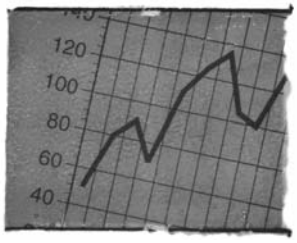


ANALYSIS OF THE NEW JERSEY BUDGET

# DEPARTMENT OF HUMAN SERVICES

FISCAL YEAR 2014 - 2015

PREPARED BY OFFICE OF LEGISLATIVE SERVICES
NEW JERSEY LEGISLATURE • APRIL 2014

# NEW JERSEY STATE LEGISLATURE

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This report was prepared by the Human Services Section of the Office of Legislative Services under the direction of the Legislative Budget and Finance Officer. The co-authors were David H. Drescher and Nathan E. Myers.

Questions and comments may be directed to the OLS Human Services Section (Tel. 609-847-3860) or the Legislative Budget and Finance Office (Tel. 609-847-3105).

# DEPARTMENT OF HUMAN SERVICES

Budget Pages..... B-8 to B-10, B-12 to B-15; C-5, C-13, C-21, C-24, C-26, C-27; D-157 to D-215; E-1, E-3, E-4, E-7; F-1, F-3, F-4, F-8, F-10; G-3, G-4; H-3 to H-5, H-8, H-12, H-15, H-16, H-17 to H-19

**Fiscal Summary ($000)**

| | Expended FY 2013 | Adjusted Appropriation FY 2014 | Recommended FY 2015 | Percent Change 2014-15 |
|---|---|---|---|---|
| State Budgeted | $6,908,148 | $6,485,607 | $6,638,872 | 2.4% |
| Federal Funds | $5,965,412 | $7,757,386 | $9,218,459 | 18.8% |
| Other | $399,191 | $786,007 | $980,588 | 24.8% |
| Grand Total | $13,272,751 | $15,029,000 | $16,837,919 | 12.0% |

*Other includes Revolving Funds displayed on page C-27 of the recommended budget.

**Personnel Summary - Positions By Funding Source**

| | Actual FY 2013 | Revised FY 2014 | Funded FY 2015 | Percent Change 2014-15 |
|---|---|---|---|---|
| State | 9,438 | 9,248 | 8,356 | ( 9.6%) |
| Federal | 4,966 | 4,828 | 4,171 | ( 13.6%) |
| Other | 64 | 62 | 64 | 3.2% |
| Total Positions | 14,468 | 14,138 | 12,591 | ( 10.9%) |

FY 2013 (as of December) and revised FY 2014 (as of January) personnel data reflect actual payroll counts. FY 2015 data reflect the number of positions funded.

Link to Website: http://www.njleg.state.nj.us/legislativepub/finance.asp

## Highlights (Cont'd)

### BUDGET OVERVIEW AND KEY DEVELOPMENTS

The Governor's FY 2015 Budget recommends a total of $16.84 billion (gross) for the Department of Human Services (DHS) in Fiscal Year (FY) 2015, an increase of about $1.81 billion from the FY 2014 adjusted appropriation. State funds account for nearly $6.64 billion of the total FY 2015 recommendation, representing an increase of $153.3 million (or 2.4%) from FY 2014 State appropriations of $6.49 billion. Anticipated federal funds account for $9.22 billion of the FY 2015 recommendation, representing a significant increase of $1.46 billion (or 18.8%) over the FY 2014 adjusted appropriation of $7.76 billion. Anticipated Other funds account for $980.6 million, increasing by $194.6 million (24.8%) over the FY 2014 adjusted appropriation of $786.0 million.

In part, the significant increase in anticipated federal funds is related to the continuing expansion of the State's Medicaid program in accordance with the federal Affordable Care Act (ACA). Another key development, the shifting of long-term care services to managed care delivery and reimbursement, through the Managed Long Term Services and Supports initiative, will begin to have significant programmatic and fiscal impacts within DHS in FY 2015. Both of these developments are discussed in more detail below and throughout this analysis.

#### Medicaid Expansion and the Affordable Care Act

Effective January 1, 2014, the State expanded Medicaid eligibility to all non-elderly adults with household incomes up to 133 percent of the federal poverty level, pursuant to the ACA (The ACA provides for a five percent income disregard, effectively raising the threshold to 138 percent of the federal poverty level.) This ACA Medicaid expansion renders many non-elderly and non-disabled adults without dependents newly eligible for Medicaid coverage. Expenditures for these "newly eligible" Medicaid enrollees will be paid entirely by federal funds until calendar year 2017, when the federal matching rate will begin to phase down to 90 percent by 2020. In addition, certain individuals eligible for coverage under the Medicaid and NJ FamilyCare programs prior to January 1, 2014 are now deemed to be "newly eligible" for Medicaid under the ACA expansion, with expenditures for those individuals qualifying for enhanced federal reimbursement.

#### Managed Long Term Services and Supports

In FY 2015, the State will begin full implementation of the Managed Long Term Supports and Services (MLTSS) initiative within the Division of Aging Services. Under MLTSS, which is authorized pursuant to the State's Comprehensive Medicaid Waiver approved in October 2012, the State will shift Medicaid institutional long-term care services (i.e., nursing facility services) and home- and community-based services from fee-for-service reimbursement to a managed care delivery and financing system. The State will contract with Medicaid managed care organizations (MCOs) for the provision of these long-term care services, and the MCOs will become responsible for coordinating and delivering the services and supports to eligible elderly Medicaid clients and Medicaid clients with disabilities. It is noted that the shifts of long-term care services to managed care will not include nursing facility services provided to current Medicaid residents of such facilities, which will continue to be reimbursed on a fee-for-

## Highlights (Cont'd)

service basis. For more details regarding MLTSS, see the *Implementation of Managed Long Term Services and Supports* background paper included within this analysis (page 68).

### Closure of North Jersey and Woodbridge Developmental Centers

The Governor's FY 2015 Budget anticipates the closure of two State developmental centers: North Jersey Developmental Center is scheduled to close on July 1, 2014, followed by Woodbridge Developmental Center on January 1, 2015. These closures reflect the binding recommendations of the Task Force on the Closure of State Developmental Centers issued in 2012. The closures also occur in the context of a settlement agreement between the State and Disability Rights New Jersey requiring the State to discharge approximately 600 individuals residing in State developmental centers to community placements during the period from Fiscal Year 2013 to 2017.

The sections below provide more detail regarding the Governor's FY 2015 Budget Recommendations for the specific DHS divisions, as well as some additional detail regarding key programmatic and fiscal developments in FY 2015.

## HIGHLIGHTS BY DIVISION

### Division of Mental Health and Addiction Services

The Division of Mental Health and Addiction Services (DMHAS) provides a wide array of community-based mental health and substance abuse services. DMHAS also operates the State's four psychiatric hospitals and provides State Aid to support low-income patients in five county-operated psychiatric hospitals.

The Governor's FY 2015 Budget recommends a grand total of $971.2 million (gross)[1] for the division, an increase of $7.8 million from the FY 2014 adjusted appropriation. However, total State appropriations from the General Fund and Property Tax Relief Fund are recommended to decrease by $0.5 million, to $839.2 million, as follows:

**Direct State Services** funding for State psychiatric hospitals ($285.3 million) and administration of community mental health and addiction services ($17.5 million) is recommended to remain unchanged from the FY 2014 adjusted appropriations, totaling $302.8 million.

**Grants-in-Aid** funding is recommended to decrease by $0.5 million net, to $406.2 million, as follows:

- $7.2 million in additional funding recommended for Olmstead Support Services to develop new community-based placements for individuals in need of mental health services in FY 2015, and to support the annualized costs of placements created in FY 2014. A total of 330 new placements are projected for FY 2015, including both State and federal resources.

[1] Revolving funds displayed on page C-24 are not included in the totals here.

## Highlights (Cont'd)

- $6.9 million in reduced State expenditures in the Community Care line item due to increased federal Medicaid revenues for services provided to individuals who are newly eligible for Medicaid under the Affordable Care Act.

- $1.4 million in new funding for the Involuntary Outpatient Commitment program (also found in the Community Care line item) to support the program's Statewide expansion in FY 2015.

- $2.1 million in reduced State expenditures for the Medication Assisted Treatment Initiative, offset by an identical increase in anticipated federal funds.

**State Aid** for county psychiatric hospitals, supported by the Property Tax Relief Fund, is unchanged from the FY 2014 appropriation of $130.2 million.

### Division of Medical Assistance and Health Services

The Division of Medical Assistance and Health Services (DMAHS) is the division primarily responsible for the Medicaid and NJ FamilyCare medical assistance programs, which provide health care coverage to low-income New Jersey residents with a combination of State, federal, and Other funds.

The Governor's FY 2015 Budget recommends a net increase of $1.45 billion in overall funding for the division, to a total of approximately $9.79 billion (gross). The increase is driven by growth in federal funds, which increase by $1.21 billion, primarily as a result of the State's Medicaid expansion under the Affordable Care Act (ACA). Other funds, in the form of Medicaid drug manufacturer rebates, hospital mental health offset payments, and dedicated fund payments for NJ FamilyCare children, increase by a total of $192.9 million.

Total recommended State appropriations of $3.18 billion are approximately $38.3 million higher than the FY 2014 adjusted appropriations, primarily reflecting a combination of increased Medicaid managed care costs, certain State savings realized under the ACA Medicaid expansion, and the impact of an ACA-related health insurance providers fee. The net increase in State appropriations is attributed to the following changes:

- **Direct State Services** funding, representing administrative costs, remains unchanged at $30.9 million.

- **Grants-in-Aid** funding for health care benefits to eligible individuals would increase by $38.3 million, to $3.15 billion. Major changes include the following:

    - $160.2 million in total savings from previously enrolled General Assistance Medicaid beneficiaries and NJ FamilyCare parent beneficiaries being deemed "newly eligible" under the ACA Medicaid expansion, whereby the State will receive enhanced, 100 percent federal Medicaid reimbursement for their medical assistance expenditures. These savings are budgeted in the General Assistance Medical Services ($31.8 million) and NJ FamilyCare--Affordable and Accessible Health Coverage Benefits ($128.3 million) line items, respectively.

## Highlights (Cont'd)

- $39.2 million in new funding to cover the costs of an ACA-related federal fee on for-profit health insurers (including Medicaid managed care organizations), budgeted in the new ACA Health Insurance Providers Fee line item.

- $173.5 million in net increased funding for Medicaid managed care (budgeted in the Managed Care Initiative line item and through which most Medicaid enrollees' services are provided), reflecting the following:

    - $12.8 million in projected costs from new, ACA-related Medicaid enrollments of certain previously eligible parents and children whose Medicaid expenditures receive only 50 percent federal reimbursement;

    - $27.0 million in projected savings associated with new federal Medicaid reimbursement for certain previously State-funded Medicaid enrollees; and certain enrollees being transitioned to the federal health insurance exchange;

    - $187.7 million in projected costs from anticipated increases in managed care capitation rates and enrollment increases not specifically related to the ACA.

- $37.9 million in net reduced funding for Medicaid fee-for-service expenditures, resulting from:

    - $37.1 million in reduced expenditures on fee-for-service Payments for Medical Assistance Recipients – Prescription Drugs, reflecting projections of lower costs and increased rebates.

    - $3.5 million in savings from certain Federally Qualified Health Center (FQHC) recoveries.

    - $2.7 million in overall, net increased costs associated with other Medicaid fee-for-service expenditures.

- $3.7 million in increased funding for Health Benefit Coordination Services.

- Discontinuation of $20.0 million in FY 2014 savings from enhanced Medicaid fraud recoveries.

### Division of Aging Services

The Division of Aging Services (DoAS) administers New Jersey's programs for senior citizens. These include medical services and long-term care, in both nursing homes and community settings, pharmaceutical assistance programs, and several non-health programs intended to improve seniors' quality of life, such as home delivered meals, transportation, and legal assistance. The division also provides State Aid to counties for the operations of the County Offices on Aging and the State share of the Older Americans Act.

The Governor's FY 2015 Budget recommends a net increase of $383.0 million in total funding for the division, for a total budget of $2.74 billion (gross). Federal funds increase by $237.7 million, to $1.42 billion. The net increase in federal funds is primarily due to

## Highlights (Cont'd)

anticipated federal Medicaid reimbursement for State expenditures on the new Managed Long Term Care Services and Supports (MLTSS) initiative in FY 2015, including federal funds for existing services transferred from the Division of Disability Services.

Other funds decrease by $4.3 million, to $171.5 million, primarily due to a projected $5.5 million decrease in Pharmaceutical Assistance to the Aged and Disabled (PAAD) drug manufacturer rebates offset by a $1.2 million increase in Nursing Home Provider Assessment revenues.

Total State appropriations from the General Fund, Casino Revenue Fund, and Property Tax Relief Fund are recommended to increase by $149.6 million, to $1.15 billion, primarily reflecting the implementation of MLTSS. The net increase in State appropriations is attributed to the following changes:

- **Direct State Services** funding remains unchanged at $11.9 million.

- **Grants-in-Aid** funding would increase by $149.6 million, to $1.13 billion, reflecting the following changes:

    - $55.3 million in funding transferred from the Division of Disability Services (DDS) for Medicaid home- and community-based services incorporated into MLTSS, including $19.4 million in FY 2015 funding growth for transferred Medicaid personal care assistance (PCA) services and "waiver initiative" services.

    - $125.4 million in entirely new funding for MLTSS, related to managed care capitation payments covering the costs of care management, administration, and growth in long-term care services (e.g., home- and community-based services, nursing facility services, etc.) for new and existing Medicaid clients under MLTSS. This amount also includes one-time costs for paying out claims of long-term care services that were rendered under previous fee-for-service arrangements.

    - $25.0 million in reduced funding for fee-for-service Payments for Medical Assistance Recipients – Nursing Homes, due to a projection of decreasing nursing facility patient days.

    - $1.9 million in increased funding for the Program for All-Inclusive Care for the Elderly (PACE).

    - $7.7 million in overall reductions for Pharmaceutical Assistance to the Aged and Disabled (PAAD) ($7.2 million) and Senior Gold ($0.5 million), generally reflecting program trends.

    - $0.1 million in reduced funding for fee-for-service Medical Day Care Services.

    - Elimination of the $0.2 million appropriation for Holocaust Survivor Assistance Program, Samost Jewish Family & Children's Service of Southern NJ.

- **State Aid** funding remains unchanged at $7.2 million.

## Highlights (Cont'd)

### Division of Disability Services

The Division of Disability Services (DDS) currently administers Medicaid personal care assistance (PCA) services, which provide assistance with aspects of daily living to children and adults with functional limitations. DDS also administers several other Medicaid and non-Medicaid programs providing home- and community-based services to individuals with disabilities and provides information, referral assistance, transportation and vocational services, and other services to such individuals.

It is noted that the Governor's FY 2015 Budget anticipates that a significant portion of the division's services will be transferred to the Division of Aging Services (DoAS) in FY 2015, to be incorporated into the Managed Long Term Services and Supports (MLTSS) initiative in that division. This transfer also coincides with the shifting of Medicaid reimbursement for these services from a fee-for-service basis to a managed care arrangement.

Overall funding for the division is recommended to decrease by $71.7 million, to $39.2 million (gross). The overall decrease represents the aforementioned transfer of services, and corresponding State and federal funding, from DDS to DoAS as part of implementing the MLTSS initiative. Of the overall amount, State appropriations from the General Fund and Casino Revenue Fund decrease by $35.9 million, to $24.5 million. federal funds (primarily federal Medicaid matching funds) decrease by $35.8 million, to $11.7 million. Other funds remain unchanged at $3.0 million.

The net decrease in State appropriations is distributed as follows:

- **Direct State Services** funding is recommended to remain unchanged, at $1.3 million.

- **Grants-in-Aid** funding is recommended to decrease by $35.9 million, to $23.1 million. As noted above, this represents funds transferred from DDS to DoAS, corresponding to the incorporation of the following services into the MLTSS initiative:

  - Medicaid personal care assistance (PCA) services, including services related to the Personal Preference Program; and

  - Other home-and community-based services previously associated with Medicaid waiver programs, including services associated with the Traumatic Brain Injury Program, the AIDS Community Care Alternatives Program, and the Community Resources for People with Disabilities Program.

  It is also noted that the transferred services include a total of $19.4 million in FY 2015 funding growth, resulting in a total of $55.3 million in FY 2015 funding shifted from DDS to DoAS.

### Division of Developmental Disabilities

The Division of Developmental Disabilities (DDD) funds a broad range of community-based residential care services, individual and family support services, and day programs for individuals with developmental disabilities. DDD also operates the State's developmental centers.

## Highlights (Cont'd)

The Governor's FY 2015 Budget anticipates the closure of North Jersey Developmental Center on July 1, 2014, followed by Woodbridge Developmental Center on January 1, 2015, pursuant to the binding recommendations of the Task Force on the Closure of State Developmental Centers issued in 2012. Consequently, recommended funding for developmental centers is reduced by $74.0 million (gross), to $401.6 million. This reduction is composed of $33.5 million in State funds and $40.6 million in federal funds.

Funding for community-based services is recommended to increase by $85.7 million (gross), to $1,263.0 million, including $702.4 million in State appropriations from the General Fund and Casino Revenue Fund; $497.2 million in federal funds; and $63.4 million in Other funds. The recommended increase includes $43.4 million in State funds, allocated as follows:

- State funding for **Direct State Services** for DDD community programs remain unchanged at $39.0 million.

- State funds for **Grants-in-Aid** are recommended to increase by $43.4 million:

    - A net increase of $7.6 million from FY 2014 for new community placements for individuals who are transitioning to the community from developmental centers or are at risk of institutionalization, or $45.1 million total State funding for new placements in FY 2015.

    - An increase of $35.8 million in General Fund and Casino Revenue Fund appropriations for ongoing costs for individuals receiving community-based services. This increase results after deducting $5.5 million in funding for sheltered workshops that is recommended to shift from DDD to the Department of Labor and Workforce Development, and $4.1 million related to terminated contracts for services identified by the Executive as redundant of existing services.

### Commission for the Blind and Visually Impaired

The New Jersey Commission for the Blind and Visually Impaired (CBVI) provides and promotes services in the areas of education, employment, independence, and eye health for individuals who are blind or visually impaired, as well as their families and the community at large.

The Governor's FY 2015 Budget recommends a decrease of $0.2 million in CBVI's overall budget, to $28.2 million (gross). State appropriations would remain unchanged at $14.3 million, with $11.0 million provided for **Direct State Services** and $3.3 million provided for **Grants-in-Aid**. Federal funds would also remain unchanged at $13.4 million.

Other funds would decrease by $0.2 million, to $0.4 million. The recommended decrease appears to be associated with funds received from the federal Social Security Administration to support vocational rehabilitation services provided to CBVI clients.

## Highlights (Cont'd)

### Division of Family Development

The Division of Family Development (DFD) provides various support services and assistance to financially insecure families and adults without dependents. In cooperation with the county welfare agencies, DFD provides nutrition assistance, temporary cash assistance, rental and emergency housing assistance, child care subsidies, and other support services to these families and individuals.

Overall funding for the division is recommended to increase by $33.3 million, to $1.51 billion (gross).[2] Of this amount, $553.8 million represents State appropriations from the General Fund and Property Tax Relief Fund, which decrease by $7.7 million overall. The recommended State appropriations are allocated as follows:

- **Direct State Services** funding is recommended to increase by $2.8 million, to $43.1 million. The net State increase is attributed to:
  - $2.7 million in increased funding for Work First New Jersey – Technology Investment, intended for technology expenditures delayed from FY 2014 to FY 2015 and associated with a corresponding projected FY 2014 lapse of $2.7 million.
  - $0.1 million in increased funding for Personal Services.
- **Grants-in-Aid** funding is recommended to increase by $14.5 million, to $172.0 million.

  The net State increase is attributed to $14.5 million in increased funding for Work First New Jersey Child Care, for projected FY 2015 growth in program utilization. (It is noted that the Executive also currently projects that $14.5 million will lapse from the program in FY 2014, due to lower than expected utilization in the current fiscal year.)
- **State Aid** funding is recommended to decrease by $25.0 million, to $338.8 million. The net State decrease is attributed to:
  - $14.9 million in savings for Payments for the Cost of General Assistance (GA), attributed to program trends within the GA cash assistance program;
  - $11.8 million in savings for the General Assistance Emergency Assistance Program, attributed to program trends;
  - $0.1 million in reduced funding for Work First New Jersey – Client Benefits, which funds cash assistance for recipients of Temporary Assistance for Needy Families (TANF);
  - $1.6 million in increased funding for Payments for Supplemental Security Income, attributed to program trends; and
  - $0.3 million in increased funding for the State Supplemental Security Income Administrative Fee paid to the federal Social Security Administration.

[2] Revolving funds displayed on page C-24 are not included in the totals here.

## Highlights (Cont'd)

Federal funds are recommended to increase by $41.0 million, to $918.0 million. The increases are primarily associated with: Work First New Jersey (WFNJ) Child Care ($8.1 million); General Assistance County Administration ($5.0 million); County Administration Funding for other division programs ($20.4 million); WFNJ Client Benefits ($2.5 million); WFNJ Emergency Assistance, provided to TANF recipients ($7.4 million); Child Support Incentive Funding allocated to Direct State Services ($5.3 million); and various other increases totaling $1.6 million. Offsetting these increases are an $8.9 million decrease in federal funding for the Work First New Jersey – Technology Investment account and an additional $0.2 million decrease in federal funding for Direct State Services. Other funds would remain unchanged at $41.9 million.

### Division of the Deaf and Hard of Hearing

The Division of the Deaf and Hard of Hearing (DDHH) provides services to New Jersey residents who are deaf, hard of hearing, deaf-blind, or have speech disorders. It also conducts activities that enhance public awareness of hearing loss, and provides communications access referral services to State and other governmental programs.

The DDHH's recommended budget is unchanged from the FY 2014 adjusted appropriation, at $1.0 million in State funds (entirely **Direct State Services**).

### Division of Management and Budget

The Division of Management and Budget performs the central administrative functions of the Department of Human Services.

The Governor's FY 2015 Budget recommends a decrease of $1.1 million for overall division funding, to $82.2 million (gross). Federal funds decrease by $0.1 million, to $23.0 million. Other funds decrease by $0.6 million, to $10.0 million. The decrease in Other funds is entirely associated with a decrease in Mental Health Fees, shown on page C-13 of the Governor's Budget.

State appropriations are recommended to decrease by $0.4 million, to $49.2 million. The recommended decrease reflects a $0.4 million reduction in funding for **Direct State Services**, to $40.4 million. This reduction is budgeted within the Additions, Improvements, and Equipment line item, and available information attributes the decrease to a reduced "line of credit" that funded a department-wide technology upgrade which has been completed. State appropriations for **Grants-in-Aid** would remain unchanged, at $8.7 million.

**Background Paper**

# Fiscal and Personnel Summary

**AGENCY FUNDING BY SOURCE OF FUNDS ($000)**

| | Expended FY 2013 | Adj. Approp. FY 2014 | Recom. FY 2015 | Percent Change 2013-15 | Percent Change 2014-15 |
|---|---|---|---|---|---|
| **General Fund** | | | | | |
| Direct State Services | $689,330 | $637,097 | $606,080 | ( 12.1%) | ( 4.9%) |
| Grants-In-Aid | $5,406,289 | $4,986,926 | $5,267,028 | ( 2.6%) | 5.6% |
| State Aid | $361,062 | $370,979 | $291,547 | ( 19.3%) | ( 21.4%) |
| Capital Construction | $6,834 | $0 | $0 | ( 100.0%) | 0.0% |
| Debt Service | $0 | $0 | $0 | 0.0% | 0.0% |
| **Sub-Total** | **$6,463,515** | **$5,995,002** | **$6,164,655** | **( 4.6%)** | **2.8%** |
| **Property Tax Relief Fund** | | | | | |
| Direct State Services | $0 | $0 | $0 | 0.0% | 0.0% |
| Grants-In-Aid | $0 | $0 | $0 | 0.0% | 0.0% |
| State Aid | $152,810 | $130,165 | $184,566 | 20.8% | 41.8% |
| **Sub-Total** | **$152,810** | **$130,165** | **$184,566** | **20.8%** | **41.8%** |
| **Casino Revenue Fund** | $291,823 | $360,440 | $289,651 | ( 0.7%) | ( 19.6%) |
| **Casino Control Fund** | $0 | $0 | $0 | 0.0% | 0.0% |
| **State Total** | **$6,908,148** | **$6,485,607** | **$6,638,872** | **( 3.9%)** | **2.4%** |
| **Federal Funds** | $5,965,412 | $7,757,386 | $9,218,459 | 54.5% | 18.8% |
| **Other Funds** | $399,191 | $786,007 | $980,588 | 145.6% | 24.8% |
| **Grand Total** | **$13,272,751** | **$15,029,000** | **$16,837,919** | **26.9%** | **12.0%** |

**PERSONNEL SUMMARY - POSITIONS BY FUNDING SOURCE**

| | Actual FY 2013 | Revised FY 2014 | Funded FY 2015 | Percent Change 2013-15 | Percent Change 2014-15 |
|---|---|---|---|---|---|
| State | 9,438 | 9,248 | 8,356 | ( 11.5%) | ( 9.6%) |
| Federal | 4,966 | 4,828 | 4,171 | ( 16.0%) | ( 13.6%) |
| All Other | 64 | 62 | 64 | 0.0% | 3.2% |
| **Total Positions** | **14,468** | **14,138** | **12,591** | **( 13.0%)** | **( 10.9%)** |

FY 2013 (as of December) and revised FY 2014 (as of January) personnel data reflect actual payroll counts. FY 2015 data reflect the number of positions funded.

## AFFIRMATIVE ACTION DATA

| | | | | | |
|---|---|---|---|---|---|
| Total Minority Percent | 63.6% | 62.4% | 63.4% | ---- | ---- |

## Significant Changes/New Programs ($000)

| Budget Item | Adj. Approp. FY 2014 | Recomm. FY 2015 | Dollar Change | Percent Change | Budget Page |
|---|---|---|---|---|---|
| **DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES (DMHAS)** | | | | | |
| **GRANTS-IN-AID** | | | | | |
| **Olmstead Support Services** | **$88,817** | **$96,006** | **$ 7,189** | **8.1%** | **D-170** |

The Governor's FY 2015 Budget recommends an increase of $7.2 million for Olmstead Support Services, for a total State appropriation of $96.0 million. Information from the Executive indicates that $5.3 million of this increase represents the annualized cost of community-based beds developed during FY 2014. (Performance data on page D-162 indicate that 334 beds will have been developed by the end of FY 2014.)

The remaining $1.9 million would be used to develop 175 new community placements during FY 2015, of which 155 are specifically for patients discharged from the State's psychiatric hospitals, and 20 will serve individuals at risk of institutionalization. The appropriation also supports the initial stages of development for an additional 25 beds that will not be available for patients until FY 2016. The Executive has also indicated that it intends to allocate federal funds provided under the Social Services Block Grant to develop an additional 155 beds during FY 2015, for a total of 330 new placements in FY 2015.

Olmstead Support Services funds contracts with community mental health agencies to provide an array of mental health services, 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 requires that individuals with mental illness receive services in the least restrictive appropriate environment.

It is noted that the Executive plans to lapse $5.6 million from the Olmstead Support Services account in FY 2014. No details have been provided with regard to why the full appropriation was not needed in FY 2014, but lapses in past years have been usually been attributed to delays in development of new beds.

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| **GRANTS-IN-AID** | | | | | |
| **Community Care** | **$264,975** | **$259,326** | **($5,649)** | **( 2.1%)** | **D-170** |

The Governor recommends a State appropriation for Community Care of $259.3 million, a decreased of $5.6 million from FY 2014. According to the Executive, this decrease is possible because approximately $6.9 million in State funds can be replaced with federal funds related to the Medicaid expansion under the Affordable Care Act (ACA). These additional federal funds are anticipated because certain individuals previously receiving State-funded mental health services became "newly eligible" for Medicaid effective January 1, 2014, and a portion of their mental health expenditures will receive 100 percent federal reimbursement under the ACA Medicaid expansion.

## Significant Changes/New Programs ($000) (Cont'd)

| Budget Item | Adj. Approp. FY 2014 | Recomm. FY 2015 | Dollar Change | Percent Change | Budget Page |
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The appropriation includes an additional $1.35 million to support Statewide implementation of the Involuntary Outpatient Commitment (IOC) program, established pursuant to P.L.2009, c.112. The FY 2014 appropriation includes $2.0 million to support IOC programs in six counties. A related language provision on page D-172 would appropriate the unexpended FY 2014 balance of the Community Care account, not to exceed $2.4 million, for the IOC program, bringing the total resources recommended for the program in FY 2015 to $5.75 million.

Community Care funds contracts with community mental health agencies to provide an array of mental health services, including: early intervention and support services; screening services; outpatient, partial care, and residential services; supported housing and employment; integrated case management; legal services; and family support services.

It is noted that an indeterminate amount of additional funding may be transferred from the State Aid account for Support of Patients in County Psychiatric Hospitals (page D-170) when Camden County finalizes the privatization of its psychiatric hospital, as noted in footnote (e) on page D-169. Union County has also been taking steps to sell its psychiatric hospital, though no reference to this privatization is included in the Budget.

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| **GRANTS-IN-AID** | | | | | |
| **Medication Assisted Treatment Initiative** | **$9,232** | **$7,167** | **($2,065)** | **( 22.4%)** | **D-170** |

The Governor recommends a reduction of $2.1 million in State funding for the Medication Assisted Treatment Initiative (MATI), due to an increase in anticipated federal funds. Combined State and federal funding for the program would remain unchanged, at approximately $11.3 million.

The MATI program delivers an array of medication-assisted treatment and other clinical services to opiate-dependent, low-income adults with mental illness or chronic medical conditions. These services are intended to: reduce drug dependence; reduce the spread of blood-borne diseases resulting from the sharing of syringes; stabilize chronic physical and mental health conditions; and improve housing and employment outcomes.

It is noted that the Executive has indicated that it plans to lapse $3.2 million from the MATI account in FY 2014, citing a "surplus." However, as of April 2014, only $7,000 is uncommitted in the account.

## Significant Changes/New Programs ($000) (Cont'd)

| Budget Item | Adj. Approp. FY 2014 | Recomm. FY 2015 | Dollar Change | Percent Change | Budget Page |
|---|---|---|---|---|---|
| **FEDERAL FUNDS** | | | | | |
| **Addiction Services** | **$42,361** | **$48,289** | **$ 5,928** | **14.0%** | **D-170** |

The Governor's Budget anticipates $5.9 million in additional federal funds, including $2.1 million that would be used to offset State expenses for the Medication Assisted Treatment Initiative, described above. An additional $3.9 million appears to be associated with the federal Substance Abuse and Mental Health Services Administration's Strategic Prevention Framework Partnerships for Success program, a substance abuse prevention program, but no details have been provided regarding this anticipated increase in funds.

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| **OTHER FUNDS** | | | | | |
| **Addiction Services** | **$12,994** | **$15,272** | **$ 2,278** | **17.5%** | **D-170** |

Nearly all of the anticipated increase in Other Funds in the Addiction Services program class is attributable to an anticipated $2.3 million in internet gaming permit fees, which are dedicated for compulsive gambling programs. It is noted that materials associated with the FY 2015 Budget do not include any revenue from this source in FY 2014, but the State accounting system shows approximately $2.0 million in FY 2014 revenues, as of April 2014.

## Significant Changes/New Programs ($000) (Cont'd)

| Budget Item | Adj. Approp. FY 2014 | Recomm. FY 2015 | Dollar Change | Percent Change | Budget Page |
|---|---|---|---|---|---|
| **DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES (DMAHS)** | | | | | |
| **GRANTS-IN-AID** | | | | | |
| **Payments for Medical Assistance Recipients** | | | | | |
| **TOTAL** | **$2,901,827** | **$3,076,632** | **$174,805** | **6.0%** | |
| **Managed Care Initiative** | **$1,976,127** | **$2,149,662** | **$173,535** | **8.8%** | **D-176** |
| **ACA Health Insurance Providers Fee** | **$0** | **$39,151** | **$39,151** | **—** | **D-176** |
| **Adult Mental Health Residential** | **$28,778** | **$30,916** | **$ 2,138** | **7.4%** | **D-176** |
| **Inpatient Hospital** | **$225,351** | **$226,112** | **$ 761** | **0.3%** | **D-176** |
| **Prescription Drugs** | **$242,608** | **$205,527** | **($37,081)** | **(15.3%)** | **D-176** |
| **Outpatient Hospital** | **$76,366** | **$77,999** | **$ 1,633** | **2.1%** | **D-176** |
| **Physician Services[3]** | **$23,646** | **$23,726** | **$ 80** | **0.3%** | **D-176** |
| **Medicare Premiums** | **$168,046** | **$169,073** | **$ 1,027** | **0.6%** | **D-176** |
| **Clinic Services** | **$82,045** | **$81,043** | **($1,002)** | **(1.2%)** | **D-177** |
| **Transportation Services** | **$51,516** | **$51,121** | **($ 395)** | **(0.8%)** | **D-177** |
| **Other Medicaid Services[4]** | **$27,344** | **$22,302** | **($5,042)** | **(18.4%)** | |

The Governor's FY 2015 Budget recommends total State appropriations for Medicaid managed care and fee-for-service programs (excluding services administered by other divisions or departments) increase by approximately $174.8 million, to $3.077 billion.

The recommended increase in appropriations appears to represent the sum of three major factors: new costs associated with the federal Patient Protection and Affordable Care Act (ACA), savings associated with the ACA, and managed care cost trends. Specific costs and savings contributing to the recommended increase are as follows:

- $39.2 million in additional costs, associated with the recommended new appropriation for ACA Health Insurance Providers Fee. Beginning in calendar year 2014, the ACA imposes an annual fee on certain for-profit health insurers based upon their net health

[3] Physician Services, as displayed in the Governor's FY 2015 Budget, includes Dental Services.
[4] Other Medicaid Services combines, for presentation purposes, the following Medicaid fee-for-service line items with recommended FY 2015 State appropriations below $10 million: ICF/MR, Psychiatric Hospital, Programs for Assertive Community Treatment, and Other Services (as displayed in the Governor's FY 2015, "Other Services" includes Home Health Care and Medical Supplies).

## Significant Changes/New Programs ($000) (Cont'd)

| Budget Item | Adj. Approp. FY 2014 | Recomm. FY 2015 | Dollar Change | Percent Change | Budget Page |
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care premiums written.[5] Private insurers that contract with government organizations to provide Medicare and Medicaid health benefits are among those insurers that will be subject to the fee.

It is noted that federal regulations require that capitation rates paid to Medicaid managed care plans be "actuarially sound," which involves a consideration of managed care plans' costs, including health benefits, marketing and administrative expenses, and taxes and fees. In addition, because of cost-sharing limitations in Medicaid, the costs of the ACA health insurers fee may not be easily passed on to enrollees. Thus, states may need to increase Medicaid managed care capitation rates to maintain actuarially sound rates. Available information from the department suggests that the need to maintain actuarially sound rates is one rationale for the recommended new appropriation of $39.2 million.

- A net $173.5 million increase in the Managed Care Initiative line, representing the following:

  - $12.8 million in additional costs resulting from additional Medicaid enrollments of certain previously eligible parents and children whose service expenditures will receive only 50 percent federal Medicaid reimbursement in FY 2015. Informal information from the department partially attributes these additional enrollments to increased public awareness of the ACA Medicaid expansion resulting from various outreach efforts. (The OLS notes that such outreach activities occurred within the context of other potential contributing factors, such as the ACA individual insurance mandate and the presence of the health insurance marketplace as a new pathway into Medicaid.)

  - $27.0 million in additional *savings* for certain individuals previously receiving State-only-funded medical assistance and who: began receiving 50 percent or 100 percent federal Medicaid reimbursement, effective January 2014, as a result of revised Medicaid eligibility standards; or were transitioned to the federal health insurance exchange for health coverage. Examples of these individuals are certain individuals deemed to be "essential spouses" of elderly or disabled Medicaid recipients.

  - $187.7 million in additional costs attributed to projected increases in managed care capitation rates, reflecting general health care cost trends, and ongoing enrollment increases not specifically related to the ACA.

- $3.5 million in savings associated with Federally Qualified Health Center (FQHC) wraparound audit recoveries, reflected in the Clinic Services line.

[5] Federal regulations define "net premiums written" as gross premiums from insurance sales, minus: refunds to enrollees under ACA medical loss ratio provisions, certain commissions, and premiums ceded to reinsurers.

## Significant Changes/New Programs ($000) (Cont'd)

| Budget Item | Adj. Approp. FY 2014 | Recomm. FY 2015 | Dollar Change | Percent Change | Budget Page |
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Under Medicaid managed care, managed care organizations (MCOs) contract with FQHCs to provide various medical services. Federal Medicaid law requires the State to make supplemental payments (or "wraparound payments") at least once every four months, to make up the difference between the MCO's payments to FQHCs and certain federally required prospective payments that the State must make to its FQHCs.

Available information indicates that the $3.5 million in savings result from the State's recovery of emergency payments made to FQHCs pursuant to a U.S. District Court ruling in a lawsuit brought by the New Jersey Primary Care Association. The lawsuit concerned a State policy making wraparound payments to FQHCs contingent upon the MCOs' acceptance and prior payment of claims submitted by the FQHCs to the MCOs. The State successfully appealed the lower court's ruling and was able to recover the emergency payments.

- A recommended decrease of $37.1 million in Medicaid expenditures on fee-for-service Prescription Drugs. Informal information from the department attributes the decrease to projections of lower expenditure trends, increased Medicaid drug rebates collected by the State, and decreases in mandated State payments to the federal government for persons who are dually eligible for Medicare and Medicaid. (These payments, known as "clawback," were part of the overall Medicare Part D legislation and phase down each year through calendar year 2015.)

- Other increases and decreases among the various fee-for-service line items, associated with medical assistance "trends," yielding a net increase of $2.7 million.

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| **GRANTS-IN-AID** | | | | | |
| **General Assistance Medical Services** | **$31,842** | **$0** | **($31,842)** | **( 100.0%)** | **D-177** |

The Governor's FY 2015 Budget recommends the elimination of the $31.8 million State appropriation for General Assistance Medical Services.

Anticipated State savings of $31.8 million entirely account for this decrease. The savings are associated with certain low-income adults without dependents, who were previously eligible for Medicaid through the General Assistance program, being deemed "newly eligible" for Medicaid, thereby generating enhanced, 100 percent federal reimbursement for State medical assistance expenditures for these adults effective January 1, 2014.

(Prior to January 1, 2014, State medical assistance expenditures for this adult population received 50 percent federal reimbursement under the State's "Childless Adults" Medicaid waiver program.)

## Significant Changes/New Programs ($000) (Cont'd)

| Budget Item | Adj. Approp. FY 2014 | Recomm. FY 2015 | Dollar Change | Percent Change | Budget Page |
|---|---|---|---|---|---|
| **GRANTS-IN-AID NJ FamilyCare – Affordable and Accessible Health Coverage Benefits** | **$172,217** | **$43,892** | **($128,325)** | **( 74.5%)** | **D-177** |

The Governor's FY 2015 Budget recommends a decrease of $128.3 million in the State appropriation for the NJ FamilyCare – Affordable and Accessible Health Coverage Benefits, to $43.9 million.

Anticipated State savings of $128.3 million entirely account for this decrease. The savings are associated with certain parents with incomes up to 133 percent of the federal poverty level (FPL), who were previously eligible for the NJ FamilyCare program, being deemed "newly eligible" for Medicaid, thereby generating enhanced, 100 percent federal reimbursement for State medical assistance expenditures for these parents effective January 1, 2014.

(Prior to January 1, 2014, State medical assistance expenditures for this population of parents received between 50 to 57.5 percent federal reimbursement through Medicaid and the Children's Health Insurance Program.)

The $43.9 million remaining in the appropriation supports services for certain previously eligible adult populations such as pregnant women.

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| **GRANTS-IN-AID Health Benefit Coordination Services** | **$11,502** | **$15,152** | **$ 3,650** | **31.7%** | **D-177** |

The Governor's FY 2015 Budget recommends an increase of $3.7 million in the State appropriation for Health Benefit Coordination Services, to $15.2 million.

The Health Benefit Coordination Services appropriation supports the State's contract with Xerox State Healthcare, LLC to operate the Medicaid/NJ FamilyCare toll-free hotline and customer service call center. Informal information from the department indicates that the recommendation reflects increased contract costs due to growth in the volume of calls and Medicaid applications under the State's ACA Medicaid expansion.

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| **GRANTS-IN-AID Enhanced Medicaid Fraud Recoveries** | **($20,000)** | **$0** | **$20,000** | **100%** | **D-177** |

The Governor's FY 2015 Budget discontinues the assumption of $20.0 million in enhanced Medicaid fraud recoveries that were assumed to offset State appropriations in FY 2014. The FY 2014 enhanced recoveries were primarily associated with certain one-time national settlements with drug manufacturers.

## Significant Changes/New Programs ($000) (Cont'd)

| Budget Item | Adj. Approp. FY 2014 | Recomm. FY 2015 | Dollar Change | Percent Change | Budget Page |
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In response to an FY 2014 OLS Discussion Point, the department indicated that, since FY 2012, $40 million in base recoveries has been incorporated into the department's base budget and that the FY 2014 budget anticipated a total of $60 million in recoveries. Available information indicates that $40 million in base Medicaid recoveries are assumed for FY 2015.

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| **FEDERAL FUNDS** | | | | | |
| **General Medical Services** | **$4,479,365** | **$5,692,823** | **$1,213,458** | **27.1%** | **D-177** |

The Governor's Budget anticipates an increase of $1.21 billion in federal funds for the General Medical Services program classification within the Division of Medical Assistance and Health Services.

The increase is primarily a result of the State's Medicaid expansion under the Affordable Care Act (ACA), whereby the federal government provides 100 percent reimbursement for Medicaid service expenditures on certain Medicaid enrollees who become "newly eligible" as of January 1, 2014 (i.e., non-elderly and non-disabled adults with household incomes under 133 percent of the FPL). The increase also reflects certain ACA-related and non-ACA-related increases in Medicaid enrollments and expenditures involving the State's "regular" 50 percent federal Medicaid reimbursement rate.

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| **OTHER FUNDS** | | | | | |
| **General Medical Services** | **$467,555** | **$660,354** | **$192,799** | **41.2%** | **D-177** |

The Governor's Budget anticipates an increase of $192.8 million in Other Funds for the General Medical Services program classification within the Division of Medical Assistance and Health Services.

The increase reflects a $169.9 million increase in Medicaid drug manufacturer rebates and a $22.9 million increase in dedicated funds for NJ FamilyCare children (from the Health Care Subsidy Fund).

## Significant Changes/New Programs ($000) (Cont'd)

| Budget Item | Adj. Approp. FY 2014 | Recomm. FY 2015 | Dollar Change | Percent Change | Budget Page |
|---|---|---|---|---|---|
| **DIVISION OF AGING SERVICES (DoAS)** | | | | | |
| **GRANTS-IN-AID** | | | | | |
| **Payments for Medical Assistance Recipients -- Nursing Homes** | **$719,012** | **$694,013** | **($24,999)** | **( 3.5%)** | **D-186** |

The Governor's FY 2015 Budget recommends a decrease of $25.0 million in the State appropriation for the Payments for Medical Assistance Recipients – Nursing Homes appropriation, to $694.0 million.

The appropriation funds Medicaid nursing facility services reimbursed by the State on a fee-for-service basis. Informal information from the department attributes the recommended decrease to an anticipated trend of decreasing nursing facility patient days. The same information indicates that various initiatives and programs designed to divert, delay, or transition individuals away from institutional care and into home- and community-based care (such as the Program of All-Inclusive Care for the Elderly) may partially explain this trend.

It is noted that evaluation data on page D-183 of the Governor's FY 2015 Budget estimate that 9,822,647 fee-for-service nursing facility patient days will be provided in FY 2015, representing a decrease of approximately 380,000 (or 3.7 percent) from the original FY 2014 estimate of 10,202,296 patient days in the Governor's FY 2014 Budget (page D-188).

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| **GRANTS-IN-AID** | | | | | |
| **Managed Long Term Services and Supports** | **$0** | **$281,182** | **$281,182** | **—** | **D-186** |
| **Global Budget for Long Term Care** | **$62,656** | **$0** | **($62,656)** | **( 100.0%)** | **D-186** |
| **Global Budget for Long Term Care (CRF)** | **$37,850** | **$0** | **($37,850)** | **( 100.0%)** | **D-186** |

The Governor's FY 2015 Budget recommends a new State appropriation of $281.2 million in FY 2015 for Managed Long Term Services and Supports (MLTSS), representing $155.8 million from the consolidation of certain existing line item appropriations, plus $125.4 million in entirely new funding as explained at length below.

Under MLTSS, which is authorized by the State's Comprehensive Medicaid Waiver, New Jersey will shift Medicaid institutional long-term care services (i.e., nursing facility services) and home- and community-based services from fee-for-service reimbursement to managed care delivery. The State will contract with Medicaid managed care organizations (MCOs) for the provision of these long-term care services, and the MCOs will become responsible for coordinating and delivering the services and supports to eligible elderly Medicaid clients and Medicaid clients with disabilities. For more details regarding MLTSS, see the *Implementation of Managed Long Term Services and Supports* background paper included within this analysis (page 68).

## Significant Changes/New Programs ($000) (Cont'd)

| Budget Item | Adj. Approp. FY 2014 | Recomm. FY 2015 | Dollar Change | Percent Change | Budget Page |
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The $281.2 million in recommended FY 2015 funding consolidates $155.8 million from existing programs that previously received separate appropriations in the Division of Aging Services and the Division of Disability Services as follows:

- $100.5 million in funding at the existing FY 2014 level from the Global Budget for Long Term Care appropriations in the Division of Aging Services, which previously funded Medicaid home-and community-based services under the Global Options for Long Term Care waiver program. (The State's Comprehensive Medicaid Waiver consolidated Global Options for Long Term Care into MLTSS.)

- $55.3 million transferred from the Division of Disability Services, including:

    - approximately $35.6 million in funding at the existing FY 2014 level for Medicaid personal care assistance (PCA) services and Medicaid home- and community- based "waiver initiative" services (including $14.0 million for Medicaid PCA services and $21.7 million for "waiver initiative" services, respectively);

    - approximately $19.4 million in FY 2015 funding growth for the aforementioned Medicaid PCA services and "waiver initiative" services; and

    - approximately $0.3 million in funding at the existing FY 2014 level for "other services" previously provided through the Division of Disability Services.

In addition to consolidating the $155.8 million in funding described above, the Governor's FY 2015 Budget recommends $125.4 million in entirely new funding for MLTSS. Informal information from the department indicates that the $125.4 million is intended to support the following costs:

- Care management for Medicaid clients participating in the MLTSS program, including coordination of clients' behavioral, medical, and long-term care;

- Additional demand for certain home- and community-based services among existing Medicaid clients, who previously received more narrowly defined service packages under separate Medicaid waiver programs and who will gain access to a broader, consolidated package of those services under MLTSS;

- Funding for long-term care services (e.g., home- and community-based services, nursing facility services, etc.) associated with new Medicaid clients;

- One-time costs for payments of claims for long-term care services that were rendered under previous fee-for-service arrangements in prior fiscal years (informal information from the department indicates that these costs are approximately five percent of the $125.4 million); and

- Other factors, including administrative costs.

## Significant Changes/New Programs ($000) (Cont'd)

| Budget Item | Adj. Approp. FY 2014 | Recomm. FY 2015 | Dollar Change | Percent Change | Budget Page |
|---|---|---|---|---|---|
| **GRANTS-IN-AID** | | | | | |
| **Medical Day Care Services** | **$919** | **$814** | **($ 105)** | **( 11.4%)** | **D-186** |

The Governor's FY 2015 Budget recommends a decrease of $0.1 million in the State appropriation for fee-for-service Medicaid Medical Day Care Services, to $814,000.

Medical Day Care Services provide preventive, diagnostic, therapeutic, and rehabilitative services to adults who, due to their physical or cognitive impairment, require such services to be maintained in community living. The services are provided in an ambulatory care setting, under medical and nursing supervision.

Evaluation data on page D-183 of the Governor's FY 2015 Budget indicate that the recommended appropriation is expected to fund an estimated 18,782 service days in FY 2015, which represents a 4.9 percent decrease from the revised FY 2014 estimate (19,750 service days) and a 23.2 percent decrease from the original FY 2014 estimate (24,444 service days) provided in the Governor's FY 2014 Budget (page D-188).

It is noted that this appropriation generally funds fee-for-service adult medical day care services for Medicaid clients who are pending enrollment into a managed care plan. Effective July 2011, the State shifted most Medicaid adult medical day care services from fee-for-service to managed care delivery, with funding for most services budgeted within the Managed Care Initiative appropriation in the Division of Medical Assistance and Health Services.

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| **GRANTS-IN-AID** | | | | | |
| **PACE** | **$24,141** | **$26,059** | **$ 1,918** | **7.9%** | **D-186** |

The Governor's FY 2015 Budget recommends an increase of $1.9 million in the State appropriation for the Program for All-Inclusive Care for the Elderly (PACE), to $26.1 million.

PACE is designed to divert, delay, or transition elderly individuals away from institutional care and into community-based care. The program is jointly funded by Medicare and the State Medicaid program, with the State paying a capitated rate for each enrollee rather than paying for services on a fee-for-service basis. The program will remain separate from the State's Managed Long Term Services and Supports initiative.

Informal information from the department indicates that the recommended increase is due to continued enrollment growth in PACE, partially reflecting the State's efforts to direct clients to the program as a substitute for nursing facility placements. The number of PACE agencies operating in New Jersey is also anticipated to grow, with two additional agencies added to the four agencies currently operating.

## Significant Changes/New Programs ($000) (Cont'd)

| Budget Item | Adj. Approp. FY 2014 | Recomm. FY 2015 | Dollar Change | Percent Change | Budget Page |
|---|---|---|---|---|---|
| **GRANTS-IN-AID** | | | | | |
| **PAAD TOTAL** | **$81,818** | **$74,590** | **($7,228)** | **( 8.8%)** | |
| **Pharmaceutical Assistance to the Aged – Claims** | **$ 2,250** | **$ 2,250** | **$0** | **—** | **D-186** |
| **Pharmaceutical Assistance to the Aged and Disabled – Claims** | **$29,568** | **$22,340** | **($7,228)** | **( 24.4%)** | **D-186** |
| **Pharmaceutical Assistance to the Aged and Disabled – Claims (CRF)** | **$50,000** | **$50,000** | **$0** | **—** | **D-186** |

The Governor's FY 2015 Budget recommends overall FY 2015 State appropriations of $74.6 million for Pharmaceutical Assistance to the Aged and Disabled, representing a decrease of $7.2 million from the adjusted FY 2014 level.

This $7.2 million reduction is reflected in the FY 2015 appropriation for Pharmaceutical Assistance to the Aged and Disabled (PAAD) – Claims. It is noted that the FY 2014 adjusted appropriation of $22.3 million for this line item includes a proposed $14.2 million supplemental appropriation.

Informal information from the department attributes the projected FY 2014 supplemental appropriation to a need for additional funding to resolve lower than anticipated PAAD drug manufacturer rebates in each fiscal year since FY 2012. In turn, the recommended appropriation decrease for FY 2015 reflects an expectation that only about one-half (approximately $7 million) of the projected FY 2014 supplemental amount is needed in FY 2015 to fully offset the cumulative impact of lower than expected rebates.

Evaluation data in the Governor's FY 2014 Budget (page D-189) originally estimated drug manufacturer rebates associated with the Pharmaceutical Assistance to the Aged and Disabled (PAAD) program at $48.0 million in FY 2013 (revised) and $48.0 million in FY 2014. However, the Governor's FY 2015 Budget (page D-183) indicates that actual rebates were $35.4 million in FY 2013, and estimates rebates of $32.5 million in FY 2014 (revised) and $39.2 million in FY 2015. Informal information from the department indicates that annual PAAD rebate revenues of $30 to $40 million are currently anticipated in future years.

It is also noted that State costs associated with the PAAD are expected to decrease over the long term, due to Medicare Part D covering a greater percentage of prescription drug costs for PAAD enrollees in the future.[6]

[6] Under the ACA, and through 2020, Medicare Part D beneficiaries will experience gradual reductions in the amount of their prescription drug costs falling into the Part D "coverage gap" (also known as the "doughnut hole"), which costs are not covered by the Part D program and which may be partially paid through PAAD, if the Part D beneficiary is co-enrolled in either program. (Under program rules, any

## Significant Changes/New Programs ($000) (Cont'd)

| Budget Item | Adj. Approp. FY 2014 | Recomm. FY 2015 | Dollar Change | Percent Change | Budget Page |
|---|---|---|---|---|---|
| **GRANTS-IN-AID** | | | | | |
| **Holocaust Survivor Assistance Program, Samost Jewish Family & Children's Service of Southern NJ** | **$200** | **$0** | **($ 200)** | **( 100.0%)** | **D-186** |

The Governor's FY 2015 Budget eliminates $200,000 in State funding for the Holocaust Survivor Assistance Program, Samost Jewish Family & Children's Service of Southern NJ line item, which was added by a Legislative budget resolution to the FY 2014 Appropriations Act.

According to available information, these funds were intended to support health and social services provided to elderly Holocaust survivors by Jewish Family Services agencies across the State. Samost Jewish Family and Children's Service of Southern New Jersey was to receive the appropriated funds and distribute the funds to Holocaust survivors assistance activities Statewide.

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| **FEDERAL FUNDS** | | | | | |
| **Division of Aging Services** | | | | | |
| **GRAND TOTAL** | **$1,184,943** | **$1,422,643** | **$237,700** | **20.1%** | **D-187** |
| **Medical Services for the Aged** | **$1,133,025** | **$1,369,890** | **$236,865** | **20.9%** | **D-187** |
| **Programs for the Aged** | **$50,418** | **$50,453** | **$ 35** | **0.1%** | **D-187** |
| **Office of the Public Guardian** | **$1,500** | **$2,300** | **$ 800** | **53.3%** | **D-187** |

The Governor's Budget anticipates an overall increase of $237.7 million in federal funds across all program classifications within the Division of Aging Services.

The net increase includes a $236.9 million increase in the Medical Services for the Aged program classification, primarily due to anticipated federal Medicaid reimbursement for State expenditures on the new Managed Long Term Care Services and Supports (MLTSS) initiative in FY 2015, including federal funds for existing services transferred from the Division of Disability Services.

In addition, the Office of the Public Guardian is anticipated to receive an increase of $0.8 million in federal Medicaid funds, primarily budgeted for Salaries and Wages.

PAAD enrollees who are eligible for Medicare Part D must enroll in Part D, so most PAAD are co-enrolled.)

## Significant Changes/New Programs ($000) (Cont'd)

| Budget Item | Adj. Approp. FY 2014 | Recomm. FY 2015 | Dollar Change | Percent Change | Budget Page |
|---|---|---|---|---|---|
| **OTHER FUNDS** | | | | | |
| **Division of Aging Services** | | | | | |
| **GRAND TOTAL** | **$175,744** | **$171,457** | **($4,287)** | **( 2.4%)** | **D-187** |
| **Medical Services for the Aged** | **$126,000** | **$127,176** | **$1,176** | **0.9%** | **D-187** |
| **Pharmaceutical Assistance to the Aged and Disabled** | **$48,250** | **$42,750** | **($5,500)** | **( 11.4%)** | **D-187** |
| **Programs for the Aged** | **$150** | **$150** | **$0** | **—** | **D-187** |
| **Office of the Public Guardian** | **$1,344** | **$1,381** | **$ 37** | **2.8%** | **D-187** |

The Governor's Budget anticipates an overall decrease of $4.3 million in Other Funds across all program classifications within the Division of Aging Services.

The net decrease primarily reflects a projected $5.5 million decrease in Pharmaceutical Assistance to the Aged and Disabled (PAAD) drug manufacturer rebates offset by a $1.2 million increase in Nursing Home Provider Assessment revenues (in the Medical Services for the Aged program classification).

### DIVISION OF DISABILITY SERVICES (DDS)

| | | | | | |
|---|---|---|---|---|---|
| **GRANTS-IN-AID** | | | | | |
| **Payments for Medical Assistance Recipients -- Personal Care** | **$19,955** | **$6,000** | **($13,955)** | **( 69.9%)** | **D-194** |

The Governor's FY 2015 Budget recommends a decrease of $14.0 million for Payments for Medical Assistance – Personal Care, to $6.0 million. This decrease reflects the transfer of existing funding for Medicaid personal care assistance (PCA) services from the Division of Disability Services to the Division of Aging Services, where such funding and services are to be incorporated into the new Managed Long Term Services and Supports (MLTSS) program.

Informal information from the department indicates that approximately $29.5 million in total FY 2015 funding for Medicaid PCA services will be incorporated into MLTSS, of which $14.0 million represents the transfer of existing FY 2014 funding (described above) and approximately $15.5 million represents a recommended FY 2015 funding increase to support growth in these services.

The department attributes a portion of the $15.5 million in funding growth to the growth of the Personal Preference Program, which allows elderly and disabled adult Medicaid recipients to direct and manage their own PCA services by receiving and managing a monthly cash allowance, and working with a consultant to identify the services they need and the individuals

## Significant Changes/New Programs ($000) (Cont'd)

| Budget Item | Adj. Approp. FY 2014 | Recomm. FY 2015 | Dollar Change | Percent Change | Budget Page |
|---|---|---|---|---|---|

and/or agencies they can hire to provide those services. (This is also referred to as a "cash and counseling" or "consumer-directed" approach.)

PCA services generally 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-administrated medications, use of a wheelchair or other equipment).

| | | | | | |
|---|---|---|---|---|---|
| **GRANTS-IN-AID** | | | | | |
| **Waiver Initiatives** | | | | | |
| **TOTAL** | **$23,663** | **$2,000** | **($21,663)** | **( 91.5%)** | **D-194** |
| **Payments for Medical Assistance Recipients -- Waiver Initiatives** | **$7,161** | **$2,000** | **($5,161)** | **( 72.1%)** | **D-194** |
| **Payments for Medical Assistance Recipients -- Waiver Initiatives (CRF)** | **$16,502** | **$0** | **($16,502)** | **( 100.0%)** | **D-194** |

The Governor's FY 2015 Budget recommends a total decrease of $21.7 million across the two appropriations for Payments for Medical Assistance – Waiver Initiatives, of which $5.2 million reflects a decrease in the General Fund appropriation and $16.5 million reflects a decrease in the Casino Revenue Fund appropriation.

The $21.7 million total decrease results from the recommended transfer of existing funding for Waiver Initiative services from the Division of Disability Services to the Division of Aging Services, where such funding and services are to be consolidated under the Managed Long Term Services and Supports (MLTSS) program, in accordance with the State's Comprehensive Medicaid Waiver.

Informal information from the department indicates that approximately $25.7 million in total funding for Waiver Initiative services will be incorporated into MLTSS, of which $21.7 million represents the transfer of existing FY 2014 funding (described above) and approximately $4.0 million represents a recommended FY 2015 funding increase to support growth in these services.

Waiver Initiatives funds Medicaid home-and community-based services previously associated with several Medicaid waiver programs for persons with disabilities, including the Traumatic Brain Injury Program, the AIDS Community Care Alternatives Program, and the Community Resources for People with Disabilities Program.

## Significant Changes/New Programs ($000) (Cont'd)

| Budget Item | Adj. Approp. FY 2014 | Recomm. FY 2015 | Dollar Change | Percent Change | Budget Page |
|---|---|---|---|---|---|
| **GRANTS-IN-AID** | | | | | |
| **Payments for Medical Assistance Recipients – Other Services** | **$527** | **$270** | **($ 257)** | **( 48.8%)** | **D-194** |

The Governor's FY 2015 Budget recommends a decrease of $257,000 for the Payments for Medical Assistance – Other Services appropriation, to $270,000. This decrease reflects the transfer of existing funding for these Medicaid services from the Division of Disability Services to the Division of Aging Services, where such funding and services are to be incorporated into the Managed Long Term Services and Supports (MLTSS) program.

| | | | | | |
|---|---|---|---|---|---|
| **FEDERAL FUNDS** | | | | | |
| **Disability Services** | **$47,552** | **$11,721** | **($35,831)** | **( 75.4%)** | **D-194** |

The Governor's Budget anticipates a decrease of $35.8 million in federal funds for the Disability Services program classification within the Division of Disability Services (DDS).

The decrease corresponds to the transfer of federal Medicaid funds from DDS to the Division of Aging Services (DoAS) in FY 2015, reflecting the incorporation of certain DDS Medicaid Personal Care Assistance and Waiver Initiative services within the Managed Long Term Services and Supports (MLTSS) initiative in DoAS.

### DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)

*(Note: The Governor's Budget displays the Division of Developmental Disabilities' budget line items in a gross budget format, indicating the aggregated total of State, Federal, and Other Funds. Below, the OLS disaggregates each line item into its various components, as applicable.)*

| | | | | | |
|---|---|---|---|---|---|
| **DIRECT STATE SERVICES** | | | | | |
| **Developmental Centers** | | | | | |
| **GRAND TOTAL** | **$475,577** | **$401,554** | **($74,023)** | **( 15.6%)** | **D-197** |
| **General Fund** | **$158,992** | **$125,533** | **($33,459)** | **( 21.0%)** | **D-197** |
| **Federal Funds** | **$316,585** | **$276,021** | **($40,564)** | **( 12.8%)** | **D-197** |

Gross funding for developmental centers is recommended to decrease by $74.0 million, to $401.6 million. (The State share would decrease by $33.5 million, to $125.5 million.) The reduction is primarily related to the scheduled closure of North Jersey Developmental Center on July 1, 2014, followed by Woodbridge Developmental Center on January 1, 2015, pursuant to the binding recommendations of the Task Force on the Closure of State Developmental Centers issued in 2012.

## Significant Changes/New Programs ($000) (Cont'd)

| Budget Item | Adj. Approp. FY 2014 | Recomm. FY 2015 | Dollar Change | Percent Change | Budget Page |
|---|---|---|---|---|---|

According to the Executive, $13.5 million of the reduced State funds will directly follow clients who are transitioned into community placements, allocated to the Olmstead Residential Services line item (see page D-201). Funding associated with care for individuals transitioning to other developmental centers would follow those individuals, remaining in the developmental centers system, though the OLS is not able to identify a specific dollar amount due to other changes in developmental center census and staffing policies, such as overtime reductions. Under the Governor's FY 2015 Budget, the remaining $20.0 million in reduced State funding would be offset by increased funding for various DDD community programs, as required by the binding recommendations of the Task Force on the Closure of State Developmental Centers. Similarly, the reduction of federal funds for the developmental centers would generally be offset by increased federal matching funds for community services, though these funds come from different programs subject to different rules.

| | | | | | |
|---|---|---|---|---|---|
| **DIRECT STATE SERVICES** | | | | | |
| **Salaries and Wages** | | | | | |
| **TOTAL** | **$64,687** | **$69,918** | **$ 5,231** | **8.1%** | **D-200** |
| **General Fund** | **$36,720** | **$36,720** | **$ 0** | **—** | |
| **Federal Funds** | **$27,967** | **$33,198** | **$ 5,231** | **18.7%** | |

DDD plans to add an additional 27 staff members responsible for planning, oversight, and administration of DDD community programs in FY 2015. The Governor's Budget Recommendation anticipates additional federal funds to support these positions, and holds State funding at the same level as the FY 2014 adjusted appropriation.

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|---|---|---|---|---|---|
| **GRANTS-IN-AID** | | | | | |
| **Community Services** | | | | | |
| **Waiting List Placements** | | | | | |
| **TOTAL** | **$2,968** | **$2,241** | **($ 727)** | **( 24.5%)** | **D-201** |
| **General Fund** | **$1,491** | **$1,138** | **($ 353)** | **( 23.7%)** | |
| **Federal Funds** | **$1,477** | **$1,103** | **($ 374)** | **( 25.3%)** | |

The Governor's FY 2015 Budget recommends $2.2 million (gross) for Community Services Waiting List Placements. This account represents Community Care Waiver (CCW) program services provided to individuals selected from the CCW waiting list. The CCW program provides long-term community-based services and supports for people with developmental disabilities.

This line item reflects only the total costs associated with new placements, as indicated by footnote (b) on page D-202. Thus, the decrease of $0.7 million relative to the FY 2014 adjusted appropriation represents a year-to-year decrease in the amount of funding appropriated to new placements only. (In future fiscal years, the ongoing funding for these new

## Significant Changes/New Programs ($000) (Cont'd)

| Budget Item | Adj. Approp. FY 2014 | Recomm. FY 2015 | Dollar Change | Percent Change | Budget Page |
|---|---|---|---|---|---|

placements will be reallocated to the applicable DDD Grants-In-aid Accounts reflecting the actual services received.)

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|---|---|---|---|---|---|
| **GRANTS-IN-AID** | | | | | |
| **Dental Program for Non-Institutionalized Children** | **$564** | **0** | **($ 564)** | **( 100.0%)** | **D-201** |

The Governor proposes to eliminate DDD's State-funded dental program for non-institutionalized children, reasoning that the services are duplicative and not eligible for a federal match. All DDD consumers are now required to enroll in Medicaid, which provides dental care as part of its package of covered benefits. The OLS does not have detailed information with regard to what differences, if any, exist between the DDD dental program benefits and Medicaid dental benefits.

| | | | | | |
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| **GRANTS-IN-AID** | | | | | |
| **Group Homes** | | | | | |
| **GRAND TOTAL** | **$663,549** | **$691,105** | **$27,556** | **4.2%** | **D-201** |
| **Group Homes** | **$439,096** | **$483,089** | **$43,993** | **10.0%** | **D-201** |
| **General Fund** | **$74,360** | **$102,367** | **$28,007** | **37.7%** | |
| **Federal Funds** | **$305,384** | **$317,350** | **$11,966** | **3.9%** | |
| **Other Funds** | **$59,352** | **$63,372** | **$ 4,020** | **6.8%** | |
| **Group Homes (CRF)** | **$224,453** | **$208,016** | **($16,437)** | **( 7.3%)** | **D-201** |

The Governor's FY 2015 Budget recommends an increase of $27.6 million for Group Homes, to $691.1 million (gross). Evaluation data on pages D-198 to D-199 suggest that the recommended appropriation will support:

- 5,568 group home placements at a per capita cost of approximately $106,500.
- 1,465 supervised apartments at a per capita cost of approximately $80,900.
- 747 supported living placements at a per capita cost of approximately $45,100.

Group homes are living arrangements which allow individuals with developmental disabilities to live together in a home, sharing in daily living tasks and in the overall management of the residence. Supervised apartments are occupied by individuals with developmental disabilities who receive supervision, guidance, and training in activities of daily living, as needed, from support staff. Supported living provides a flexible array of services and supports to individuals with developmental disabilities residing in a variety of settings.

## Significant Changes/New Programs ($000) (Cont'd)

| Budget Item | Adj. Approp. FY 2014 | Recomm. FY 2015 | Dollar Change | Percent Change | Budget Page |
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The FY 2015 recommendation would shift $16.4 million in expenditures for Group Homes from the Casino Revenue Fund to the General Fund. The Executive also anticipates approximately $4.0 million in additional client contributions to care (represented above as Other Funds).

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|---|---|---|---|---|---|
| **GRANTS-IN-AID** | | | | | |
| **Olmstead Residential Services** | | | | | |
| **TOTAL** | **$19,697** | **$31,381** | **$11,684** | **59.3%** | **D-201** |
| **General Fund** | **$8,523** | **$13,472** | **$ 4,949** | **58.1%** | |
| **Federal Funds** | **$11,174** | **$17,909** | **$ 6,735** | **60.3%** | |

The Governor recommends $31.4 million (gross) for Olmstead Residential Services. Consistent with the U.S. Supreme Court's Olmstead decision, Olmstead Residential Services funds support the transitioning of current developmental center residents into community residential settings. According to performance data on page D-162, the Executive anticipates that 166 individuals will be transitioned from developmental centers to community placements in FY 2015, representing nine percent of the total developmental center census at the start of the fiscal year.

About $7.4 million of the federal funds allocated to Olmstead Residential Services represents Hurricane Sandy-related disaster recovery funds from the federal Community Development Block Grant. These funds will support the new construction of group homes for community-based placements.

This line item reflects only the total costs associated with new Olmstead placements, as indicated by footnote (b) on page D-202. Thus, the increase of $11.7 million relative to the FY 2014 adjusted appropriation represents a year-to-year increase in the amount of funding appropriated to new Olmstead placements only. (In future fiscal years, the ongoing funding for these new placements will be reallocated to the applicable DDD Grants-In-Aid accounts reflecting the actual services received.)

| | | | | | |
|---|---|---|---|---|---|
| **GRANTS-IN-AID** | | | | | |
| **Emergency Placements** | | | | | |
| **TOTAL** | **$30,572** | **$34,595** | **$ 4,023** | **13.2%** | **D-201** |
| **General Fund** | **$23,398** | **$25,066** | **$ 1,668** | **7.1%** | |
| **Federal Funds** | **$7,174** | **$9,529** | **$ 2,355** | **32.8%** | |

The Governor's FY 2015 Budget recommends $34.6 million (gross) for Emergency Placements. Emergency Placements are short-term placements provided to individuals with developmental disabilities who are at risk of homelessness or in imminent peril. Information is not provided as to the number of persons assisted by this program or the average cost of such placements.

## Significant Changes/New Programs ($000) (Cont'd)

| Budget Item | Adj. Approp. FY 2014 | Recomm. FY 2015 | Dollar Change | Percent Change | Budget Page |
|---|---|---|---|---|---|

This line item reflects only the total costs associated with new placements, as indicated by footnote (b) on page D-202. Thus, the increase of $4.0 million relative to the FY 2014 adjusted appropriation represents a year-to-year increase in the amount of funding appropriated to new placements only. (In future fiscal years, the ongoing funding for these new placements will be reallocated to the applicable DDD Grants-In-Aid accounts reflecting the actual services received.)

| | | | | | |
|---|---|---|---|---|---|
| **GRANTS-IN-AID** | | | | | |
| **Purchase of Adult Activity Services** | | | | | |
| **GRAND TOTAL** | **$211,528** | **$229,201** | **$17,673** | **8.4%** | |
| **Purchase of Adult Activity Services** | **$204,154** | **$221,827** | **$17,673** | **8.7%** | **D-201** |
| **General Fund** | **$137,666** | **$145,431** | **$ 7,765** | **5.6%** | |
| **Federal Funds** | **$66,488** | **$76,396** | **$ 9,908** | **14.9%** | |
| **Purchase of Adult Activity Services (CRF)** | **$7,374** | **$7,374** | **$0** | **—** | **D-201** |

The Governor's FY 2014 Budget recommends an increase of $17.7 million for Adult Activity Services, to $229.2 million (gross). Adult activity services provide community-based day services to adults with developmental disabilities, supporting the development of each person's personal, social, and work skills.

The recommended increase in General Fund appropriations of $7.8 million incorporates the following changes:

- An increase of $6.2 million related to new community placements.
- A reduction of $5.5 million in funding for sheltered workshops, shifted to the Vocational Rehabilitative Services line item in the Department of Labor and Workforce Development, displayed on page D-231. As noted in footnote (c) on page D-202, this shift is recommended to implement a plan that is to be submitted to the Joint Budget Oversight Committee. This plan is required pursuant to appropriations language added by the Legislature to the FY 2014 Appropriations Act.
- A reduction of $3.6 million related to the elimination of certain unspecified contracts, which the Executive has indicated are duplicative of other services.
- An additional increase of $10.7 million, for which the Executive has not provided a specific explanation. This most likely represents the annualized costs for services to individuals who received community placements in FY 2014, as those costs were allocated to different line items in the FY 2014 Appropriations Act.

## Significant Changes/New Programs ($000) (Cont'd)

| Budget Item | Adj. Approp. FY 2014 | Recomm. FY 2015 | Dollar Change | Percent Change | Budget Page |
|---|---|---|---|---|---|
| **GRANTS-IN-AID** | | | | | |
| **Day Program Age Outs** | | | | | |
| **TOTAL** | **$2,359** | **$4,328** | **$ 1,969** | **83.5%** | **D-201** |
| **General Fund** | **$2,188** | **$3,475** | **$ 1,287** | **58.8%** | |
| **Federal Funds** | **$171** | **$853** | **$ 682** | **398.8%** | |

The Governor's FY 2015 Budget recommends $4.3 million (gross) for Day Program Age Outs. These services assist young adults with developmental disabilities with transitioning from special education services in their local school districts to adult day programs.

This line item reflects only the total costs associated with new placements, as indicated by footnote (b) on page D-202. Thus, the increase of $2.0 million relative to the FY 2014 adjusted appropriation represents a year-to-year increase in the amount of funding appropriated to new adult day program placements only. (In future fiscal years, the ongoing funding for these new placements will be reallocated to the applicable DDD Grants-In-aid Accounts reflecting the actual services received.)

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|---|---|---|---|---|---|
| **GRANTS-IN-AID** | | | | | |
| **Self Directed Services** | | | | | |
| **TOTAL** | **$57,007** | **$75,826** | **$18,819** | **33.0%** | **D-201** |
| **General Fund** | **$30,176** | **$47,220** | **$17,044** | **56.5%** | |
| **Federal Funds** | **$26,831** | **$28,606** | **$ 1,775** | **6.6%** | |

The Governor's FY 2015 Budget recommends an increase of $18.8 million for Self Directed Services, to $75.8 million (gross). Self Directed Services provide DDD clients with budgets to obtain community-based day services from providers of their choice. Self-directing clients exercise greater control over the services they receive, how they receive them, and who provides them. Self-directing clients and their families also accept certain additional responsibilities for managing the services.

According to evaluation data on page D-199, the number of persons receiving services is expected to increase by 300, from 2,454 to 2,754. The same data indicate that average per-capita costs are expected to increase by nearly 16 percent, to $28,105, though no explanation for this increase has been made available.

## Significant Changes/New Programs ($000) (Cont'd)

| Budget Item | Adj. Approp. FY 2014 | Recomm. FY 2015 | Dollar Change | Percent Change | Budget Page |
|---|---|---|---|---|---|
| **DIVISION OF FAMILY DEVELOPMENT (DFD)** | | | | | |
| *(Note: The Governor's Budget displays the Division of Family Development's budget line items in a gross budget format, indicating the aggregated total of State, Federal, and Other Funds. Below, the OLS disaggregates each line item into its various components, as applicable.)* | | | | | |
| **DIRECT STATE SERVICES** | | | | | |
| **Income Maintenance Management TOTAL** | **$188,354** | **$187,522** | **($ 832)** | **(0.4%)** | **D-208** |
| **General Fund** | **$40,217** | **$43,051** | **$ 2,834** | **7.0%** | **D-208** |
| **Federal Funds** | **$148,137** | **$144,471** | **($3,666)** | **( 2.5%)** | **D-208** |
| **Personal Services TOTAL** | **$24,292** | **$27,122** | **$ 2,830** | **11.6%** | **D-208** |
| **Materials and Supplies TOTAL** | **$2,878** | **$297** | **($2,581)** | **( 89.7%)** | **D-208** |
| **Services Other Than Personal TOTAL** | **$33,863** | **$44,496** | **$10,633** | **31.4%** | **D-208** |
| **Maintenance and Fixed Charges TOTAL** | **$3,639** | **$343** | **($3,296)** | **( 90.6%)** | **D-208** |
| **Electronic Benefit Transfer/Distribution System TOTAL** | **$6,136** | **$6,198** | **$ 62** | **1.0%** | **D-208** |
| **Work First New Jersey – Technology Investment TOTAL** | **$115,154** | **$108,986** | **($6,168)** | **( 5.4%)** | **D-208** |
| **Additions, Improvements, and Equipment TOTAL** | **$2,392** | **$80** | **($2,312)** | **( 96.7%)** | **D-208** |

Overall Direct States Services funding for the division (budgeted in the Income Maintenance Management program classification) is recommended to decrease by $0.8 million from the FY 2014 adjusted appropriation, to $187.5 million (gross) in FY 2015.

The following recommended increases and decreases account for the overall change:

- Reallocations of certain federal "public welfare administration" funds involving a total of $8.2 million shifted out of Materials and Supplies, Maintenance and Fixed Charges, and Additions, Improvements, and Equipment and into Personal Services ($2.9 million) and Services Other Than Personal ($5.3 million).

  Informal information from the department suggests that the reallocations are intended to facilitate fund accounting and presentation. These "public welfare administration" funds support State administrative costs associated with various DHS programs, including: Work First New Jersey/Temporary Assistance for Needy Families

## Significant Changes/New Programs ($000) (Cont'd)

| Budget Item | Adj. Approp. FY 2014 | Recomm. FY 2015 | Dollar Change | Percent Change | Budget Page |
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(WFNJ/TANF); the Supplemental Nutrition Assistance Program (SNAP); Medicaid; the Refugee Resettlement Program; Child Support Enforcement; and Work First New Jersey Child Care.

- A net decrease of $6.2 million (gross) for Work First New Jersey – Technology Investment, described in more detail below.

- An increase of $5.3 million in federal Child Support Incentive funding in Services Other Than Personal.

- Various other minor, offsetting increases and decreases involving Personal Services and the Electronic Benefit Transfer/Distribution System not exceeding $0.2 million.

| | | | | | |
|---|---|---|---|---|---|
| **DIRECT STATE SERVICES** | | | | | |
| **Work First New Jersey – Technology Investment** | | | | | |
| **TOTAL** | **$115,154** | **$108,986** | **($6,168)** | **( 5.4%)** | **D-208** |
| **General Fund** | **$21,265** | **$23,958** | **$ 2,693** | **12.7%** | |
| **Federal** | **$93,889** | **$85,028** | **($8,861)** | **( 9.4%)** | |

The Governor's FY 2015 Budget recommends a net decrease of $6.2 million for Work First New Jersey – Technology Investment, to $109.0 million (gross). State funds increase by $2.7 million, offset by a decrease of $8.9 million in federal funds.

This appropriation supports various technology projects related to DFD programs as well as programs in other DHS divisions (i.e., Medicaid). The following recommended FY 2015 increases and decreases account for the overall change:

- A State increase of $2.7 million, which available information indicates is intended for technology expenditures deferred from FY 2014 to FY 2015, associated with delays in the implementation of various DFD technology projects and a corresponding FY 2014 lapse of $2.7 million.

- An anticipated decrease of $8.9 million in federal funds, based on a projection of reduced information technology expenditures associated with those funds in FY 2015.

Available information indicates that the major FY 2015 technology projects funded by the Work First New Jersey – Technology Investment appropriation will include development and enhancement of the following systems:

- Consolidated Assistance Support System (CASS): This new system will allow county welfare agencies to manage client information and determine eligibility for a number of

## Significant Changes/New Programs ($000) (Cont'd)

| Budget Item | Adj. Approp. FY 2014 | Recomm. FY 2015 | Dollar Change | Percent Change | Budget Page |
|---|---|---|---|---|---|

programs in DFD and other DHS divisions, including: General Assistance, Temporary Assistance for Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP), child care assistance, Medicaid, and NJ FamilyCare.

- Document Imaging Management System (DIMS): This new system will allow county welfare agencies to electronically image, store and retrieve verifications and other documents for various DHS programs. DIMS will be linked to CASS.

- New Jersey Kids Deserve Support (NJKiDS): This is the State's existing automated child support case management system.

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|---|---|---|---|---|---|
| **GRANTS-IN-AID** | | | | | |
| **Work First New Jersey Child Care** | | | | | |
| **TOTAL** | **$294,809** | **$317,371** | **$22,562** | **7.7%** | **D-209** |
| **General Fund** | **$86,458** | **$100,958** | **$14,500** | **16.8%** | |
| **Federal** | **$173,351** | **$181,413** | **$ 8,062** | **4.7%** | |
| **Other Funds** | **$35,000** | **$35,000** | **0** | **—** | |

The Governor's FY 2015 Budget recommends an increase of approximately $22.6 million for Work First New Jersey Child Care, to $317.4 million (gross). Within this overall change, State funds increase by $14.5 million and federal funds increase by $8.1 million.

This appropriation supports subsidized child care benefits for several categories of low-income families and for children receiving protective services through the Department of Children and Families (DCF).

Although an increase in State and federal funds is recommended for FY 2015, the Executive currently projects that $14.5 million will lapse from the program in FY 2014. According to informal information available from the department, the FY 2014 lapse is due to lower than expected program utilization in the current fiscal year; however, utilization is expected to increase in FY 2015.

Evaluation data on page D-207 of the Governor's FY 2015 Budget estimate gross FY 2015 expenditures of $257.5 million for Work First New Jersey Child Care, which are $9.6 million (3.9 percent) above the revised FY 2014 estimate of $247.9 million, and $23.8 million (10.2 percent) above the originally estimated FY 2014 gross expenditures of $233.6 million from page D-214 of the Governor's FY 2014 Budget. (The OLS notes that expenditures reported by the applicable evaluation data exclude certain administrative and service costs associated with this program, accounting for differences between the evaluation data on page D-207 and the total expenditures and appropriations budgeted for the program displayed on page D-209.)

## Significant Changes/New Programs ($000) (Cont'd)

| Budget Item | Adj. Approp. FY 2014 | Recomm. FY 2015 | Dollar Change | Percent Change | Budget Page |
|---|---|---|---|---|---|

It is further noted that the evaluation data estimate an average of 49,735 children receiving child care assistance per month in FY 2015, which is 3.4 percent above the revised FY 2014 estimate of 48,098 children but 6.3 percent below the original FY 2014 estimate of 53,078 children from page D-214 of the Governor's FY 2014 Budget. Available information does not reconcile the apparent discrepancy between a 6.3 percent decrease in caseload and a 10.2 increase in expenditures (described above) when comparing the original FY 2014 estimates and the FY 2015 recommended amounts.

Finally, it is noted that the original FY 2014 estimate suggested average annual per-child costs of $4,402 (for 53,078 children supported by $233.6 million in expenditures). The revised FY 2014 estimate suggests average per-child costs of $5,154 (for 48,098 children supported by $247.9 million in expenditures), while the FY 2015 estimate suggests per-child costs of $5,177 (for 49,735 children supported by $257.5 million in expenditures). It is unknown whether these apparent increases in per-child costs partially account for the simultaneous decrease in caseload and increase in expenditures.

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|---|---|---|---|---|---|
| **GRANTS-IN-AID** | | | | | |
| **Wage Supplement Program** | **$2,069** | **$2,280** | **$ 211** | **10.2%** | **D-209** |

The Governor's FY 2015 Budget recommends an increase of $0.2 million for the Wage Supplement Program, to $2.3 million (federal). Informal information from the department attributes the increase to higher projected expenditures, based on program caseload trends.

This appropriation supports a program for Work First New Jersey Temporary Assistance for Needy Families (WFNJ/TANF) recipients who voluntarily close their TANF cases and receive a monthly supplemental work support payment to help offset the cost of their working. By closing their cases, these individuals are able to maintain employment and not draw from their 60-month lifetime limit on receipt of TANF cash assistance benefits.

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| **STATE AID** | | | | | |
| **County Administration Funding TOTAL** | **$294,728** | **$315,101** | **$20,373** | **6.9%** | **D-209** |
| **General Fund** | **$11,197** | **$11,197** | **0** | **—** | |
| **Federal** | **$283,531** | **$303,904** | **$20,373** | **7.2%** | |

The Governor's FY 2015 Budget recommends an increase of $20.4 million for County Administration Funding, to $315.1 million (gross). A $20.4 million increase in federal funds entirely accounts for this change.

This appropriation reimburses counties for the costs of administering various DHS programs, including: Work First New Jersey/Temporary Assistance for Needy Families (WFNJ/TANF); the

## Significant Changes/New Programs ($000) (Cont'd)

| Budget Item | Adj. Approp. FY 2014 | Recomm. FY 2015 | Dollar Change | Percent Change | Budget Page |
|---|---|---|---|---|---|

Supplemental Nutrition Assistance Program (SNAP); Medicaid and NJ FamilyCare; the Refugee Resettlement Program; and Child Support Enforcement.

The anticipated $20.4 million increase in federal funds is due to:

- $8.0 million for Medicaid county administrative activities, reflecting the anticipation of enhanced, 75 percent federal Medicaid reimbursement for costs of Medicaid eligibility determinations processed through the new Consolidated Assistance Support System (CASS). Currently, eligibility determination costs receive 50 percent federal Medicaid reimbursement, but federal policy allows for 75 percent reimbursement for the ongoing maintenance and operations of new or improved Medicaid eligibility determination systems (once operational) upon the systems' compliance with certain federal standards and conditions. Informal information from the department indicates that certain Medicaid eligibility determination activities are anticipated to receive this enhanced federal reimbursement once CASS becomes operational, which is scheduled for FY 2015;

- $10.0 million for SNAP administrative costs, resulting from increased SNAP caseloads that require the processing of additional SNAP applications and the rendering of additional eligibility determinations; and

- $2.4 million for a projected increase in WFNJ/TANF county administrative costs.

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|---|---|---|---|---|---|
| **STATE AID** | | | | | |
| **Work First New Jersey – Emergency Assistance** | | | | | |
| **TOTAL** | **$109,131** | **$116,505** | **$ 7,374** | **6.8%** | **D-209** |
| **Federal** | **$103,989** | **$111,363** | **$ 7,374** | **7.1%** | |
| **Other Funds** | **$5,142** | **$5,142** | **0** | **—** | |

The Governor's FY 2015 Budget recommends an increase of $7.4 million for Work First New Jersey (WFNJ) Emergency Assistance, to $7.4 million (gross). A $7.4 million increase in federal funds entirely accounts for this change. Informal information from the department attributes the recommended increase to projected increases in program caseloads and expenditures.

WFNJ Emergency Assistance provides certain emergency benefits to very low-income parents and children through the Work First New Jersey program, including: essential food, clothing, shelter and household furnishings; temporary rental assistance or back rent or mortgage payments; utility payments (such as heat, water, electric); transportation to search for housing; and moving expenses.

Evaluation data on page D-207 of the Governor's FY 2015 Budget estimate 21,390 average monthly recipients in FY 2015, which is 6.3 percent above the revised FY 2014 estimate of

## Significant Changes/New Programs ($000) (Cont'd)

| Budget Item | Adj. Approp. FY 2014 | Recomm. FY 2015 | Dollar Change | Percent Change | Budget Page |
|---|---|---|---|---|---|

20,113 recipients and 4.6 percent above the original FY 2014 estimate of 20,446 recipients from page D-214 of the Governor's FY 2014 Budget.

It is also noted that the evaluation data estimate State FY 2015 expenditures of $116.5 million on WFNJ Emergency Assistance, which are $7.4 million (6.8 percent) above the revised FY 2014 estimate of $109.1 million, and $5.5 million (4.8 percent) above the originally estimated FY 2014 State expenditures of $111.2 million from page D-214 of the Governor's FY 2014 Budget.

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| **STATE AID** | | | | | |
| **General Assistance Emergency Assistance Program TOTAL** | **$66,558** | **$54,722** | **($11,836)** | **( 17.8%)** | **D-209** |
| **General Fund** | **$64,800** | **$52,964** | **($11,836)** | **( 18.3%)** | |
| **Other Funds** | **$1,758** | **$1,758** | **0** | **—** | |

The Governor's FY 2015 Budget recommends a decrease of nearly $11.8 million (State) for the General Assistance Emergency Assistance Program, to $54.7 million (gross). Informal information from the department attributes the recommended decrease to projected decreases in program caseloads and expenditures.

General Assistance Emergency Assistance provides certain emergency benefits to very low-income single adults and couples without dependent children through the Work First New Jersey program, including: essential food, clothing, shelter and household furnishings; temporary rental assistance or back rent or mortgage payments; utility payments (such as heat, water, electric); transportation to search for housing; and moving expenses.

Evaluation data on page D-206 of the Governor's FY 2015 Budget estimate 4,813 average monthly recipients in FY 2015, which is 10.0 percent below the revised FY 2014 estimate of 5,346 recipients and 17.7 percent below the original FY 2014 estimate of 5,848 recipients from page D-213 of the Governor's FY 2014 Budget.

It is also noted that the evaluation data estimate FY 2015 State expenditures of $54.7 million for General Assistance Emergency Assistance, which are $5.9 million (9.8 percent) below the revised FY 2014 estimate of $60.7 million, and $11.8 million (17.7 percent) below the originally estimated FY 2014 State expenditures of $66.6 million from page D-213 of the Governor's FY 2014 Budget.

## Significant Changes/New Programs ($000) (Cont'd)

| Budget Item | Adj. Approp. FY 2014 | Recomm. FY 2015 | Dollar Change | Percent Change | Budget Page |
|---|---|---|---|---|---|
| **STATE AID** | | | | | |
| **Payments for Cost of General Assistance** | **$65,247** | **$50,334** | **($14,913)** | **( 22.9%)** | **D-209** |

The Governor's FY 2015 Budget recommends a decrease of nearly $14.9 million for Payments for Cost of General Assistance, to $50.3 million (State). Informal information from the department attributes the recommended decrease to projected reductions in program caseloads and expenditures.

General Assistance (GA) provides cash assistance to very low-income single adults and couples without dependent children through the Work First New Jersey program.

Evaluation data on page D-206 of the Governor's FY 2015 Budget estimate 31,296 average monthly recipients (totaling employable and unemployable GA recipients) in FY 2015, which is 9.1 percent below the revised FY 2014 estimate of 34,442 recipients and 18.6 percent below the original FY 2014 estimate of 38,464 recipients (from page D-213 of the Governor's FY 2014 Budget).

It is also noted that the evaluation data estimate FY 2015 State expenditures of $50.3 million on General Assistance payments (again, totaling employable and unemployable GA recipients), which are $5.9 million (10.5 percent) below the revised FY 2014 estimate of $56.3 million, and $14.9 million (22.9 percent) below the originally estimated FY 2014 State expenditures of $65.2 million from page D-213 of the Governor's FY 2014 Budget.

In response to previous OLS Discussion Points, the department has highlighted several factors that have contributed to the ongoing decreases in GA cash assistance caseloads:

- FY 2012: Implementation of a requirement that new GA applicants engage in an employment-related activity, such as a job search, for four consecutive weeks prior to receiving assistance or, if failing to complete that activity, be rendered ineligible for assistance for 30 days (the "30-day protocol") and other changes to GA eligibility criteria.

- FY 2013: Appropriations language prohibiting the General Assistance 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.

- Ongoing: Implementation and expansion of GA compliance teams assigned to selected county welfare agencies to review and monitor GA cases. Compliance Teams recommend cases for closure or denial when client information does not support eligibility for GA benefits.

## Significant Changes/New Programs ($000) (Cont'd)

| Budget Item | Adj. Approp. FY 2014 | Recomm. FY 2015 | Dollar Change | Percent Change | Budget Page |
|---|---|---|---|---|---|
| **STATE AID** | | | | | |
| **General Assistance County Administration** | | | | | |
| **GRAND TOTAL** | **$42,678** | **$47,678** | **$ 5,000** | **11.7%** | |
| **General Assistance County Administration** | | | | | |
| **TOTAL** | **$42,678** | **$20,000** | **($22,678)** | **( 53.1%)** | **D-209** |
| **General Fund** | **$27,678** | **$0** | **($27,678)** | **( 100.0%)** | |
| **Federal** | **$15,000** | **$20,000** | **$ 5,000** | **33.3%** | |
| **General Assistance County Administration (PTRF)** | **$0** | **$27,678** | **$27,678** | **—** | **D-209** |

The Governor's FY 2015 Budget recommends a net increase of $5.0 million for General Assistance County Administration, to $47.7 million (gross). Entirely accounting for this increase is $5.0 million in additional federal funds. Overall State funding remains flat at $27.7 million, but the source of State funding is shifted from the General Fund to the Property Tax Relief Fund (PTRF).

This appropriation reimburses counties for the costs of administering the General Assistance (GA) program, including certain Medicaid administrative costs associated with General Assistance recipients previously receiving limited Medicaid benefits under the Childless Adults Medicaid waiver. (Effective January 1, 2014, these individuals became included in the category of newly eligible NJ FamilyCare Adults under the ACA Medicaid expansion.)

The $5.0 million increase in federal funds reflects the anticipation of an enhanced, 75 percent federal reimbursement for Medicaid eligibility determinations that will be processed through the new Consolidated Assistance Support System (CASS), scheduled to begin operating in FY 2015. This enhanced federal reimbursement is identical to the enhanced federal reimbursement anticipated for County Administration Funding.

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| **STATE AID** | | | | | |
| **Fair Labor Standards Act – Minimum Wage Requirements (TANF)** | **$604** | **$468** | **($ 136)** | **( 22.5%)** | **D-210** |

The Governor's FY 2015 Budget recommends a decrease of $136,000 for the Fair Labor Standards Act – Minimum Wage Requirements (TANF) appropriation, to $468,000 (federal). Informal information from the department attributes the decrease to lower projected expenditures, based on projected program caseload trends.

# Significant Language Changes

## DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES (DMHAS)

### Capital Construction for Addiction Services Providers

Revision

2014 Handbook: p. B-84
2015 Budget: p. D-171

Notwithstanding the provisions of any law or regulation to the contrary, monies in the "Alcohol Treatment Programs Fund" established pursuant to section 2 of P.L.2001, c.48 (C.26:2B-9.2), not to exceed $12,500,000, ~~and the amounts hereinabove appropriated for Community Based Substance Abuse Treatment and Prevention - State Share, not to exceed $2,200,000~~, are ~~hereby~~ appropriated, as determined by the Assistant Commissioner or designee of the Department of Human Services, subject to the approval of the Director of the Division of Budget and Accounting, for grants to providers of addiction services for capital construction projects selected and approved by the Assistant Commissioner of the Division of Mental Health and Addiction Services provided that: (1) such grants are made only after the Division of Property Management and Construction (DPMC) has reviewed and approved the proposed capital projects for validity of estimated costs and scope of the project; (2) the capital projects selected by the Assistant Commissioner of the Division of Mental Health and Addiction Services shall be based upon the need to retain existing capacity, complete the construction of previously funded projects which are currently under contract and necessary for the delivery of addiction services, or to relocate existing facilities to new sites; (3) the capital projects may consist of new construction and/or renovation to maintain and increase capacity at existing sites or at new sites; (4) the grant agreement entered into between the Assistant Commissioner of the Division of Mental Health and Addiction Services and the Grantee, or the governmental entity, as the case may be, described below, shall follow all applicable grant procedures which shall include, in addition to all other provisions, requirements for oversight by DPMC; (5) receipt of grant monies pursuant to this appropriation shall not obligate or require the Division of Mental Health and Addiction Services to provide any additional funding to the provider of addiction services to operate their existing facilities or the facility being funded through the construction grant; and (6) instead of the grant being made to the eligible provider for the approved capital project, the grant may be made to a governmental entity to undertake the approved capital project on behalf of the provider of addiction services. ~~Prior to the end of calendar year 2013 and again prior to the end of the fiscal year, the Commissioner of Human Services shall notify the Joint Budget Oversight Committee of each grant awarded, the amount of each grant, and the recipients of the grants.~~

**Explanation**

The Governor's FY 2014 Budget Recommendation eliminates language that had previously authorized up to $2.2 million from the "Community Based Substance Abuse Treatment and Prevention - State Share" line item to be used for capital construction projects for addiction services providers. Under the revised language, $12.5 million from the "Alcohol Treatment Programs Fund" would continue to be available for this purpose.

EXPLANATION: FY 2014 language not recommended for FY 2015 denoted by strikethrough.
Recommended FY 2015 language that did not appear in FY 2014 denoted by underlining.

## Significant Language Changes (Cont'd)

This language provision first appeared in the FY 2009 Appropriations Act, and included the requirement that the Joint Budget Oversight Committee (JBOC) be notified of each grant award, the amount of the grant, and the recipient of the grant. The recommended language would delete the requirement for the Commissioner of Human Services to provide such notifications to JBOC. Thus far, the department has not submitted the report due by December 31, 2013 to JBOC.

**Transfer Authority among DMHAS Grants-in-Aid Accounts**

Revision

2014 Handbook: p. B-85
2015 Budget: p. D-172

In order to permit flexibility in the handling of appropriations and assure timely payment to service providers, funds may be transferred within the Grants-In-Aid accounts within the Division of Mental Health and Addiction Services, in a cumulative amount not to exceed ~~$2,000,000~~ $4,000,000, subject to the approval of the Director of the Division of Budget and Accounting.

**Explanation**

This proposed revision would permit the Executive to transfer a cumulative total of $4 million among the Grants-in-Aid accounts in the Division of Mental Health and Addiction Services without obtaining the approval of the Legislative Budget and Finance Officer. No information has been provided to explain why a greater volume of transfers may be necessary in FY 2015.

**Involuntary Outpatient Commitment Program**

Revision

2014 Handbook: p. B-85
2015 Budget: p. D-172

The unexpended balance at the end of the preceding fiscal year in the Community Care account, not to exceed $2,400,000, is appropriated for the Involuntary Outpatient Commitment Program. ~~Not later than December 31, 2013, the Commissioner shall provide to the Joint Budget Oversight Committee a plan for the Statewide implementation of the program by June 30, 2014. Such additional sum as is required to achieve implementation of the plan is appropriated, subject to the approval of the Director of the Division of Budget and Accounting.~~

**Explanation**

The Governor's FY 2015 Budget recommends eliminating language that would require the Commissioner of Human Services to submit a plan to the Joint Budget Oversight Committee for the Statewide implementation of the Involuntary Outpatient Commitment (IOC) program, and would appropriate such additional sums necessary to implement the plan. The commissioner

EXPLANATION: FY 2014 language not recommended for FY 2015 denoted by strikethrough.
Recommended FY 2015 language that did not appear in FY 2014 denoted by underlining.

## Significant Language Changes (Cont'd)

has not submitted a plan submitted as of April 2014, and the program is operational in only six counties.

Notwithstanding this recommended language change, the Executive has indicated that it expects the program to be operational in all 21 counties during FY 2015. The Governor recommends a total of $5.75 million for the program in FY 2015, $3.75 million more than is expected to be spent in FY 2014. The FY 2015 recommendation includes an additional $1.35 million to support Statewide implementation of IOC. A related language provision on page D-172 would appropriate the unexpended FY 2014 balance of the Community Care account, not to exceed $2.4 million, for the IOC program, bringing the total resources recommended for the program in FY 2015 to $5.75 million.

**Medicaid Participation by Addiction Services Providers**

Addition

2014 Handbook: n/a
2015 Budget: p. D-172

Notwithstanding the provisions of any law or regulation to the contrary, the amounts hereinabove appropriated for Substance Abuse Treatment for DCP&P/WorkFirst Mothers, Community Based Substance Abuse Treatment and Prevention – State Share, Medication Assisted Treatment Initiative, and Mutual Agreement Parolee Rehabilitation Project for Substance Abusers are subject to the following condition: all providers of addiction services under these programs shall be required, not later than January 1, 2015, to enroll as Medicaid providers and to bill the State Medicaid program for all appropriate services provided to eligible beneficiaries who are covered under the Medicaid State Plan.

**Explanation**

The Governor's FY 2015 Budget recommends requiring that most State-funded providers of addiction services enroll as Medicaid providers and bill appropriate services to Medicaid, beginning January 1, 2015. This would allow the State to claim federal Medicaid matching funds for certain services provided to Medicaid and NJ FamilyCare recipients, which otherwise would be paid for with State funds or federal block grant funds. According to available information, approximately 60 percent of addiction services providers are already Medicaid providers, so the language may affect only a subset of providers.

Medicaid has historically provided very limited coverage of addiction services; however, the Affordable Care Act (ACA) requires that individuals who are newly eligible for Medicaid under the Act must be provided a benefits package that includes a much wider range of addiction services benefits. Benefits for these newly eligible individuals are paid for entirely with federal funds. In addition, a different proposed language provision (see "Expansion of Medicaid Alternative Benefit Plan," in the Division of Medical Assistance and Health Services, below) would authorize the Commissioner of Human Services to extend these same benefits to most Medicaid recipients who are eligible under pre-ACA rules, and claim a 50 percent federal match.

EXPLANATION: FY 2014 language not recommended for FY 2015 denoted by strikethrough.
Recommended FY 2015 language that did not appear in FY 2014 denoted by underlining.

## Significant Language Changes (Cont'd)

**Transfer of Funding to Medicaid Accounts**

Addition

2014 Handbook: n/a
2015 Budget: p. D-172

In order to permit flexibility in the handling of appropriations and ensure the timely payment of claims to providers of medical services, the amounts hereinabove appropriated may be transferred from the Substance Abuse Treatment for DCP&P/WorkFirst Mothers, Community Based Substance Abuse Treatment and Prevention – State Share, Medication Assisted Treatment Initiative, and Mutual Agreement Parolee Rehabilitation Project for Substance Abusers accounts in the Division of Mental Health and Addiction Services to the various items of appropriation within the General Medical Services program classification in the Division of Medical Assistance and Health Services, subject to the approval of the Director of the Division of Budget and Accounting. Notice thereof shall be provided to the Legislative Budget and Finance Officer on the effective date of the approved transfer.

**Explanation**

This new language would authorize the transfer of funding from various addiction services Grants-in-Aid accounts to accounts in the Division of Medical Assistance and Health Services (DMAHS) associated with the Medicaid program. Such funding transfers may be necessary to process Medicaid payments to providers of these services. As noted above, certain addiction treatment services that have historically been paid for with State funds and federal block grant funds may now be eligible for a federal Medicaid match, allowing those State funds and federal block grant funds to be used for other purposes.

EXPLANATION: FY 2014 language not recommended for FY 2015 denoted by strikethrough.
Recommended FY 2015 language that did not appear in FY 2014 denoted by underlining.

## Significant Language Changes (Cont'd)

### DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES (DMAHS)

**Transition to Managed Long-Term Care**

Deletion

2014 Handbook: p. B-90
2015 Budget: n/a

~~The appropriations hereinabove for Personal Services are conditioned upon the Department of Human Services working with stakeholders affected by the move to managed care for long term care on an ongoing basis to develop policies and implementation plans for enrollee transition, access to and continuity of care, assessment, appeals, competitive bidding, quality, and monitoring.~~

**Explanation**

The Governor's Budget Recommendation excludes a language provision added by the Legislature to the FY 2014 Appropriations Act that requires the Department of Human Services to work with stakeholders affected by the shift to managed long-term care to develop policies and implementation plans related to the transition.

The Executive has not provided any specific explanation for its recommendation to eliminate this language; however, it is likely that the Executive feels that the language is redundant with requirements in the Comprehensive Medicaid Waiver, which authorizes the transition of long-term care services to managed care and provides for very similar requirements.

**Medicaid Enrollment of County Inmates**

Deletion

2014 Handbook: p. B-90
2015 Budget: n/a

~~The amounts hereinabove appropriated for Personal Services are conditioned upon the Department of Human Services working collaboratively with the various county corrections agencies to promote the proper enrollment in the Medicaid program of all eligible inmates requiring medical services. The department shall provide guidance to the county corrections agencies on this subject and, upon request, shall provide such additional assistance as may be necessary to support the counties in ensuring that all eligible Medicaid reimbursements are properly claimed consistent with federal law.~~

**Explanation**

The Governor's FY 2015 Budget recommends eliminating a language provision that was added to the FY 2014 Appropriations Act by a Legislative budget resolution that requires the Department of Human Services to work with the county corrections agencies to help enroll eligible inmates in Medicaid. Enrolling inmates in Medicaid would allow the State to claim

EXPLANATION: FY 2014 language not recommended for FY 2015 denoted by strikethrough.
Recommended FY 2015 language that did not appear in FY 2014 denoted by underlining.

## Significant Language Changes (Cont'd)

federal matching funds for eligible expenditures; in the case of county inmates, the State would presumably return those federal reimbursements back to the counties. With the exception of inpatient services exceeding 24 hours provided in medical institutions (e.g., hospitals), federal law precludes Medicaid coverage for inmates.

It is noted that the Hudson County Board of Freeholders has recently authorized a lawsuit against the State seeking reimbursement retroactively for the cost of long-term hospital care for inmates.

**Reporting to Legislature on Managed Care Provider Contracts**

Deletion

2014 Handbook: p. B-90
2015 Budget: n/a

~~The amounts hereinabove appropriated for Personal Services are conditioned upon the department providing to the Presiding Officers of the Legislature with notification, on an ongoing basis, as new managed care provider contracts are approved by the department. Additionally, the department shall provide the Presiding Officers of the Legislature with a written report, on or before April 1, 2014, listing all managed care provider contracts approved during the fiscal year.~~

**Explanation**

The Governor's Budget Recommendation does not include this language, added to the FY 2014 Appropriations Act by a Legislative budget resolution, requiring the department to notify the Presiding Officers of the Legislature of new managed care provider contracts. The Office of Legislative Services is not aware if the department has been making the required reports.

**MLTSS Steering Committee Report**

Deletion

2014 Handbook: p. B-90
2015 Budget: n/a

~~The appropriations hereinabove for Personal Services are conditioned upon following: promptly upon its completion, the department shall provide the Presiding Officers of the Legislature with the final report of the Managed Long Term Services and Supports Steering Committee and also shall provide those Officers with any supplements or updates to that report or any other similar report in a timely manner.~~

**Explanation**

This language provision requiring the department to report to the Presiding Officers of the Legislature on the Managed Long Term Services and Supports Steering Committee, added by the Legislature to the FY 2014 Appropriations Act, is not included in the Governor's Budget

EXPLANATION: FY 2014 language not recommended for FY 2015 denoted by strikethrough.
Recommended FY 2015 language that did not appear in FY 2014 denoted by underlining.

## Significant Language Changes (Cont'd)

Recommendation. It is noted that the final report of the Managed Long Term Services and Supports (MLTSS) Steering Committee was issued in June 2012. Although the steering committee and several of its subcommittees have continued to meet since that time, the Office of Legislative Services is not aware of any formal supplements or updates to that report, or any similar reports, that have been issued.

**Presumptive Eligibility for Individuals Newly Eligible for Medicaid**

Revision

2014 Handbook: p. B-91
2015 Budget: p. D-178

In addition to the amounts hereinabove appropriated for payments to providers on behalf of medical assistance recipients, such additional amounts as may be required are appropriated from the General Fund to cover costs consequent to the establishment of presumptive eligibility for children ~~and~~, pregnant women, single adults and childless couples, and parents and caretaker relatives in the Medicaid (Title XIX) program and the NJ FamilyCare Program as defined in P.L.2005, c.156 (C.30:4J-8 et al.).

**Explanation**

Medicaid has long permitted hospitals, federally qualified health centers, and certain other qualified entities to make presumptive eligibility determinations for pregnant women, children, and individuals with certain specific medical diagnoses. These entities are authorized to screen patients based on gross income and temporarily enroll them in Medicaid or NJ FamilyCare until a final eligibility determination is made. Under the Affordable Care Act, states are permitted to expand this authority to nearly all patients, not just pregnant women and children. This proposed language revision would authorize the appropriation of funds necessary to cover the costs of extending presumptive eligibility to these new categories of individuals.

**Medicaid Payment Rate for Non-Contracted Hospitals**

Revision

2014 Handbook: p. B-91
2015 Budget: p. D-178

Notwithstanding the provisions of any law or regulation to the contrary, the amounts hereinabove appropriated in the Managed Care Initiative account are subject to the following condition: Non-contracted hospitals providing emergency services to Medicaid or NJ FamilyCare members enrolled in the managed care program shall accept as payment in full ~~95%~~ 90% of the amounts that the non-contracted hospital would receive from Medicaid for the emergency services and/or any related hospitalization if the beneficiary were enrolled in Medicaid fee-for-service.

EXPLANATION: FY 2014 language not recommended for FY 2015 denoted by strikethrough.
Recommended FY 2015 language that did not appear in FY 2014 denoted by underlining.

## Significant Language Changes (Cont'd)

**Explanation**

Under this proposed revision to appropriations language, hospitals would be required to accept 90 percent of the Medicaid fee-for-service payment for emergency services provided by the hospital to a Medicaid or NJ FamilyCare recipient who is enrolled in a managed care plan with which the hospital does not hold a contract. According to the department, this proposed language change is intended to encourage hospitals to negotiate contracts with managed care plans. Because most hospitals are already in managed care plans' networks, this language revision may have a minimal impact.

**Elimination of General Assistance Medical Services**

Deletion

2014 Handbook: p. B-92
2015 Budget: n/a

~~Notwithstanding the provisions of any law or regulation to the contrary, the amount hereinabove appropriated in the General Assistance Medical Services account shall be conditioned upon the following provisions which shall apply to the dispensing of prescription drugs through that account: (a) all Maximum Allowable Cost (MAC) drugs dispensed shall state "Brand Medically Necessary" in the prescriber's own handwriting if the prescriber determines that it is necessary to override generic substitution of drugs; and (b) each prescription order shall follow the requirements of P.L.1977, c.240 (C.24:6E-1 et seq.). The list of drugs substituted shall conform to all requirements pertaining to drug substitution and federal upper limits for MAC drugs as administered by the State Medicaid Program.~~

Revision

2014 Handbook: p. B-93
2015 Budget: p. D-179

Notwithstanding the provisions of any law or regulation to the contrary, the appropriations for the Payments for Medical Assistance Recipients - Prescription Drugs, ~~General Assistance Medical Services,~~ and NJ FamilyCare accounts shall be conditioned upon the following provision: each prescription order for protein nutritional supplements and specialized infant formulas dispensed shall be filled with the generic equivalent unless the prescription order states "Brand Medically Necessary" in the prescriber's own handwriting.

Revision

2014 Handbook: p. B-93
2015 Budget: p. D-179

Notwithstanding the provisions of any law or regulation to the contrary, of the ~~amounts~~ amount hereinabove appropriated to Payments for Medical Assistance Recipients - Prescription Drugs ~~and General Assistance Medical Services~~, no payment shall be expended for drugs used for the treatment of erectile dysfunction, select cough/cold medications as defined by the Commissioner of Human Services, or cosmetic drugs, including, but not limited to: drugs used for baldness, weight loss, and purely cosmetic skin conditions.

EXPLANATION: FY 2014 language not recommended for FY 2015 denoted by strikethrough.
Recommended FY 2015 language that did not appear in FY 2014 denoted by underlining.

## Significant Language Changes (Cont'd)

Revision

2014 Handbook: p. B-93
2015 Budget: p. D-180

Notwithstanding the provisions of any law or regulation to the contrary, and subject to the notice provisions of 42 CFR 447.205 where applicable, the ~~amounts~~ amount hereinabove appropriated for fee-for-service prescription drugs in the Payments for Medical Assistance Recipients - Prescription Drugs ~~or General Assistance Medical Services~~ account are subject to the following conditions: (1) the maximum allowable cost for legend and non-legend drugs shall be calculated based on the lowest of (i) the Estimated Acquisition Cost (EAC), defined as a drug's Wholesale Acquisition Cost less a volume discount of one (1) percent; (ii) the federal upper limit (FUL); or (iii) the State upper limit (SUL); and (iv) cost acquisition data submitted by providers of pharmaceutical services for single-source or brand-name multi-source drugs where an alternative pricing benchmark is not available; (2) pharmacy reimbursement for legend and non-legend drugs shall be calculated based on the (i) the lowest of the EAC, FUL or SUL plus a dispensing fee of $3.73 to $3.99; or a provider's usual and customary charge; or (ii) the lower of cost acquisition data submitted by providers of pharmaceutical services for single- source or brand-name multi-source drugs, where an alternative pricing benchmark is not available, plus a professional fee; or a provider's usual and customary charge. To effectuate the calculation of SUL rates and/or the calculation of single-source and brand-name multi-source legend and non-legend drug costs where an alternative pricing benchmark is not available, which is intended to be budget neutral, the Department of Human Services shall mandate ongoing submission of current drug acquisition data by providers of pharmaceutical services. No funds hereinabove appropriated shall be paid to any entity that fails to submit required data.

Deletion

2014 Handbook: p. B-93
2015 Budget: n/a

~~In accordance with the "Family Health Care Coverage Act," P.L.2005, c.156 (C.30:4J-8 et al.), rebates collected during the current fiscal year from the pharmaceutical manufacturing companies for prescription expenditures made to providers on behalf of General Assistance Medical Services clients are appropriated to NJ FamilyCare - Affordable and Accessible Health Coverage Benefits.~~

**Explanation**

The Governor's Budget Recommendation omits several references to the General Assistance Medical Services line item that were included in the FY 2014 Appropriations Act, because that line item is eliminated in the FY 2015 Budget. Beginning January 1, 2014, General Assistance recipients have been eligible for full Medicaid benefits as a result of the Medicaid expansion under the Affordable Care Act, obviating the need for a separate program.

EXPLANATION: FY 2014 language not recommended for FY 2015 denoted by strikethrough.
Recommended FY 2015 language that did not appear in FY 2014 denoted by underlining.

## Significant Language Changes (Cont'd)

**Restriction of Managed Care Provider Agreements**

Revision

2014 Handbook: p. B-95
2015 Budget: p. D-181

Notwithstanding the provisions of any law or regulation to the contrary, the amounts hereinabove appropriated for the Managed Care Initiative are subject to the following condition: the Director of the Division of Medical Assistance and Health Services may restrict the number of provider agreements with managed care entities ~~under the State plan, in accordance with 42 U.S.C. s.1396u-2(a)(1)(A)(ii)~~, if such restriction does not substantially impair access to services.

**Explanation**

This proposed language revision is not expected to have any significant impact, as the cited section of federal law is virtually identical to the remaining part of the language provision.

**Medicaid Reimbursement for Outpatient Hospital Psychiatric Services**

Revision

2014 Handbook: p. B-96
2015 Budget: p. D-182

Notwithstanding the provisions of any law or regulation to the contrary, amounts appropriated to Payments for Medical Assistance Recipients - Outpatient Hospital for outpatient hospital reimbursement for all billable psychiatric services provided as an outpatient hospital service to all eligible individuals regardless of age, shall be paid at the lower of charges or the prospective hourly rates as defined in chapter 52 of Title 10 of the New Jersey Administrative Code, with the following exceptions and conditions which are effective for dates of service on or after January 1, 2009 with dates of payment on or after July 1, 2013: (1) individual outpatient hospital psychiatric therapy for individuals age 21 and older, excluding partial hospitalization, shall be billed on a unit basis of 30 minutes, with a daily billing limit of two units per recipient per day and a 30 minute unit rate of $50.00; (2) outpatient hospital initial evaluative psychiatric testing for individuals age 21 and older, excluding partial hospitalization, shall be billed on a unit basis of 30 minutes with a daily billing limit of four units per recipient per day and a 30 minute unit rate of $62.50; (3) outpatient hospital psychiatric medication monitoring and medication management for individuals age 21 and older, excluding partial hospitalization, shall be billed on a unit basis of 15 minutes with a daily billing limit of two units per recipient per day and a 15 minute unit rate of $42.00. ~~In addition, a one-time prospective payment shall be made by the Division of Medical Assistance and Health Services to hospitals for billable psychiatric services provided as an outpatient hospital service. This one-time prospective payment amount shall be defined as the unit volume for services (1) through (3) above for individuals age 21 and older that were provided from January 1, 2009 through June 30, 2013, and paid through July 1, 2013, multiplied by the following amounts per unit: individual outpatient hospital psychiatric therapy for individuals age 21 and older, excluding partial hospitalization, $10.00; outpatient hospital initial evaluative psychiatric testing for~~

EXPLANATION: FY 2014 language not recommended for FY 2015 denoted by strikethrough.
Recommended FY 2015 language that did not appear in FY 2014 denoted by underlining.

## Significant Language Changes (Cont'd)

~~individuals age 21 and older, excluding partial hospitalization, $12.50; and outpatient hospital psychiatric medication monitoring and medication management for individuals age 21 and older, excluding partial hospitalization, $8.00.~~ Costs related to outpatient hospital psychiatric services shall be excluded from outpatient hospital cost settlements.

**Explanation**

The FY 2014 Appropriation Act provided for an increase in Medicaid fee-for-service payment rates for outpatient psychiatric services provided by hospitals above the rates established pursuant to N.J.A.C.10:52-4.3, and a one-time retroactive payment to hospitals for services provided between January 1, 2009 and June 30, 2013. The FY 2015 Proposed Budget would continue the rate increase through FY 2015, while eliminating the language that provided for the retroactive payment.

**Expansion of Medicaid Alternative Benefit Plan**

Addition

2014 Handbook: n/a
2015 Budget: p. D-182

Notwithstanding the provisions of any law or regulation to the contrary, the amounts hereinabove appropriated in the General Medical Services program classification are subject to the following condition: effective January 1, 2015, the Commissioner of Human Services is authorized to provide any or all types and levels of services that are provided through the Medicaid State Plan's Alternative Benefit Plan to any or all of the types of qualified applicants described in C.30:4D-3i (1), (2), (4), (6), (7), (9), (10), (11), (12), (13), (16a), (17), (18), and (19), subject to the approval of the Director of the Division of Budget and Accounting and subject to any required federal approval.

**Explanation**

In order to implement the Medicaid expansion under the Affordable Care Act (ACA), the State was required to establish an Alternative Benefit Package for the newly eligible enrollees in order to comply with the ACA's requirement that this population receive coverage for the ten Essential Health Benefits specified by the ACA. The Alternative Benefit Package includes coverage for a range of mental health and substance abuse services, in addition to all Medicaid State Plan benefits except for long-term care services. This proposed language would authorize the Commissioner of Human Services to make these additional benefits available to most other Medicaid populations, effective January 1, 2015, subject to federal approval.

It is noted that some of these services are currently provided at State expense through the Division of Mental Health and Addiction Services, so expanding Medicaid coverage may allow some State expenditures to be offset with federal funds. However, Medicaid benefits function as an open-ended entitlement, so the State would lose some of its ability to control costs related to these services. According to informal information provided by the department, its intent is that the expansion of the Alternative Benefit Plan be budget-neutral.

EXPLANATION: FY 2014 language not recommended for FY 2015 denoted by strikethrough.
Recommended FY 2015 language that did not appear in FY 2014 denoted by underlining.

## Significant Language Changes (Cont'd)

**Medicaid Eligibility Criteria for Medically Needy**

Addition

2014 Handbook: n/a
2015 Budget: p. D-182

Notwithstanding the provisions of C.30:4D-3i(8), C.30:4D-6g(3), (4), and (5), or any other law or regulation to the contrary, the amounts hereinabove appropriated in the General Medical Services program classification are subject to the following conditions: in order to encourage home and community services as an alternative to nursing home placement, consistent with the federally approved 1115 Medicaid demonstration waiver and any approved amendments thereto, the Commissioner of Human Services is authorized to adjust financial eligibility and other requirements and services for medically needy eligibility groups, subject to the approval of the Director of the Division of Budget and Accounting and subject to any other required federal approval.

**Explanation**

This proposed language would authorize the Commissioner of Human Services to adjust eligibility and other requirements for medically needy Medicaid eligibility groups, subject to federal approval. The medically needy program allows certain individuals with high medical expenses but whose incomes are too high to qualify for regular Medicaid benefits to obtain partial Medicaid coverage.

According to informal information provided by the department, this proposed language is primarily intended to allow the department to encourage individuals who are eligible to receive long-term care to remain in the community, rather than entering nursing homes. Medicaid long-term care benefits are subject to an asset test for eligibility, and individuals who are in need of long-term care but fail the asset test must spend down their assets to become eligible for Medicaid coverage. The department has indicated that, in order to spend down their assets and become eligible for Medicaid more quickly, some individuals may enter a nursing home when they would prefer to receive services at home and in the community. It has not yet been determined what specific changes, if any, will be made, but the department has indicated that the purpose would be to encourage people to remain in the community whenever possible.

**Role of County Welfare Agencies in Medicaid Eligibility Determination**

Addition

2014 Handbook: n/a
2015 Budget: D-182

Notwithstanding the provisions of any law or regulation to the contrary, the amounts hereinabove appropriated for Eligibility Determination Services and Health Benefit Coordination Services are subject to the following condition: the Commissioner of Human Services is authorized to implement a pilot program, effective on or after January 1, 2015, to

EXPLANATION: FY 2014 language not recommended for FY 2015 denoted by strikethrough.
Recommended FY 2015 language that did not appear in FY 2014 denoted by underlining.

## Significant Language Changes (Cont'd)

remove the Medicaid/NJ FamilyCare eligibility determination and redetermination process from one or more county welfare agencies, as determined by the Commissioner of Human Services, subject to any required federal approval.

**Explanation**

The 21 county welfare agencies are currently responsible for determining whether applicants are eligible for Medicaid or NJ FamilyCare, and for redetermining recipients' eligibility each year. This proposed language would authorize the Commissioner of Human Services to remove this function from one or more county welfare agencies on a pilot basis, subject to federal approval. This authority would likely be used to transfer some responsibility away from those county welfare agencies that have faced challenges with rendering timely eligibility determinations. No information has been provided with regard to which counties would be affected, or what entity would take over the responsibility.

EXPLANATION: FY 2014 language not recommended for FY 2015 denoted by strikethrough.
Recommended FY 2015 language that did not appear in FY 2014 denoted by underlining.

## Significant Language Changes (Cont'd)

### DIVISION OF AGING SERVICES (DoAS)

**Medicaid Reimbursement of Nursing Facility Services**

Revision

2014 Handbook: p. B-99
2015 Budget: p. D-188

Notwithstanding the provisions of ~~chapter~~ N.J.A.C. 8:85 ~~of Title 8 of the New Jersey Administrative Code~~ or any other law or ~~other~~ regulation to the contrary and subject to any required federal approval, the amounts hereinabove appropriated for Payments for Medical Assistance Recipients – Nursing Homes ~~and Global Budget for Long Term Care shall be conditioned upon the following: (1) the per diem rate for each nursing home shall not be less than the per diem rate last received by that facility for Fiscal Year 2013; (2) the per diem reimbursement rate for Special Care Nursing Facilities shall be adjusted on January 1, 2014 such that an additional $325,000 shall be allocated to Special Care Nursing Facilities during the fiscal year; and (3)~~ are subject to the following conditions: (1) no nursing facility that is being paid on a fee-for-service basis shall receive a per diem reimbursement rate adjustment and each shall receive the same per diem reimbursement rate received on June 30, 2014; (2) nursing facilities that are being paid by a Managed Care Organization (MCO) for custodial care through a provider contract that includes a negotiated rate shall receive that negotiated rate; (3) any Class I (private) or Class III (special care) nursing facility that is being paid by an MCO for custodial care through a provider contract but has not yet negotiated a rate shall receive the same per diem reimbursement rate as it received on June 30, 2014, and any Class II (county) nursing facility that is being paid by an MCO but has not yet negotiated a rate shall receive the per diem reimbursement rate it would have received on June 30, 2014, had it been a Class I nursing facility; and (4) monies designated pursuant to subsection c. of section 6 of P.L.2003, c.105 (C.26:2H-97), for distribution to nursing ~~homes~~ facilities, less the portion of those funds to be paid as pass-through payments in accordance with paragraph 1 of subsection d. of section 6 of P.L.2003, c.105 (C.26:2H-97) shall be combined with amounts hereinabove appropriated for Payments for Medical Assistance Recipients – Nursing Homes ~~and Global Budget for Long Term Care~~ for the purpose of calculating Medicaid ~~reimbursement to~~ reimbursements for nursing facilities ~~according to the rate setting methodology established in Chapter 85 of Title 8 of the New Jersey Administrative Code~~. For the purposes of this paragraph, a nursing facility's per diem reimbursement rate or negotiated rate shall not include, if the nursing facility is eligible for reimbursement, the difference between the full calculated provider tax add-on and the quality of care portion of the provider tax add-on, which difference shall be payable as an allowable cost pursuant to C.26:2H-97(d). Provided, further, that on or before September 15, 2014, the Department shall calculate and disseminate to the MCOs the amount of the add-on payable during the year starting October 1, 2014 as an allowable cost, as well as the list of nursing facilities that will receive this add-on, and the MCOs shall adjust the rates paid to nursing facilities accordingly; the add-ons calculated for FY 2014 shall be applied from July 1, 2014, through September 30, 2014 and the first add-on shall be applied to fee-for-service per diem reimbursement rates effective October 1, 2014.

EXPLANATION: FY 2014 language not recommended for FY 2015 denoted by strikethrough.
Recommended FY 2015 language that did not appear in FY 2014 denoted by underlining.

## Significant Language Changes (Cont'd)

**Explanation**

This revised language sets forth new requirements for Medicaid reimbursement of nursing facility services, in accordance with the State's anticipated implementation of the Managed Long Term Services and Supports (MLTSS) program in FY 2015. Under MLTSS, Medicaid reimbursement for nursing facility services is to be transitioned from a fee-for-service basis, where the State sets the Medicaid reimbursement rate for such services, to a managed care arrangement, where the facilities will contract with managed care organizations (MCOs) and negotiate reimbursement rates with the MCOs.

Specifically, the revised language provides that:

1. Nursing facilities receiving reimbursement for Medicaid clients on a fee-for-service basis will receive the same reimbursement rates that they were receiving as of June 30, 2014, without adjustment (effectively, such facilities will continue to receive the fee-for-service reimbursement rate as calculated for April 2014 through the State's current case mix rate-setting methodology, which will be the rate in effect at the end of FY 2014). Available information indicates that this rate will largely apply to Medicaid beneficiaries residing in nursing facilities prior to July 1, 2014, who will not be required to enroll in a managed care plan to continue receiving their nursing facility services. As noted below, this rate is also intended to serve as the "default" Medicaid nursing facility reimbursement rate in situations where nursing facilities receive reimbursement for Medicaid clients through managed care arrangements, but have not yet negotiated rates for those clients with the MCOs.

2. Nursing facilities receiving reimbursement for Medicaid clients covered under contracts negotiated with MCOs shall receive the reimbursement rates that have been negotiated under those contracts. Available information indicates that this will largely apply to new Medicaid beneficiaries (including current nursing facility residents who enroll in Medicaid after July 1, 2014), who will be required to enroll in a managed care plan to receive nursing facility services beginning in FY 2015. This provision allows the rates negotiated between nursing facilities and MCOs to be higher or lower than the "default" Medicaid nursing facility reimbursement rate (where, as noted above, the default rate is the fee-for-service rate received by a nursing facility as of June 30, 2014). Available information also indicates that the State's new contract with the Medicaid MCOs will stipulate that nursing facilities are not to receive a managed care reimbursement rate lower than the default fee-for-service rate for a period of two years, effective July 1, 2014, unless nursing facilities choose to negotiate lower rates with MCOs.

3. Class I (privately operated) or class III (special care[7]) nursing facilities receiving Medicaid reimbursement for Medicaid beneficiaries enrolled in managed care plan that have not yet negotiated a rate with that plan's MCO shall receive a "default" rate equal to the fee-for-service reimbursement rate that the facility received from the State as of June 30, 2014. As indicated above, the State's new contract with the MCOs is anticipated to include requirements that

[7] Special care nursing facilities (SCNFs) provide care to individuals requiring specialized health care services beyond the scope of conventional nursing facility services, such as services to patients with ventilator dependency, traumatic brain injury, HIV/AIDS, neurological impairment, Huntington's Disease, behavioral management needs, and other conditions.

EXPLANATION: FY 2014 language not recommended for FY 2015 denoted by strikethrough.
Recommended FY 2015 language that did not appear in FY 2014 denoted by underlining.

## Significant Language Changes (Cont'd)

nursing facilities are not to receive managed care reimbursement rates lower than the "default" fee-for-service rates (in place as of June 30, 2014) for a period of two years, effective July 1, 2014, unless nursing facilities choose to negotiate lower rates with an MCO.

4. Class II (county operated) nursing facilities receiving Medicaid reimbursement for Medicaid beneficiaries enrolled in managed care plan that have not yet negotiated a rate with that plan's MCO shall receive a "default" rate equal to the fee-for-service reimbursement rate the facility would have received from the State as of June 30, 2014 had it been a class I (privately operated) facility. It is noted that class II nursing facilities have received somewhat higher Medicaid reimbursement rates than class I facilities under the State's current rate-setting methodology (all other factors such as operational costs and resident case mix being equal) due to differences in how class I and class II rates have been calculated. Available information indicates that the revised language is intended to equalize the calculation of "default" class I and class II rates for nursing facility residents enrolling in Medicaid after July 1, 2014, but that the revised language would not apply to reimbursement for Medicaid beneficiaries residing in class II nursing facilities prior to July 1, 2014. Those beneficiaries' services will continue to receive fee-for-service reimbursement at the "enhanced" class II rates calculated under the current methodology, pursuant to the provision explained above in #1.

5. The revised language provides that monies from the State's nursing home provider assessment, which the State collects and redistributes to nursing facilities pursuant to P.L.2003, c.105 (C.26:2H-92 et seq.), shall continue to be utilized for: calculating Medicaid reimbursements for nursing facilities; and providing a "provider tax add-on" payment to offset nursing facility costs associated with paying the provider assessment. The revised language indicates that, for nursing facilities receiving Medicaid managed care reimbursement, the department will calculate the specific provider tax add-on payment to be received by each nursing facility and disseminate that calculation to MCOs by September 15, 2014, whereby the MCOs will adjust their reimbursement rates to contracted nursing facilities by the amount of the add-on payment effective October 1, 2014. The revised language also indicates that, for nursing facilities continuing to receive fee-for-service reimbursement for applicable residents, the new add-on will also be applied effective October 1, 2014. (The revised language provides that the existing FY 2014 provider tax add-on amounts are to be applied from July 1, 2014 to September 30, 2014, which appears associated with the new add-ons not being calculated until mid-September.)

**Payment of Prior Obligations for Community Based Senior Programs**
**(General Fund)**

Revision

2014 Handbook: p. B-100
2015 Budget: p. D-189

The amounts hereinabove appropriated for payments for the Pharmaceutical Assistance to the Aged and Disabled program, P.L.1975, c.194 (C.30:4D-20 et seq.), ~~and~~ the Senior Gold Prescription Discount Program, P.L.2001, c.96 (C.30:4D-43 et seq.), and Community Based Senior Programs are available for the payment of obligations applicable to prior fiscal years.

EXPLANATION: FY 2014 language not recommended for FY 2015 denoted by strikethrough.
Recommended FY 2015 language that did not appear in FY 2014 denoted by underlining.

## Significant Language Changes (Cont'd)

**Payment of Prior Obligations for Community Based Senior Programs (Casino Revenue Fund)**

Revision

2014 Handbook: p. B-102
2015 Budget: p. D-191

The amounts hereinabove appropriated for payments for the Pharmaceutical Assistance to the Aged and Disabled program, P.L.1975, c.194 (C.30:4D-20 et seq.), and Community Based Senior Programs are available for the payment of obligations applicable to prior fiscal years.

**Explanation**

The two existing language provisions, applying identically to the General Fund and the Casino Revenue Fund (CRF), allow funds appropriated for the Pharmaceutical Assistance to the Aged and Disabled program (which receives appropriations from the General Fund and the CRF) and the Senior Gold Prescription Discount Program (which receives a General Fund appropriation only) to be expended on the payment of obligations from prior fiscal years. The revised language provisions provide similar authority to expend funds appropriated for Community Based Senior Programs on the payment of obligations from prior fiscal years. Informal information from the department indicates that these revisions are intended to provide consistent authority to address potential lags between prior obligations being incurred and claims or other requests for reimbursement being submitted to the department and paid.

It is also noted that General Provision #30 (see page E-3 of the FY 2014 Appropriations Handbook) currently provides the Office of Management and Budget with general authority to approve payment of obligations applicable to prior fiscal years.

**Transfers of Funds among Medical Services for the Aged Accounts**

Revision

2014 Handbook: p. B-101
2015 Budget: p. D-190

In order to permit flexibility in implementing ElderCare Initiatives hereinabove appropriated as part of Community Based Senior Programs, and the ~~Global Budget for~~ Managed Long Term ~~Care~~ Services and Supports within the Medical Services for the Aged program classification, amounts may be transferred between Direct State Services and Grants-In-Aid accounts, subject to the approval of the Director of the Division of Budget and Accounting. Notice thereof shall be provided to the Legislative Budget and Finance Officer on the effective date of the approved transfer.

**Explanation**

This revised language updates an existing provision authorizing transfers of funds between Direct State Services and Grants-in-Aid accounts associated within Community Based Senior Programs and the Global Budget for Long Term Care appropriations. As indicated by footnote (b) on page D-187 of the Governor's FY 2015 Budget, the FY 2015 appropriations for Global

EXPLANATION: FY 2014 language not recommended for FY 2015 denoted by strikethrough.
Recommended FY 2015 language that did not appear in FY 2014 denoted by underlining.

## Significant Language Changes (Cont'd)

Budget for Long Term Care are included within the new appropriation for Managed Long Term Services and Supports. Thus, the reference to Global Budget for Long Term Care is replaced with a reference to Managed Long Term Services and Supports.

**Eligible Grantees for Alzheimer's Disease Activities**
**(General Fund and Casino Revenue Fund)**

Deletions

2014 Handbook: p. B-101; p. B-104
2015 Budget: n/a

~~Notwithstanding the provisions of section 2 of P.L.1988, c.114 (C.26:2M-10) or any other law or regulation to the contrary, the amount appropriated for Community Based Senior Programs is subject to the following condition: private for profit agencies shall be eligible grantees for funding from the Community Based Senior Programs account for Alzheimer's Disease activities.~~

**Explanation**

Available information from the department indicates that these language provisions are recommended for deletion because private for-profit agencies are currently eligible grantees for funding for Alzheimer's Disease activities authorized pursuant to P.L.1988, c.114 (C.26:2M-9 et seq.).

It is noted that P.L.1999, c.285 amended section 2 of P.L.1988, c.114 (C.26:2M-10) to define "grantee" as a "public agency, private for profit agency, or private nonprofit agency selected by the department to establish an adult day care program for participants pursuant to this act."

Further, N.J.A.C.8:92-1.4, applying to the Adult Day Services Program for Persons with Alzheimer's Disease or Related Disorders authorized pursuant to P.L.1988, c.114, currently defines "agency" to mean an adult day services program, "either public or private, nonprofit or proprietary," which contracts for the provision of services under the program.

**FY 2014 Requirements for Managed Care Reimbursement**
**of Medicaid Nursing Facility Services**

Deletion

2014 Handbook: p. B-102
2015 Budget: n/a

~~Notwithstanding the provisions of any law or regulation to the contrary, the amount hereinabove appropriated for Payments for Medical Assistance Recipients - Nursing Homes and Global Budget for Long Term Care is subject to the following conditions: if nursing facility or assisted living residence reimbursement is shifted to managed long term care during fiscal year 2014 under the Medicaid Comprehensive Waiver, the managed care organizations for the State shall maintain, at a minimum, the reimbursement rates last calculated pursuant to chapter 85 of Title 8 of the New Jersey Administrative Code, in the case of nursing homes or in the case of assisted living, the rates listed at the "Procedure~~

EXPLANATION: FY 2014 language not recommended for FY 2015 denoted by strikethrough.
Recommended FY 2015 language that did not appear in FY 2014 denoted by underlining.

## Significant Language Changes (Cont'd)

~~Master Listing - Medicaid Fee for Service" rates for assisted living, effective in fiscal year 2014, through the end of fiscal year 2014. Provided, further, any nursing home or assisted living facility willing to accept the contract terms of a managed care organization participating in the Medicaid managed long term care program shall be recognized as a participating provider of services within that managed care organization's Medicaid provider network through the end of fiscal year 2014.~~

**Explanation**

This recommended deletion removes language requiring: that in the event that nursing facility services or assisted living services were transitioned to managed long-term care in FY 2014, those services would receive the reimbursement rate last determined by the State through the end of FY 2014; and that Medicaid managed care organizations (MCO) would be required to accept into their provider networks any nursing facility or assisted facility willing to accept the MCOs' contract terms (as described below, this is sometimes referred to as an "any willing provider" policy).

The implementation of managed long term care in FY 2015 through the Managed Long Term Services and Supports (MLTSS) program, coupled with proposed language revisions on page D-188 of the Governor's FY 2015 Budget (which set forth FY 2015 requirements for Medicaid reimbursement of nursing facility services, as described above), appear to partially obviate this language provision.

The proposed language revisions on page D-188 establish conditions under which nursing facilities could: continue to receive their FY 2014 fee-for-service rates in FY 2015; or receive managed care reimbursement at higher or lower rates negotiated with Medicaid MCOs. As noted above, the State's new contract with the Medicaid MCOs is expected to stipulate that nursing facilities are not to receive a managed care reimbursement rate lower than their "default" fee-for-service rates for a period of two years, effective July 1, 2014, unless nursing facilities choose to negotiate lower rates with MCOs.

Moreover, available information indicates that the State's new contract with the Medicaid MCOs will include a two-year period of "any willing provider" and "any willing plan" policies during the roll-out of MLTSS implementation, beginning July 1, 2014. Although the specific terms of these requirements are not yet known, "any willing provider" policies generally prevent managed care organizations from excluding from their networks "any willing provider"; that is, any nursing facility that is willing to meet the terms of a managed care contract and is willing to accept the MCO rate of reimbursement. An "any willing plan" policy might place similar requirements on nursing facilities to accept Medicaid clients enrolled in any managed care plan, so long as the MCO is willing to meet the provider's terms.

However, it is noted that, with the deletion of this language provision, nothing within State statutory, regulatory, or appropriations law expressly requires that the State include or maintain within its Medicaid MCO contract: the requirement that nursing facilities receive their "default" Medicaid fee-for-service rates for a period of two years if they choose not to accept MCOs'

EXPLANATION: FY 2014 language not recommended for FY 2015 denoted by strikethrough.
Recommended FY 2015 language that did not appear in FY 2014 denoted by underlining.

## Significant Language Changes (Cont'd)

negotiated rates; or the requirements regarding two-year "any willing provider" and "any willing plan" periods.

**Restriction on Payments for Bed Hold and Therapeutic Leave Days**

Revision

2014 Handbook: p. B-102
2015 Budget: p. D-190

Notwithstanding the provisions of any law or regulation to the contrary, the amounts hereinabove appropriated for Payments for Medical Assistance Recipients - Nursing Homes and ~~Global Budget for Long Term Care~~ are subject to the following condition: nursing facilities shall not receive payments for bed hold or therapeutic leave days for Medicaid beneficiaries; provided that nursing facilities shall continue to reserve beds for Medicaid beneficiaries who are hospitalized or on therapeutic leave as required by N.J.A.C. 8:85-1.14.

**Explanation**

This revised language updates an existing provision that: restricts nursing facilities from receiving Medicaid reimbursements for bed hold or therapeutic leave days; and cites the regulatory requirements at N.J.A.C. 8:85-1.14 for nursing facilities to continue to reserve beds for Medicaid beneficiaries who are hospitalized or on therapeutic leave.

As indicated by footnote (b) on page D-187 of the Governor's FY 2015 Budget, the FY 2015 appropriations for Global Budget for Long Term Care are included within the new appropriation for Managed Long Term Services and Supports. Thus, the reference to Global Budget for Long Term Care is deleted. It is noted that, although the revised language does not refer to the new appropriation for Managed Long Term Services and Supports (MLTSS), the bed reservation requirements of N.J.A.C. 8:85-1.14 would continue to apply to Medicaid nursing facility services delivered and reimbursed through managed care arrangements under MLTSS.

EXPLANATION: FY 2014 language not recommended for FY 2015 denoted by strikethrough.
Recommended FY 2015 language that did not appear in FY 2014 denoted by underlining.

## Significant Language Changes (Cont'd)

**Use of Funds Appropriated for Home Care Expansion Program (Casino Revenue Fund)**

Deletion

2014 Handbook: p. B-102
2015 Budget: n/a

~~Notwithstanding the provisions of P.L.1988, c.92 (C.30:4E-5 et seq.) or any law or regulation to the contrary, funds appropriated for the Home Care Expansion Program (HCEP) shall be paid only for individuals enrolled in the program as of June 30, 1996 who are not eligible for the Global Budget for Long Term Care or alternative programs, and only for so long as those individuals require services covered by the HCEP.~~

**Explanation**

According to information provided by the Office of Management and Budget, this language deletion is recommended because all Home Care Expansion Program enrollees have been transferred to other programs or are no longer receiving State services.

The Home Care Expansion (HCEP) program, pursuant to the "Home Care Expansion Act," P.L.1988, c.92 (C.30:4E-5 et seq.) is authorized to provide home health care, medical day care, non-emergency medical transportation, case management, social adult day care, homemaker care and respite care to certain low-income individuals who are: age 65 or older; eligible for Medicare coverage; and ineligible for Medicaid coverage or unable to access Medicaid services comparable to HCEP services due to local unavailability.

It is noted that HCEP was one of several aging-related grant programs that were consolidated into the single Community Based Senior Programs (CBSP) line item in the FY 2011 Appropriations Act. It is also noted that, according to the New Jersey State Strategic Plan on Aging for 2013-2017, the department is planning to formally consolidate several State-funded programs (Home Care Expansion, Alzheimer's Adult Day Services, Jersey Assistance to Community Caregiving, Supplemental Home Delivered Meals, Statewide Respite Care Program for the Elderly, and Safe Housing and Transportation) into a single Community Based Senior Programs (CBSP) program, with "a comprehensive planning and implementation process with stakeholder participation" to be initiated in fall 2014.

According to the Strategic Plan, the goals associated with CBSP consolidation include the standardizing of the programs' service packages, clinical and financial criteria, and sliding scale fees, as well as general shift from provider-based contracts to a consumer-directed model. The Strategic Plan states that "during the planning and implementation phases, all programs consolidated into the CBSP budget line item will continue to operate as currently mandated."

EXPLANATION: FY 2014 language not recommended for FY 2015 denoted by strikethrough.
Recommended FY 2015 language that did not appear in FY 2014 denoted by underlining.

## Significant Language Changes (Cont'd)

**Charge to Casino Simulcasting Fund**
**(Casino Revenue Fund)**

Revision

2014 Handbook: p. B-104
2015 Budget: p. D-192

Notwithstanding the provisions of any law or regulation to the contrary, of the amount hereinabove appropriated for the Community Based Senior Programs (CRF) account, ~~$350,000~~ $300,000 shall be charged to the Casino Simulcasting Fund.

**Explanation**

This language revision decreases the amount of Casino Revenue Funds appropriated for Community Based Senior Programs that may be charged to the Casino Simulcasting Fund. This change aligns the amount to be appropriated with the revenues expected to be available in the Casino Simulcasting Fund in FY 2015, according to Schedule 1 of the Governor's FY 2015 Budget (page C-9). This revision does not affect the funding level for Community Based Senior Programs.

**DIVISION OF DISABILITY SERVICES (DDS)**

**Transfers of Funds between Waiver Initiatives and Related Accounts**

Revision

2014 Handbook: p. B-105
2015 Budget: p. D-194

In order to permit flexibility in the handling of appropriations and ensure the timely payment of claims to providers of medical services, amounts may be transferred to and from Payments for Medical Assistance Recipients - Adult Mental Health Residential and Payments for Medical Assistance Recipients - Other Services accounts within the General Medical Services program classification in the Division of Medical Assistance and Health Services and the Payments for Medical Assistance Recipients - Personal Care, the Payments for Medical Assistance Recipients - Waiver Initiatives, and the Payments for Medical Assistance Recipients - Other Services accounts in the Division of Disability Services in the Department of Human Services. Amounts may also be transferred to and from various items of appropriations within the General Medical Services program classification of the Division of Medical Assistance and Health Services in the Department of Human Services and the Medical Services for the Aged program classification in the Division of Aging Services in the Department of Human Services. All such transfers are subject to the approval of the Director of the Division of Budget and Accounting. Notice thereof shall be provided to the Legislative Budget and Finance Officer on the effective date of the approved transfer.

EXPLANATION: FY 2014 language not recommended for FY 2015 denoted by strikethrough.
Recommended FY 2015 language that did not appear in FY 2014 denoted by underlining.

## Significant Language Changes (Cont'd)

**Explanation**

This revised language would allow the transfer of funds between Payments for Medical Assistance Recipients - Waiver Initiatives appropriation and applicable accounts within the Division of Disability Services, the Division of Medical Assistance and Health Services (the State's Medicaid agency), and the Division of Aging Services.

It is noted that these divisions provide certain Medicaid-reimbursable services that may require flexible transfer of funds across programs. Further, in accordance with the expected FY 2015 implementation of the Managed Long Term Services and Supports program (MLTSS), the Governor's FY 2015 Budget recommends the transfer of a large portion of the Payments for Medical Assistance Recipients - Waiver Initiatives appropriation to the Managed Long Term Services and Supports appropriation within the Medical Services for the Aged program classification in the Division of Aging Services, corresponding to the incorporation of certain Medicaid home- and community-based services previously supported by the Waiver Initiatives appropriation into MLTSS. The revised language would allow for additional transfers of such funds, as necessary to implement MLTSS.

The language would permit transfers of funds to occur without further legislative action but with notice provided to the Legislative Budget and Finance Officer.

**DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)**

**Federal and Dedicated Revenues for DDD**

Revision

2014 Handbook: p. B-110
2015 Budget: p. D-197

The State appropriation for the State's developmental centers is based on ICF/MR revenues of ~~$337,326,000~~ $300,195,000, provided that if the ICF/MR revenues exceed ~~$337,326,000~~ $300,195,000, an amount equal to the excess ICF/MR revenues may be deducted from the State appropriation for the developmental centers, subject to the approval of the Director of the Division of Budget and Accounting.

Revision

2014 Handbook: p. B-107
2015 Budget: p. D-202

Notwithstanding the provisions of any law or regulation to the contrary, ~~$422,076,000~~ $456,921,000 of federal Community Care Waiver funds is appropriated for community-based programs in the Division of Developmental Disabilities. The appropriation of federal Community Care Waiver funds above this amount is conditional upon the approval of a plan submitted by the Department of Human Services that must be approved by the Director of the Division of Budget and Accounting.

EXPLANATION: FY 2014 language not recommended for FY 2015 denoted by strikethrough.
Recommended FY 2015 language that did not appear in FY 2014 denoted by underlining.

## Significant Language Changes (Cont'd)

Revision

2014 Handbook: p. B-107
2015 Budget: p. D-202

Cost recoveries from consumers with developmental disabilities collected during the current fiscal year, not to exceed ~~$59,352,000~~ $63,372,000, are appropriated for the continued operation of the Division of Developmental Disabilities community-based residential programs, subject to the approval of the Director of the Division of Budget and Accounting.

**Explanation**

The division anticipates a rebalancing of federal and dedicated revenues that it receives, primarily related to the closures of two developmental centers in FY 2015 and the transition of 166 individuals from developmental centers to community placements.

Federal ICF/MR revenues that the State expects to realize for services provided to clients at State developmental centers will decrease by $37.1 million in FY 2015, to $300.2 million. Federal Community Care Waiver revenues are expected to increase by $34.8 million in FY 2015, to $456.9 million. Client copayments are expected to increase by $4.0 million, to $63.4 million.

**DIVISION OF FAMILY DEVELOPMENT (DFD)**

**Work First New Jersey Quarterly Reports**

Deletion

2014 Handbook: p. B-113
2015 Budget: n/a

~~The amounts hereinabove appropriated for the Income Maintenance Management program classification are subject to the following condition: the Commissioner of Human Services shall provide the Director of the Division of Budget and Accounting, the Senate Budget and Appropriations Committee, and the Assembly Appropriations Committee, or the successor committees thereto, with quarterly reports, due within 60 days after the end of each quarter, containing written statistical and financial information on the Work First New Jersey program and any subsequent welfare reform program the State may undertake.~~

**Explanation**

This language deletion would remove a requirement that the Commissioner of Human Services provide quarterly reports, containing statistical and financial information on the Work First New Jersey (WFNJ) program and any subsequent welfare reform program, to the Office of Management and Budget, the Senate Budget and Appropriations Committee, and the Assembly Appropriations Committee. This requirement has been included in annual appropriations acts since FY 2000.

EXPLANATION: FY 2014 language not recommended for FY 2015 denoted by strikethrough.
Recommended FY 2015 language that did not appear in FY 2014 denoted by underlining.

## Significant Language Changes (Cont'd)

Informal information from the department indicates that this language provision is recommended for deletion because the required reporting activities are duplicative of other reporting activities that the department currently conducts.

It is noted that, pursuant to P.L.1997, c.13 (C.44:10-41) the Commissioner of Human Services is required to issue a public report, on at least a quarterly basis, concerning: the number of recipients in the Work First New Jersey program; the number of recipients classified as exempt from time limits or deferred from work requirements; the number of recipients classified as to the degree of employability; the number of recipients who have obtained employment; the number of recipients terminated from the program and the reasons for the terminations; the average wages and benefits earned by recipients; the types of employment obtained by recipients and whether the employment is in the public or private sector; the average length of stay in their jobs by recipients who reapply for benefits; and the number of former recipients who have re-entered the program after being terminated.

The Legislature has routinely received such reports, entitled "Work First New Jersey Quarterly Progress Update," over the last several years, with the most recent report (for the quarter ending September 2013) received in March 2014. It is also noted that P.L.1997, c.13 does not explicitly require the reporting of financial data on the program and, thus, does not entirely obviate the language that is recommended for deletion. The "Work First New Jersey Quarterly Progress Update" reports received have included financial data (e.g., program expenditures), but without the language recommended for deletion, such reporting would be at the discretion of the Executive.

**Work First New Jersey Supplemental Living Support Payments**

Deletion

2014 Handbook: p. B-114
2015 Budget: n/a

~~Notwithstanding the provisions of any law or regulation to the contrary, no funds hereinabove appropriated for Work First New Jersey - Client Benefits shall be expended for supplemental living support payments.~~

**Explanation**

This language provision is recommended for deletion because the Supplemental Living Support program was eliminated effective November 2012, with the repeal of N.J.A.C.10:90-5.14.

The Supplemental Living Support Program provided an additional $ 150.00 per month to Work First New Jersey Temporary Assistance for Needy Families (WFNJ/TANF) and General Assistance (WFNJ/GA) recipients who were exempt, due to unemployability, from the 60-month lifetime limit on receipt of WFNJ benefits. At the time of elimination, the department indicated that "due to program funding cuts, the Department is no longer able to maintain the Supplemental Living Support Program."

EXPLANATION: FY 2014 language not recommended for FY 2015 denoted by strikethrough.
Recommended FY 2015 language that did not appear in FY 2014 denoted by underlining.

## Significant Language Changes (Cont'd)

### DEPARTMENTAL LANGUAGE

**Transfer of Sheltered Workshop Services to Department of Labor and Workforce Development**

Deletion

2014 Handbook: p. B-117
2015 Budget: n/a

~~The expenditure of funds hereinabove appropriated shall be conditioned upon the following: 1) there shall be no reduction in the availability of extended employment services (also referred to as sheltered workshop services) or related ancillary services, including, but not limited to, transportation services, for any current or future clients with developmental disabilities who meet the eligibility criteria for such services that were in place as of July 1, 2012 and who choose to avail themselves of such services; 2) the funds available to support such services from the amounts hereinabove appropriated for the Purchase of Adult Activity Services shall not be reduced below the amounts allocated in fiscal year 2013, and such additional amounts as may be necessary are appropriated to support growth in the overall number of clients receiving such services, subject to the approval of the Director of the Division of Budget and Accounting, 3) there shall be no additional cost sharing imposed on clients for such services beyond any cost sharing requirements in effect as of July 1, 2012; by January 1, 2014, the Commissioner of Human Services and the Commissioner of Labor and Workforce Development shall jointly develop, and submit for the review and approval of the Joint Budget Oversight Committee, a plan for the transition of such extended employment services and related ancillary services to the Department of Labor and Workforce Development, which plan shall ensure the continued availability of such services to current and future clients who choose to avail themselves of such services at the same level of services and under the same client eligibility and cost requirements; and, except in accordance with the plan jointly developed by the Commissioner of Human Services and the Commissioner of Labor and Workforce Development and approved by the Joint Budget Oversight Committee, such services, and the funds allocated for those services, shall not be transferred to any other department.~~

### Explanation

This language, added at the behest of the Legislature to the FY 2014 Appropriations Act, requires the Commissioners of Human Services and Labor and Workforce Development to jointly develop a plan for the transition of sheltered workshop services for DDD clients to the Division of Vocational and Rehabilitative Services, to be submitted to the Joint Budget Oversight Committee (JBOC). The language was added in reaction to information circulated by DDD around the time of FY 2014 budget hearings suggesting that DDD sheltered workshop programs would be eliminated. As of April 2014, the plan has not been received by JBOC; however, the Governor's FY 2015 Budget indicates in footnote (c) on page D-202 that a plan has been submitted and is to be executed in FY 2015. The Governor's FY 2015 Budget recommends shifting $5.54 million from DDD to the Department of Labor and Workforce Development in connection with this plan.

EXPLANATION: FY 2014 language not recommended for FY 2015 denoted by strikethrough.
Recommended FY 2015 language that did not appear in FY 2014 denoted by underlining.

## Significant Language Changes (Cont'd)

**Medicaid Reimbursement for Adult Medical Day Care Services**

Revision

2014 Handbook: p. B-99
2015 Budget: p. D-215

Notwithstanding the provisions of any law or regulation to the contrary, the amounts hereinabove appropriated ~~for~~ from the Medical Day Care Services ~~shall be conditioned on~~ and the Managed Care Initiative accounts are subject to the following ~~provision~~ condition: no licensed facility in the adult Medical Day Care ~~Program~~ program may serve or receive reimbursement for more than 200 ~~Medicaid beneficiaries~~ participants per day~~. Furthermore, no reimbursement will be provided for any claim in excess of~~ and, for facilities with a ~~given facility's~~ licensed capacity of less than 200 as established by the Department of Health, no such facility may receive reimbursement for more participants per day than the facility's licensed capacity.

**Explanation**

This revised language would restrict adult medical day care facilities that are participating in the Medicaid program from serving or receiving reimbursement for more than 200 "participants" per day. The existing language restricts adult medical day care facilities from serving or receiving reimbursement for 200 "Medicaid beneficiaries" per day, so the revised language would include non-Medicaid clients in the calculation of the facilities' daily participant cap. This change may broaden the restriction's impact. For example, the class of individuals suggested by the term "participants" could include: Medicaid clients; certain non-Medicaid clients receiving State-funded services (e.g., participants in the Adult Day Services Program for Persons with Alzheimer's Disease or Related Disorders); and, potentially, private paying clients.

The revised language would also restrict an adult medical day care facility from receiving reimbursement for more participants per day than the number of participants that the facility is licensed to serve by the Department of Health. The revised language applies to: the Medical Day Care Services appropriation in the Division of Aging Services, which funds Medicaid adult medical day care services provided on a fee-for-service basis; and the Managed Care Initiative appropriation in the Division of Medical Assistance and Health Services, which supports Medicaid adult medical day care services provided through managed care (effective July 2011, the State shifted most adult medical day care services from fee-for-service to managed care provision.)

According to Department of Health licensing data from January 2014, only three adult medical day care facilities were licensed to serve more than 200 clients at any one time. However, some facilities serve multiple shifts of clients, so an indeterminate number of smaller facilities currently serving more than 200 clients per day through multiple shifts may be affected.

Available information suggests that the Department of Health may pursue a parallel regulatory change in the near future that redefines adult medical day care facilities' licensed capacities to reduce instances of facilities serving more than 200 clients per day in multiple shifts.

EXPLANATION: FY 2014 language not recommended for FY 2015 denoted by strikethrough.
Recommended FY 2015 language that did not appear in FY 2014 denoted by underlining.

# Background Paper: Implementation of Managed Long Term Services and Supports

Budget Pages.... D-183; D-186 to D-187; D-194

| State Funding ($000) | Adj. Approp. FY 2014 | Recommended FY 2015 |
|---|---|---|
| Managed Long Term Services and Supports (MLTSS) | $0 | $281,182 |
| Global Budget for Long Term Care | $62,656 | $0 |
| Global Budget for Long Term Care (CRF) | $37,850 | $0 |
| *Funds Shifted from Division of Disability Services*[8] | *$35,875* | *$0* |
| **STATE TOTAL** | **$136,381** | **$281,182** |

The Governor's FY 2015 Budget recommends a total of $281.2 million in State funding for the Managed Long Term Services and Supports (MLTSS) initiative. MLTSS will create a new financing and delivery system for the provision of Medicaid long term care services to eligible elderly individuals and individuals with disabilities. MLTSS will be formed by consolidating four previously separate home- and community-based services (HCBS) Medicaid waiver programs, as well as institutional services (i.e., nursing facility services) into a new program, and all of the consolidated long term care services will be shifted from fee-for-service reimbursement to a managed care financing and delivery system. Under this arrangement, the State will pay contracted managed care organizations (MCOs) a fixed, capitated rate to provide long-term care services and care management for each enrollee. In turn, the MCOs will separately negotiate contracts with the providers that directly serve Medicaid enrollees. In general, this purchasing model is intended to: improve access to care; improve coordination and quality of care; and reduce costs by minimizing inefficiencies and duplication of services and allowing more individuals to live in their communities instead of in potentially more costly institutional placements.

Full implementation of MLTSS is currently scheduled for July 1, 2014. MLTSS is authorized under the State's Comprehensive Medicaid Waiver, which received federal approval for the period from October 1, 2012 through June 30, 2017.

Evaluation data on page D-183 of the Governor's Budget project a gross annual cost of $562.4 million for MLTSS in FY 2015, including federal Medicaid matching funds. More

[8] As noted on pages 21 and 25-27 of this analysis, the Governor's FY 2015 Budget recommends shifting $35.875 million in funding at the existing FY 2014 level out of the following appropriations in the Division of Disability Services (DDS), displayed on page D-194, and into the Division of Aging Services' MLTSS appropriation in FY 2015: Payments for Medical Assistance Recipients – Personal Care, Payments for Medical Assistance Recipients – Waiver Initiatives, Payments for Medical Assistance Recipients – Waiver Initiatives (CRF), and Payments for Medical Assistance Recipients – Other Services.

The FY 2014 adjusted appropriation excludes $19.431 million in FY 2015 funding growth for services previously associated with the Payments for Medical Assistance Recipients – Personal Care and Payments for Medical Assistance Recipients – Waiver Initiatives appropriations in DDS. The Governor's FY 2015 Budget incorporates the $19.431 million in FY 2015 growth into the $281.2 million FY 2015 recommended appropriation for MLTSS. Therefore, combined with the $35.875 million in existing funding described above, a total of $55.306 million in FY 2015 funding would be shifted from DDS into the MLTSS appropriation.

# Background Paper: Implementation of Managed Long Term Services and Supports (Cont'd)

detailed information regarding the fiscal impact of MLTSS is provided on pages 20-21 and 25-27 of this analysis, and on pages 17-22 of the Department of Human Services' response to FY 2015 OLS discussion questions.

**Consolidation of Existing Medicaid Waiver Program Services into MLTSS**

Eligibility for Medicaid HCBS under the four previously separate waiver programs mentioned above was limited to the categories of enrollees served by each of the programs and to the particular subset of HCBS benefits associated with a given program (all waiver program enrollees also received coverage for the full range of "regular" Medicaid benefits). Each previous waiver program's target population and HCBS benefits are summarized below:

- *Global Options for Long Term Care Waiver,* for seniors and adults with physical disabilities, providing care management and a range of in-home, long-term supportive services including: assisted living and adult family care; attendant care; caregiver/participant training; chore service; environmental accessibility adaptations; home-based supportive care; home-delivered meal service; personal emergency response systems; respite care; special medical equipment and supplies; social adult day care; transition services and transitional care management; and transportation.

- *AIDS Community Care Alternatives Program (ACCAP) Waiver,* for persons of any age with AIDS, and children up to age 13 who are HIV positive, providing case management, private-duty nursing, medical day care, personal care assistant services, narcotic and drug abuse treatments at home, and hospice care.

- *Community Resources for People with Disabilities (CRPD) Waiver*, for individuals with disabilities of any age, providing case management and specialized services, to help maintain eligible individuals in community living in lieu of long-term placements in nursing facilities or hospital settings. Specialized services included private-duty nursing, environmental/vehicle modifications, community transitional services, and personal emergency response systems.

- *Traumatic Brain Injury (TBI) Waiver,* for TBI survivors between ages 18 and 64, providing case management, structured day programs, personal care assistants, transportation, respite care, and night supervision.

Under the Comprehensive Medicaid Waiver, services and enrollees associated with the above waiver programs will be consolidated into MLTSS, which will provide MCOs with the flexibility to provide any of the previously available HCBS benefits to any qualifying Medicaid enrollees meeting appropriate level-of-care requirements.

*Nursing facility services* will also be transitioned into managed care under the MLTSS program, where such services will also be coordinated and reimbursed by the State's Medicaid MCOs. MCOs would be able to shift MLTSS enrollees between nursing facility services and HCBS-supported community placements, depending on the most appropriate, cost-effective approach to meeting enrollees' needs.

# Background Paper: Implementation of Managed Long Term Services and Supports (Cont'd)

### Transition of Medicaid Enrollees into MLTSS

As of July 1, 2014, each enrollee who has been receiving HCBS under one of the previous Medicaid waiver programs will automatically be enrolled in MLTSS. If these enrollees continue to demonstrate a need for HCBS at the time of MLTSS implementation, they will continue to receive HCBS until the MCO completes an initial needs assessment and, if the assessment indicates that an enrollee's circumstances have changed, a more complete re-evaluation. Only following the re-evaluation would the MCO impose any reduction, suspension, denial, or termination of previously authorized services.

The approved Comprehensive Waiver requires MCOs to develop, in collaboration with the State, "NF Diversion Plans" for monitoring enrollees at risk of nursing facility placements (including short-term stays) and maximizing the extent to which they continue receiving HCBS outside of nursing facilities. MCOs are also required to develop "NF to Community Transition Plans" to transition enrollees out of nursing facilities and into HCBS-supported community settings, based on enrollees' ability and desire to return to community settings.

It is noted that Medicaid beneficiaries currently residing in nursing facilities will not be required to enroll in a managed care plan to continue receiving Medicaid nursing facility services unless their care needs change, and the facilities will continue to receive fee-for-service Medicaid reimbursement for such beneficiaries at the same per diem reimbursement rate that was received on June 30, 2014 (i.e., the fee-for-service rate last calculated through the State's current "case mix" rate-setting methodology in April 2014). Thus, for the foreseeable future, it appears that nursing facility services for these individuals will be provided outside of MLTSS.

New Medicaid beneficiaries (including current nursing facility residents who enroll in Medicaid after July 1, 2014) will be required to enroll in a managed care plan under MLTSS to receive nursing facility services. Current Medicaid beneficiaries entering a nursing facility for the first time after July 1, 2014 will also receive their nursing facility services through a managed care plan under MLTSS. Facilities will either receive a reimbursement rate that has been negotiated with an MCO for the care of such individuals (under a provider contract with the MCO) or, if a rate has not yet been negotiated with an MCO, they will receive the same per diem reimbursement rate as the facility received from the State on June 30, 2014 (i.e., the fee-for-service rate last calculated through the current rate-setting methodology in April 2014).

### MLTSS Implementation in Other States

According to a 2012 survey sponsored by the federal Centers for Medicare and Medicaid Services (CMS), at least 16 other states had implemented some form of Medicaid managed long term care by that year, and 26 states were projected to have such programs by January 2014 (including New Jersey, where implementation has been delayed, as noted below). A May 2013 report sponsored by CMS and prepared by Truven Health Analytics, *Transitioning Long Term Services and Supports Providers Into Managed Care Programs,* found that certain challenges have been common in other states implementing managed long term care, affecting providers, MCOs, enrollees, and state Medicaid agencies. Except where otherwise noted, the information below on other states' experiences is primarily derived from the May 2013 report.

## Background Paper: Implementation of Managed Long Term Services and Supports (Cont'd)

Some of the common difficulties identified in the CMS report are related to the need for providers to adapt to new business practices. Managed long term care requires providers that are accustomed to operating under a single, uniform contract with a state Medicaid agency to negotiate multiple contracts with MCOs. Furthermore, MCO contracts are often much more detailed and complex than state fee-for-service contracts, typically having been prepared by contract departments of large corporations. By contrast, the legal and contracting expertise of long-term care providers is often very limited. Compared to state fee-for-service contracts, MCO contracts may also: focus more on specific pricing of particular units of service (for example, different prices for weekday and weekend services); include more extensive operational requirements (for example, requiring that long term care services be available 24 hours a day, seven days a week, rather than during normal business hours); be more stringent with regard to providers' adherence to contract terms; and be more detailed with regard to assignment of liability. The CMS report found that, for many providers, billing practices are often much more stringent in managed care arrangements, and may vary from one MCO to another, which often results in providers devoting more resources to claims processing and having more claims denied for technical reasons, disrupting cash flow to entities that may operate with limited cash reserves.

Stakeholders have also noted that, aside from an asymmetry of legal and contracting expertise, providers may also struggle in contract negotiations with MCOs due to an asymmetry of market power. Medicaid is often the only significant payer for long-term care services, which typically are not covered by private insurance or Medicare. Providers are often in a weak negotiating position when their only potential paying customers are a small number of MCOs. By contrast, MCOs typically only need to contract with a few providers in a particular area, giving them more freedom to present their contracts as "take it or leave it" opportunities. The CMS report found that these two asymmetries raised concerns in other states about a "winnowing out" of smaller, less sophisticated providers due to a lack of business expertise unrelated to the care they provide, which may affect enrollees' access to certain smaller providers with which they feel more closely affiliated.

The CMS report found that managed care companies have also faced challenges in taking on new, unfamiliar responsibilities in managed long-term care systems. Health insurance companies are typically most familiar with the episodic, acute care side of the health care system, which differs significantly from long-term care, which is consumed on a regular basis, and often daily or continuously. The report also found that MCOs are not always prepared to develop innovative new service models that states expect of them, particularly models that are meant to be more cost-effective and patient-centered than models used in the traditional fee-for-service system. Moreover, while MCOs are generally accustomed to negotiating contracts for acute health care services with larger and more highly regulated providers, managed long term care may require MCOs to negotiate contracts with a broader range of business entities, from large national corporations to small family-operated businesses and non-profit agencies. Thus, contract terms and payment methods that are appropriate for acute care providers may not be appropriate for long-term care providers, which results in many of the problems described above for providers, but which may also make it more difficult for MCOs to maintain stable and appropriate provider networks.

Finally, the CMS report found that the amount of state technical assistance made available to long-term care providers varied, and that tight implementation schedules and

# Background Paper: Implementation of Managed Long Term Services and Supports (Cont'd)

limited resources have prevented some states from providing substantial assistance. The report suggested that state provider associations have partially filled such gaps in assistance.

**Implementation of MLTSS in New Jersey**

Although the Office of Legislative Services has incomplete information on steps that the Department of Human Services (DHS) is taking to implement MLTSS, it appears that the overall planning process has been handled slowly and deliberately – a variety of stakeholders have been engaged in planning the program, primarily through the MLTSS Steering Committee, for several years. The transition of HCBS to MLTSS was originally planned for January 1, 2014, but was delayed by six months due to concerns that the programs were not ready. (Thus, as noted above, implementation of MLTSS for all provider types is currently scheduled for July 1, 2014.) However, some aspects of preparation for implementation appear to be occurring in a more accelerated fashion, as noted below.

New Jersey already has some experience with Medicaid managed long term care, based on the transition of certain home- and community-based long term care services to managed care in July through October 2011, including adult and pediatric medical day care services, personal care assistant services, and home health services (excluding when those services are provided under a waiver program). The MCOs and the providers of these services have had several years to negotiate contracts and adapt to new contractual requirements and billing practices. Thus, to the extent that expanding MLTSS will include the same providers, the transition may not be as disruptive as in other states. This previous transition in New Jersey may have also contributed to some consolidation in the provider market – for example, according to the New Jersey Adult Day Services Association, 12 percent of adult day care providers (17 facilities) have closed since those services were transitioned to managed care.

Available information suggests that, in anticipation of the upcoming transition, some current fee-for-service providers are particularly concerned about adapting to new billing practices. For example, nursing facilities currently submit a single claim listing all residents under their care, approximately once per month. Under MLTSS, providers will instead be expected to submit a separate claim for each Medicaid beneficiary under their care. At the same time, providers are adapting to a new set of nationally standardized billing codes, which may represent a difficult transition in itself. MLTSS may also disrupt providers' cash flow because MCOs are permitted 30 days to make payments, rather than the 7-15 days typically expected for fee-for-service payments. (This 30-day window also assumes that the MCO does not reject the claim due to omitted information, errors, or other technical requirements. The 30-day requirement applies only to "clean" claims.)

The State has indicated that it will develop a standard claim form that all MCOs will be required to use for nursing facilities and presumably will do the same for other services, which may help to alleviate some additional administrative burden. In addition, each MCO is supposed to have a two-month period of provider claims testing by each provider type to identify and address any technical problems in the computer systems and familiarize providers with the systems. However, available information indicates that, in some cases, this period has been delayed from the originally planned period (March 1 to May 1). DHS plans to offer additional provider training, but most of the materials are still currently being developed (as of early May), and it appears that some of this responsibility may be shifted to the MCOs.

## Background Paper: Implementation of Managed Long Term Services and Supports (Cont'd)

To smooth the transition to MLTSS for both providers and Medicaid beneficiaries, available information indicates that DHS does not plan to require Medicaid recipients who are currently residing in nursing facilities to enroll in an MCO, and will continue to reimburse the facility according to the current fee-for-service rate. DHS also plans to provide for a two year "any willing provider" period (fiscal years 2015 and 2016) for all residential services, which would require MCOs to contract with any provider that is willing to meet the terms of their contracts, and a similar "any willing plan" requirement for providers to participate in MCO networks. During this two-year period, the rates last set by DHS in FY 2014 would serve as a "default" rate for nursing homes that have not negotiated rates with MCOs.

For individuals whose services are shifted to managed care, DHS will require MCOs to smoothly transition enrollees who are receiving services from out-of-network providers to in-network providers, though details on how this process will be enforced are not currently available. MCOs will also be required to assemble a designated team of MLTSS subject matter experts who can support enrollee and provider questions and needs, such as through provider representatives and call centers.

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**Legislative Budget and Finance Office**
**State House Annex**
**Room 140 PO Box 068**
**Trenton, NJ 08625**
**(609) 847-3105 • Fax (609) 777-2442**