2013 (47,581). This reduction resulted in a corresponding 22.3% decline in actual and anticipated GA/GA-EA expenditures from \$182.6 to \$142.0 million or an estimated \$40.6 million.

53. General Assistance (GA) caseloads have decreased significantly since June 2011 as indicated in the table below:

General Assistance Caseloads: June 2011-December 2012

	June 2011	Dec. 2011	Dec. 2012	Change (June 2011- Dec. 2012)	% Change (June 2011- Dec. 2012)
TOTAL	56,450	45,600	40,000	(16,450)	(29%)
Employable	39,930	31,870	27,170	(12,760)	(32%)
Unemployable	16,510	13,740	12,860	(3,650)	(22%)

Source: *DFD Current Program Statistics*

(<http://www.state.nj.us/humanservices/dfd/news/cps.html>)

Discussion Points (Cont'd)

In response to a FY 2013 Discussion Point, DFD reported that it had implemented the following policy changes to the General Assistance program beginning in FY 2012:

- Eliminate Emergency Assistance (EA) exceeding 18 and 36 months for all Employable and Unemployable clients respectively.
- Delay reclassification of employable clients transitioning to unemployable clients for six months.
- Eliminate Supplemental Living Support payments.
- Implement a 30-day eligibility/employment search for new applicants (the “30 day protocol”).
- Implement an additional GA Assessment team (also known as a “Compliance Team”).

DFD also indicated that the 30-day protocol appears to be a significant reason that the GA caseload had decreased between June 2011 and December 2011.

- ***Questions:*** Do the same policy changes described above account for the continued reduction in the GA caseload since December 2011, or have any additional policy changes since the previous update contributed to the continuing decrease? During the current fiscal year to date, what has been the monthly average number of new applicants for the GA program? What percentage of those applicants have not qualified for GA benefits due to the 30-day protocol?

Answer: Internal analysis appears to indicate that the continued decrease in the GA caseload is due to a combination of the changes described above. There have been no additional changes implemented to the GA program since FY12. The number of average monthly applicants has approximated 6,400 during the July 2012 through March 2013 timeframe. During the same time period, there were approximately 5,400 applicants denied GA benefits for failing the 30-day protocol.

54. The FY 2013 Appropriations Act assumed total State savings of \$40.3 million relative to FY 2012 due to caseload trends involving the Payments for Cost of General Assistance and the General Assistance Emergency Assistance Program accounts.

- ***Question:*** Is the \$40.3 million in projected FY 2013 savings still valid? If not, what accounts for any shortfall in savings, or additional savings?

Answer: The \$40.3M is still a valid estimate at this time based on cost and caseload trends where the appropriation was over funded. This amount does not represent programmatic targeted savings initiatives.

55. The Governor’s FY 2014 Budget assumes \$12.5 million and \$7.0 million in State savings, respectively, due to State Aid trends in the Temporary Assistance for Needy

Discussion Points (Cont'd)

Families (TANF) and GA programs. Available information indicates that up to \$4 million of these anticipated savings may be associated with the activities of the Compliance Teams, which are assigned to selected county welfare agencies to review and monitor TANF and GA cases. Compliance Teams recommend cases for closure or denial when client information does not support eligibility for TANF or GA benefits.

According to performance data (page D-168) in the Governor's FY 2014 Budget, the Compliance Teams reviewed 10,920 General Assistance cases in FY 2012. Of those, 594 cases were closed or denied based on review, for a total savings of \$889,262 (combining cash assistance and emergency assistance savings).

In response to an FY 2013 OLS Discussion Point, DHS indicated that each Compliance Team generally comprised five State employees with estimated annual salary and administrative expenses totaling up to \$400,000 (if one-time purchases of vehicles for field staff were included). Available information indicates that: two Compliance Teams were operating in FY 2012; a third Compliance Team was added in FY 2013; and these three Compliance Teams were anticipated to continue operating for FY 2014.

- **Questions:** What have been the most common reasons for case closure or denial identified by the Compliance Teams? What were the two Compliance Teams' total State operating costs for FY 2012? Do the FY 2012 savings reported in the Governor's FY 2014 Budget represent State savings, and are the savings net of the Compliance Teams' operating costs? What are the Compliance Teams' current number of case reviews, closures, and denials in FY 2013 to date, with what total State savings? (Please disaggregate FY 2013 reviews, closures, denials, and savings according to the following categories: GA; GA Emergency Assistance; TANF; TANF Emergency Assistance) What specific State savings from the Compliance Teams' activities are assumed in the Governor's FY 2014 Budget Recommendation?

Answer: The most common reasons for closings and denials include failing the 30-day GA protocol, insufficient information (personal, economic, etc.), college student ineligibility or because they have a record for drug distribution.

The total cost for the compliance teams during SFY 2012 was \$500,849. During the period of July through December 2012, the compliance teams reviewed approximately 13,600 cases of which over 700 were closed or denied. This amount does not include any denials based on the 30-day GA protocol. DFD estimates savings of \$1.1 million on GA cash benefits and \$1.5 million in savings on GA Emergency Assistance services.

In the Governor's FY2014 budget there is an additional \$4.8 million savings projected for SSI and TANF Compliance teams. All other compliance team savings are now part of our trend and included in our current caseload projections.

Discussion Points (Cont'd)

56. The Governor's FY 2014 Budget recommends an appropriation of \$81.8 million for Payments for Supplemental Security Income, a decrease of 4.4 percent from the FY 2013 adjusted appropriation of \$85.5 million (page D-217). The FY 2014 Budget also assumes net State savings of \$2.4 million due to "Supplemental Security Income (SSI) Trend."

However, the FY 2014 Budget indicates that the number of SSI average monthly recipients is expected to increase by 4.3 percent, from 186,920 (FY 2013 revised) to 194,977 (FY 2014 estimated) (page D-214). Associated SSI expenditures are also expected to increase.

- ***Question:*** What accounts for the recommended decrease in appropriation and anticipated savings in the context of increasing numbers of SSI recipients?

Answer: The \$85.5M is the FY13 Adjusted Appropriation figure, which does not take into account the projected surplus in FY13. The evaluation data on page D-214 projects expenditures of \$79.2M in FY13 and \$82M in FY14, which is commensurate with the increase in clients noted.

Discussion Points (Cont'd)**DIVISION OF THE DEAF AND HARD OF HEARING**

57. As of March 2013, \$102,000 from the Services to Deaf Clients account and \$20,000 from the Communication Access Services account were being held in reserve. In response to a FY 2013 OLS Discussion Point regarding Services to Deaf Clients, the department described a series of new initiatives that would require the full \$284,000 appropriation for Services to Deaf Clients. The described initiatives involved mentoring/licensure for sign language service providers, the equipment distribution program, community-based education programs, and a State-wide resource center for the deaf and hard of hearing.

- **Questions:** Has the reduced budget authority in these accounts affected implementation of any of the planned initiatives or other services? What portion of the reserved funds will lapse to the General Fund?

Answer: Currently there are no scored lapses in the budget for these accounts. Implementation of planned FY13 initiatives has not been affected as resources are made available as needed. The Division is planning to utilize the balance of the available funds. Funding will be used to administer the Division's equipment distribution program, community education programs, resource center and hearing aid program.