

Department of Human Services
Division of Management and Budget

DEPARTMENT OF HUMAN SERVICES (GENERAL)

1. In the Governor's FY 2015 Budget, General Provision #83 (page F-10) would appear to potentially override any provision of permanent statute or regulation regarding the Medicaid and NJ FamilyCare programs, and would instead defer all authority regarding eligibility, benefits, and reimbursement to the Medicaid and Children's Health Insurance Program (CHIP) State plans and the Comprehensive Medicaid Waiver (which are responsibilities of the Department of Human Services, negotiated with the federal government), "in order to comply with Pub.L.111-148, Pub.L.111-152 or with any federal regulation adopted pursuant thereto." (These citations refer to the "Patient Protection and Affordable Care Act" and the "Health Care and Education Reconciliation Act of 2010," which are together referred to as "ACA"). The language does not provide any guidance with regard to which State plan amendments were inserted (or may be inserted) into the State plans in order to comply with the ACA, and which were inserted for other reasons. A narrow interpretation may regard the language to only apply to provisions of the ACA that are mandatory and require the State to comply with a State plan amendment; a broader reading could implicate virtually any potential State plan amendment that is generally consistent with the broad goals of the ACA. The proposed language includes no requirement that the Legislature be notified of or approve any significant change in Medicaid or NJ FamilyCare, and no requirement to follow the normal rulemaking process under the Administrative Procedure Act.

- ***Questions:*** What specific provisions were added to the Medicaid or CHIP State plans in order to comply with the ACA, as the phrase is used in this proposed language provision? What provisions of statutory or regulatory law does the Executive believe need to be overridden in order to comply with the applicable federal laws, and for what purpose? If this language were enacted, what sort of public or legislative oversight would changes to Medicaid and NJ FamilyCare be subject to? How would it be ensured that the Legislature and the public have full access to the complete, updated Medicaid and CHIP State plans and the approved Comprehensive Medicaid Waiver at all times?

Answer: Approximately 25 State Plan Amendments (SPAs) were filed with CMS to ensure compliance with the Affordable Care Act (ACA) including, but not limited to, SPAs that address: Modified Adjusted Gross Income (MAGI)-based eligibility groups, MAGI-based Income methodology, eligibility process, non-financial eligibility, hospital presumptive eligibility, Alternative Benefit Package, and provider screening and enrollment requirements. Of these 25 ACA related amendments, approximately 17 have been approved and eight are pending CMS approval. All of the numerous existing statutory and regulatory provisions throughout the authorizing legislation and regulations of the Department of Human Services, the Department of Children and Families, and the Department of Health that may conflict in any way with the provisions of the State Plan would need to be overridden in order to ensure continued receipt of maximum federal reimbursement for the services provided under those State Plan provisions. The Appropriations Act language is required to give the Department the authority to enact these provisions because the legislative and regulatory processes cannot achieve this result in an expeditious manner that would ensure this maximum future federal reimbursement.

At the beginning of the federal approval process for each SPA, public notice with opportunity for public comment was published on the Department's website and in several newspapers. The Title XIX

State Plan, Comprehensive Waiver, and all notices are available for viewing on the Department's website.

2. In response to an FY 2014 OLS Discussion Point, DHS indicated that it was reviewing the potential impacts of the sequestration of federal funds pursuant to the Budget Control Act of 2011 (Pub.L.112-25) and the American Taxpayer Relief Act of 2012 (Pub.L.112-240) by monitoring programs in areas such as substance abuse services, mental health services, senior services, services to the blind and visually impaired, and child care.

At the time, DHS indicated there were no reductions from sequestration reflected in the Governor's FY 2014 Budget Recommendation. It is noted that the Bipartisan Budget Act of 2013 (Pub.L.113-67) revised the federal sequestration caps for federal fiscal years 2014 and 2015 to allow for increased discretionary spending.

- **Questions:** Please provide an update on the impacts of federal sequestration on funding for DHS programs, as reflected in the Governor's FY 2015 Budget. What specific reductions in federal funding resulting from sequestration, if any, are reflected in the FY 2014 adjusted appropriations and the FY 2015 recommended appropriations? For each federal reduction, please indicate: the specific line item(s) or programs involved; the amount(s) of the federal reduction; and the source(s) and amount(s) of any non-federal funds applied to offset the federal reduction.

Answer: In FFY13, reductions in federal appropriations were made to accounts used for substance abuse and mental health services, senior services, services to the blind and visually impaired and child care. The department was able to avoid actual service reductions through the utilization of federal balances and by eliminating excess capacity slots. No service cuts are anticipated in FY15.

3. A "Social Services Block Grant (SSBG) Supplemental Intended Use Plan and Pre-Expenditure Report," submitted in May 2013 by the DHS to the U.S. Department of Health and Human Services, outlined the State's intended uses of certain federal SSBG disaster-relief funds in response to Super Storm Sandy.

The report outlined anticipated activities in the Departments of Human Services, Health, and Children and Families. According to the report, the Department of Human Services proposed six SSBG programs, representing the following amounts of total federal funding available through September 30, 2015:

Program Area	Cumulative Funding
Housing Assistance	\$112,434,000
Behavioral Health Services	\$8,100,000
Child Care	\$2,750,000
Services for Older Adults and People with Disabilities	\$549,692
Legal Assistance for Storm Impact Residents	\$6,500,000
Administration	\$5,542,764

The report (available here: <http://www.state.nj.us/humanservices/home/hurricane.html>) indicated that two broad categories of programs were represented: community-wide programs in "highly impacted" areas including, but not limited to, clinical counseling, service coordination, and outreach; and programs addressing uncovered costs related to the storm's damage of home or property, include household repairs, restoration of accessibility enhancements, and short-term housing subsidies for residents for whom no other financial assistance was available or where gaps existed.

- Questions:** For each of the program areas identified above, what funding amount is currently allocated to program activities in FY 2014? What FY 2014 expenditures have been made, to date, in each program area? What funding amount is currently budgeted for each program area in FY 2015? Are any State savings anticipated in FY 2014 or FY 2015 due to the availability of these SSBG funds, such as savings from SSBG-funded services temporarily reducing demand for established State services? If so, please identify the amount of savings anticipated for each year and the specific division and budget line item where those savings are represented. Has the SSBG Supplemental Intended Use Plan and Pre-Expenditure Report been revised since May 2013? If so, please provide a copy of any revised report(s).

Answer: Disaster related Social Services Block Grant (SSBG) funding was received by the State from the US Department of Health and Human Services, Administration for Children and Families (ACF) in response to Superstorm Sandy. The Department of Human Services (DHS) is the cognizant agency for regular SSBG funds as well as this disaster related allocation. Three departments, Human Services, Health and Children and Families, are utilizing the funds to support residents impacted by Sandy. The original Intended Use Plan was submitted to ACF in May 2013. After the three Departments addressed comments raised by ACF, a final Intended Use Plan was submitted to ACF in December 2013. Funds allocated to the State must be spent no later than September 30, 2015. Funds have been allocated by program and not by SFY. The chart below displays the original Intended Use Plan allocations, as designated in the final Intended Use Plan, and the current expenditures (as of February 28, 2014) in each program area.

<u>Program Area</u>	<u>Original Allocation</u>	<u>Current Allocation</u>	<u>Current Expenditures</u>
Housing Assistance	\$112,434,000	\$103,608,000	\$17,035,543
Behavioral Health Services	\$ 8,100,000	\$ 18,000,000	\$ 1,954,152
Child Care	\$ 2,750,000	\$ 2,750,000	\$ 15,572
Services for Older Adults and People with Disabilities	\$ 549,692	\$ 417,692	\$ 117,692
Legal Assistance for Storm Impacted Residents	\$ 6,500,000	\$ 6,500,000	\$ 132,698
Administration	\$ 5,542,764	\$ 12,323,948	\$ 206,500

4a. The FY 2014 Appropriations Act appropriated \$13.2 million, in Interdepartmental Accounts, for “Community Provider Contract Adjustments.” A corresponding language provision (see FY 2014 Appropriations Handbook, page B-205) specifies that funds associated with the appropriation may be transferred to departments and divisions contracting with community care providers in order to provide a one-time upward contract adjustment effective January 1, 2014 for providers in good standing with the State as of January 1, 2014. According to the language provision, “in good standing with the State” means that “the provider owes no outstanding liabilities to the contracting department or division or to the State” as determined by the Director of the Division of Budget and Accounting in consultation with the contracting department or division. The appropriations language also states that: contract adjustments shall be prorated to all such eligible providers in good standing with the State proportional to their contract base; and amounts not disbursed to providers not in good standing with the State shall be reallocated and distributed among providers in good standing, subject to the approval of the Director of the Division of Budget and Accounting.

DHS maintains contracts with a number of community-based providers, and presumably many of these providers may qualify for a one-time upward contract adjustment. However, as of March 20, 2014, the applicable Interdepartmental account did not indicate any transfers or commitments of funds from the \$13.2 million, including transfers or commitments of funds to DHS providers.

- Questions:** Does DHS expect an allocation from the \$13.2 million for contract adjustments in FY 2014? If so, how does DHS currently define its “community care providers,” in terms of the specific types of providers and DHS program classifications included within that category? What amounts from the \$13.2 million, in aggregate and disaggregated by DHS division, will be

allocated to DHS community care providers? What percentage of DHS community care providers, in aggregate and disaggregated by DHS division, will receive the contract adjustments because they were in good standing with the State as of January 1, 2014? Will any of the one-time contract adjustments for DHS community care providers be continued in FY 2015, as part of the providers' base contracts?

Answer: DHS expects an allocation from the \$13.2 million for contract adjustments in FY 2014. The Department's defined contract base includes all community care providers in good standing. For the purpose of identifying eligible providers, we are applying the budget language to NJ organizations under contract as of January 1, 2014 who deliver direct care or services to clients in the community utilizing state funds.

Once the final list of providers has been completed, an analysis of their standing as per the language will be completed, and DHS will provide the final distribution information.

4b. Previously, a Statewide, three percent community provider cost-of-living adjustment was implemented during FY 2008 and FY 2009, effective January 1, 2008. At the time, the DHS portion of that cost was estimated at \$23.0 million for the first six months of the adjustment (during the third and fourth quarters of FY 2008).

- **Questions:** What would be the estimated, annualized State cost of providing a one percent cost-of-living increase to all DHS "community care providers" (as defined above) effective July 1, 2014?

Answer: As stated above, the final distribution amount for FY14 has not yet been determined.

5. DHS has contracted with Myers & Stauffer, LC, a public accounting firm, to conduct a "rate setting study" to determine appropriate provider reimbursement rates for providers of services administered by the Division of Mental Health and Addiction Services (DMHAS) and the Division of Developmental Disabilities (DDD). The rates are intended to be used in a fee-for-service reimbursement system that would replace the current arrangements in each division, which operate according to deficit-funded and cost-reimbursement contracting models.

- **Questions:** When is the rate study expected to be complete? When will the fee-for-service system begin to be implemented?

Answer: The rate study is expected to be completed by the close of Fiscal Year 2014, with implementation by the end of Fiscal Year 2015.

DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES (DMHAS)

6. A proposed language provision on page D-172 of the Governor's FY 2015 Budget would require addiction services providers that receive funds from certain specified accounts to enroll as Medicaid providers and bill the State Medicaid program for all appropriate services. This language provision would not apply to all State-funded addiction services, or any mental health service providers. It is noted that most DMHAS providers are already Medicaid providers.

- **Questions:** Approximately how many addiction providers are expected to be affected by this language? What is the rationale for applying the language only to three specific line items, rather than all DMHAS providers?

Answer: This language will affect approximately 100 addiction providers, which represents around 44% of the total contract base. As noted above, most DMHAS providers are already Medicaid providers. It is not necessary for DMHAS providers to become Medicaid providers if they operate programs which are not eligible to receive Medicaid revenue (e.g., IMD facilities, family support services). In contrast, the contracts funded through these three specific line items are for Medicaid-reimbursable services.

7a. Under the Comprehensive Medicaid Waiver, adult behavioral health services for most Medicaid recipients are to be coordinated by a managed behavioral health organization (MBHO), which would not determine payment rates, but would be responsible for administrative functions similar to functions performed by managed care organizations, such as prior authorizations, network management, utilization management, and quality management. Currently, the State is to contract with the MBHO on a "non-risk basis," as an Administrative Services Organization (ASO). This means that, although the MBHO will have care coordination responsibilities, the State will ultimately pay for services on a fee-for-service basis, rather than paying the MBHO on a capitated basis similar to a managed care organization.

In response to an FY 2014 OLS Discussion Point, DMHAS indicated: that the RFP for the ASO/MBHO would be issued in late spring 2013 with an award in the fall of 2013; that once awarded, a readiness review would be conducted for 4-6 months per the terms of the approved Comprehensive Medicaid Waiver; and that the ASO/MBHO was anticipated to "go live" sometime after July 2014. At the January 2014 Medical Assistance and Advisory Council meeting, DMHAS indicated that the RFP was still pending. No RFP has been issued, as of March 2014.

- **Questions:** Please provide an update on the anticipated timing for implementation of an adult MBHO. What is the current timeframe for: issuing the ASO/MBHO RFP; and awarding the ASO/MBHO contract? Is the anticipated 4-6 month readiness review period following the contract award still valid? What accounts for delays in issuing the RFP? What is the expected cost of the contract?

Answer: Discussions about the RFP and the MBHO project at large are not permissible because to do so has the potential to disturb the competitive footing of the State's publicly advertising bidding process, thereby jeopardizing the MBHO project. We are advising potential bidders that Treasury has an electronic bid notification system. This is an optional email subscription service that vendors may elect to use for notification about bids concerning commodities and/or services of interest. This service – the eRFP Notification Service – is explained and available on the web at <http://www.nj.gov/treasury/purchase/erfpnotifications.shtml>. There was no adjustment needed in the FY15 budget for the implementation of an ASO/MBHO.

7b. Although the Comprehensive Waiver does not address non-Medicaid mental health and addiction services administered by DMHAS, it provides an opportunity to better integrate the Medicaid and non-Medicaid sides of the State's behavioral health system. In particular, the MBHO's role could be expanded beyond Medicaid, to provide certain administrative functions related to non-Medicaid DMHAS providers.

- **Questions:** Is the department considering expanding the MBHO's eventual role to include both Medicaid and non-Medicaid behavioral health services? On what timeframe might such an expansion occur?

Answer: See response to 7a above.

8a. A language provision in the FY 2014 Appropriations Act (Appropriations Handbook, p. B-85) requires the Commissioner of Human Services to provide to the Joint Budget Oversight Committee (JBOC), by December 31, 2013, a plan for the Statewide implementation of the involuntary outpatient commitment (IOC) program by June 30, 2014. As of March 2014, no such plan has been received. A letter to the Assembly Human Services Committee from Assistant Commissioner Kovich dated March 10, 2014, indicates that the IOC program is operational in six counties, with the remaining counties to come online during FY 2015.

- **Questions:** When will the department provide the Statewide IOC implementation plan to JBOC? What is the anticipated schedule for IOC implementation?

Answer: The plan will be submitted shortly. An RFP was recently released and the 15 outstanding counties attended the bidder's conference. Subject to the receipt of qualified bids, the Department anticipates that this program will roll out Statewide during FY 2015.

8b. Based on the six IOC contracts totaling \$2.0 million in FY 2013, the average per-county expenditure for IOC activities was about \$333,000 during that year. In response to an FY 2014 OLS Discussion Point, DHS reported that the following number of individuals had been served in each county, as of April 2013, since the program's inception:

COUNTY	INDIVIDUALS SERVED
Burlington	13
Essex	24
Hudson	1
Ocean	1 referral, but no active individuals as of April 2013 (DHS indicated that program had recently begun operating)
Union	33
Warren	8

- **Questions:** What number of individuals was served by each of the six county IOC programs in FY 2014? What was the average per-client cost, across all counties, of serving these IOC participants?

Answer: Individuals served in FY 2014 are as follows:

COUNTY	INDIVIDUALS SERVED (through December 31, 2013)
Burlington	22
Essex	43
Hudson	38
Ocean	17
Union	73

Warren	16
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It costs approximately \$300,000/county to stand up each program.

9. As of March 2014, approximately \$8.2 million of the FY 2013 appropriation for Community Care were still encumbered.

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

Answer: As of the beginning of April, the encumbrance amount is \$7.6 million. The Division is in the process of contract closeout review and will identify any lapse after determining the impact of final payments or reimbursements.

10. P.L.2013, c.27 (C.5:12-95.17 et al.) authorized Internet gaming based in Atlantic City. Section 27 of the law provides that, in addition to the permit issuance and renewal fees, a casino licensee with an Internet gaming permit shall pay annually to the Division of Gaming Enforcement \$250,000 to be deposited into the State General Fund for appropriation by the Legislature to the Department of Human Services, \$140,000 of which shall be allocated to the Council on Compulsive Gambling of New Jersey and \$110,000 of which shall be used for compulsive gambling treatment programs in the State.

Information from the State accounting system indicates that, as of March 27, 2014, \$2.0 million in FY 2014 revenues have been deposited in the “Internet Gaming Permits for Compulsive Gambling Programs” account. Of this amount, \$1.12 million is encumbered. However, Schedule 2 of the Governor’s FY 2015 Budget (page C-13) projects new revenues of \$2.25 million in FY 2015 from “Internet Gaming Permits for Compulsive Gambling Programs” but projects no such revenues in FY 2014.

- **Questions:** Please explain the apparent conflict between the accounting system and the budget recommendation with regard to FY 2014 revenues. What total revenues are expected in FY 2014? What portion of these revenues is expected to be expended on compulsive gambling programs in FY 2014, with what amount allocated to the Council on Compulsive Gambling and what amount allocated to other compulsive gambling treatment programs? Of the \$2.25 million in revenues projected for FY 2015, what amount is budgeted for the Council on Compulsive Gambling and what amount is budgeted for other compulsive gambling treatment programs?

Answer: For FY 2014, the first year of implementation, budget authority in the accounting system for internet gaming revenues is based on actual receipts, rather than projected permit applications. As of April, \$2 million has been collected for 8 permits, of which \$1.12 million is allocated to the Council on Compulsive Gambling and \$880,000 is allocated to other compulsive gambling treatment programs. If all 12 casinos in Atlantic City apply, the total collection would increase to \$3 million. Now that actual collections have been deposited, DHS will update the FY14 revenue projection as part of the federal and dedicated funds update process in May.

For FY 2015, \$1.26 million is budgeted for the Council on Compulsive Gambling and \$990,000 is budgeted for other compulsive gambling treatment programs.

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES (DMAHS)

11. On January 1, 2014, the major provisions of the federal Patient Protection and Affordable Care Act (ACA) became effective, including the State's participation in the expansion of Medicaid to adults earning up to 133 percent of the federal poverty level. (The eligibility limit is effectively 138 percent of the federal poverty level, due to a five-percent income disregard under the ACA.) State costs for medical assistance for this group are eligible for an enhanced federal matching rate, which will cover 100 percent of applicable costs in FY 2015.

Accordingly, the evaluation data on pages D-174 and D-175 of the Governor's FY 2015 Budget define a new enrollment category of "NJ FamilyCare Adult Expansion" which includes: a previously eligible General Assistance population for which the State will receive enhanced federal reimbursement; a previously eligible group of NJ FamilyCare parents up to 138 percent of the federal poverty level (FPL), which will also receive enhanced federal reimbursement; and the newly eligible group of other adults up to 138 percent FPL. This new category is to receive the Medicaid Alternative Benefit Plan package as part of the Affordable Care Act.

The evaluation data project 247,953 average monthly enrollees in the "NJ FamilyCare Adult Expansion" group for FY 2014, and 298,071 enrollees for FY 2015.

- **Questions:** Please provide a breakdown of the evaluation data for the "NJ FamilyCare Adult Expansion." Of the 247,935 average monthly enrollees estimated for FY 2014, how many enrollees correspond to: the previously eligible General Assistance population; previously eligible parents up to 138 percent of the FPL; and "newly eligible" other adults? Similarly, of the 298,071 average monthly enrollees projected for FY 2015, how many enrollees correspond to: the previously eligible General Assistance population; previously eligible parents up to 138 percent of the FPL; and "newly eligible" other adults?

Answer: Average monthly numbers - For FY14, 87,538 represent adults (36,355 transitioned General Assistance) and 160,415 were parents (140,014 transitioned parents). Beginning Jan 1, 2014, we no longer included a General Assistance category and all adults (non-parents) under 138% FPL are included in this category.

For FY15, 125,966 represent adults and 172,106 represent parents.

12. Some individuals previously eligible for Medicaid or NJ FamilyCare coverage, notably some parents in NJ FamilyCare and recipients of General Assistance, were deemed "newly eligible" for Medicaid under an agreement between DHS and the federal government, so that their medical assistance expenditures would also receive a 100 percent federal Medicaid matching rate effective January 1, 2014 (prior to January 2014, these groups received only a 50 percent federal Medicaid matching rate). As noted above, these individuals are included within the "NJ FamilyCare Adult Expansion" group associated with the Medicaid expansion. Parents previously enrolled in NJ FamilyCare whose income was too high to qualify for the Medicaid expansion (i.e., above 138 percent of the FPL) had their coverage terminated effective January 1, and were directed to the health insurance marketplace to obtain replacement coverage, as provided by language in the FY 2014 Appropriations Act (Appropriations Handbook, p. B-96).

- **Questions:** How many General Assistance recipients were transitioned to the Medicaid expansion eligibility group (i.e., the NJ FamilyCare Adult Expansion) effective January 1, 2014? How many NJ FamilyCare parents were transitioned to the Medicaid expansion eligibility group effective January 1, 2014? How many NJ FamilyCare parents with incomes exceeding 138 percent of the FPL had their coverage terminated effective January 1, 2014?

Answer: 36,355 General Assistance and 140,014 parents were transitioned as part of expansion on Jan 1, 2014. There were also 3,537 higher income parents above the new 138% FPL that were transitioned to the federal health exchange effective Jan 1, 2014.

13a. The ACA provides enhanced federal reimbursements for health care costs associated with the expansion of Medicaid coverage to non-elderly adults with incomes below 138 percent of the federal poverty level (FPL). Under ACA provisions, the federal reimbursement for State expenditures on health care services for newly eligible persons under this Medicaid expansion will: be 100 percent from 2014 through 2016; phase down to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020; and remain at 90 percent in subsequent years. Administration services, such as eligibility determinations, are generally eligible for the State’s normal 50 percent matching rate.

In response to questions from the Senate Budget and Appropriations Committee in May 2013, the department estimated the following State costs associated with expanding Medicaid to a projected 104,000 newly eligible non-elderly adults with incomes below 138 percent of the FPL, who were anticipated to begin enrolling in State Fiscal Year 2014¹:

STATE FISCAL YEAR	ESTIMATED STATE COST
2014	No additional State cost
2015	No additional State cost
2016	No additional State cost
2017	\$5-15 million
2018	\$15-25 million
2019	\$20-30 million
2020	\$30-40 million

- **Questions:** Please provide an updated year-by-year estimate of the State cost, for FY 2014 through FY 2020, of expanding Medicaid coverage to newly eligible adults with incomes below 138 percent of the FPL. Please also provide each estimate’s underlying annual enrollment assumption(s) for newly eligible adults (For both the cost and enrollment estimates, please exclude the previously eligible populations of NJ FamilyCare parents and General Assistance recipients.) Finally, please provide estimated annual State costs for administration for this additional population.

Answer: Since the expansion is still in its initial stage, DHS believes that the cost estimates above are still accurate, but will continue to re-evaluate our estimates as timelier enrollment information becomes available. DHS does not expect a significant increase in administrative costs for this additional population, but will continue to re-evaluate our needs.

¹ The estimates appear to represent only costs for health care services, not administration costs.

Average Monthly Enrollment	Adults	Parents
FY 14	51,183	20,401
FY 15	89,611	32,092
FY 16	106,413	37,248
FY 17	118,102	40,738
FY 18	129,304	42,959
FY 19	140,276	43,000
FY 20	144,000	43,000
*Excludes Transitioned Population		
**Data as of February, 2014		

13b. In response to the Senate Budget and Appropriations Committee, DHS also noted that, by choosing to opt into ACA Medicaid expansion, the State was able to claim 100 percent federal reimbursement for expenditures associated with some of its existing Medicaid populations which, prior to January 2014, received only a 50 percent federal reimbursement. (As noted above, these populations are certain parents in NJ FamilyCare and recipients of General Assistance.) The FY 2014 Governor’s Budget anticipated that enhanced reimbursement for these populations would generate nearly all of the approximately \$227 million in FY 2014 savings anticipated from the Medicaid expansion, after the 100 percent reimbursement became available in January 2014. If the State had not participated in the Medicaid expansion, these State savings would not have been realized.

In its response to the Senate Budget and Appropriations Committee questions in May 2013, DHS indicated that the savings realized through the enhanced match for the existing populations would more than offset the estimated State costs reported in Discussion Point 13a. above.

- **Questions:** Please provide year-by-year estimates of the State savings, in FY 2014 through FY 2020, that are attributable to enhanced federal reimbursement for populations previously eligible for Medicaid or NJ FamilyCare before January 1, 2014, and that are anticipated to be realized as a result of New Jersey’s participation in the ACA Medicaid expansion.

Answer:

	Total State Savings (\$000's)
FY 14 (6 months)	(\$202,174)
FY 15	(\$389,390)
FY 16	(\$416,874)
FY 17	(\$445,667)
FY 18	(\$475,828)
FY 19	(\$507,413)
FY 20	(\$540,479)
Data as of April, 2014	

14. New Jersey provides a slightly different package of Medicaid benefits, called the Alternative Benefit Plan, to individuals who are newly eligible for Medicaid under the Affordable Care Act. Most notably, the Alternative Benefit Plan provides coverage for certain mental health and substance abuse treatment services that the standard Medicaid benefit plan does not cover, but which must be covered for newly eligible Medicaid recipients under the Affordable Care Act. Proposed language on page D-182 of the Governor's Budget Recommendation would authorize the commissioner "to provide any or all types and levels of services that are provided through the Medicaid State Plan's Alternative Benefit Plan" to most categories of Medicaid beneficiaries, not only those newly eligible under the ACA.

- **Questions:** What additional benefits from the Alternative Benefit Plan package does the department plan to provide? To what groups? On what schedule? What is the anticipated State cost for providing these expanded benefits?

Answer: These additional benefits for the non-expansion population would be the following: non-medical detox; substance abuse partial care; substance abuse intensive outpatient; substance abuse outpatient; substance abuse short term residential; and psychiatric emergency services.

The proposed budget authorizes the Commissioner to add these additional benefits beginning Jan 1, 2015.

The Division is currently working through the potential fiscal impact of these additional services.

15. As required by the ACA, the State has temporarily increased Medicaid reimbursement rates for primary care physician services to the rates paid by Medicare. The enhanced rates apply to Medicaid primary care services delivered under fee-for-service or managed care arrangements. Under the ACA, the federal government is paying 100 percent of the difference between the pre-ACA rates and the required enhanced rate, but the requirement and the additional federal funding apply only for calendar years 2013 and 2014. If the State were to decide to continue this rate increase into 2015, the State would be responsible for its normal share of Medicaid payments – generally 50 percent (but with no State share for expenditures on "newly eligible" individuals in the Medicaid expansion group until CY 2017, as noted above). Available information from October 2013 indicates that the enhanced payments were expected to cost \$220.0 million (federal) in FY 2014.

- **Questions:** Is the \$220 million estimate for the cost of the primary care rate increase in FY 2014 still valid? What would be the State cost of extending the primary care rate increase through the end of FY 2015? What would be the State cost in FY 2016?

Answer: The \$220 million estimate is still valid and the additional State costs in FY15 would be approximately \$50 million and \$100 million in FY16.

16. Federal law allows states to recoup Medicaid costs for recipients age 55 and older from the estates of deceased Medicaid recipients. The Affordable Care Act extends Medicaid eligibility to a population of adults that includes individuals over 55 who may be subject to estate recovery actions. However, the threat of estate recovery actions may discourage some individuals from enrolling in Medicaid, and a February 21 letter from CMS to state Medicaid directors states that "CMS intends to thoroughly explore options and to use any available authorities to eliminate recovery of Medicaid benefits consisting of items or services other than long term care and related services" related to the expansion population. At least two states, Washington and Oregon, are taking steps to exempt the ACA Medicaid expansion population from estate recovery actions.

- **Question:** Does DHS intend to pursue estate recovery actions for expenditures on behalf of recipients who are eligible for Medicaid under the ACA expansion?

Answer: New Jersey law requires the Division to pursue estate recoveries of Medicaid payments for services received on or after age 55 when the beneficiary dies, to the extent of their estate (as defined in the State Medicaid statute), and only when there is no surviving spouse, surviving permanently and totally disabled/blind child, or surviving minor child. The Division is currently reviewing the latest CMS guidance.

17. A language provision added to the FY 2014 Appropriations Act (Appropriations Handbook, p. B-90) by the Legislature requires the department to provide to the Presiding Officers of the Legislature notification, on an ongoing basis, as new Medicaid managed care provider contracts are approved by the department, as well as a written report, on or before April 1, 2014, listing all managed care provider contracts approved during the fiscal year.

- **Questions:** What information on Medicaid managed care provider contracts has been provided to the Presiding Officers of the Legislature to date? Will the required written report be submitted by April 1?

Answer: A letter dated December 16, 2013 was submitted to the Presiding Officers of the Legislature indicating that DMAHS approved WellCare Health Plans of New Jersey to enter into a contract to serve NJ FamilyCare members effective 12/1/13 and that Healthfirst Health Plan of NJ, Inc. entered into an asset purchase agreement with WellCare and expects to close in the first quarter of FY 2014.

18a. A language provision added to the FY 2014 Appropriations Act (Appropriations Handbook p. B-90) by the Legislature requires the department to work collaboratively with, and provide guidance to, county corrections agencies to enroll Medicaid-eligible inmates who are in need of medical services.

- **Questions:** Please provide information on actions taken by DHS and county corrections agencies to enroll inmates in Medicaid who require medical services. Please also provide any available data on the current number of counties actively enrolling Medicaid-eligible inmates, the number of enrollments to date, and the projected FY 2014 and FY 2015 cost savings to county corrections agencies as a result of this initiative. Will the State take on any additional costs as a result of this initiative?

Answer: The Division has been working with the county correction agencies and has outreached the New Jersey County Jail Wardens Association to brief them on this initiative to obtain “buy-in” as well as their support and assistance in facilitating the surveys and information exchange between the Division and the counties and has received completed surveys of county inmates from all counties and compiled the results. Inpatient hospital data was not provided by three counties. On February 28, 2014, the Division met with the New Jersey Association of Counties (NJAC) and two wardens to discuss the next steps for the inpatient hospital initiative. According to NJAC, 90% of county inmates are pre-adjudicated; the Division is in the process of sending a letter to CMS requesting confirmation that federal financial participation is allowed for pre-adjudicated inmates incarcerated in the county jail. The Division is determining the needed changes to the eligibility process as well as assessing modifications to its current information technology structure. To date, there are no counties actively enrolling Medicaid-eligible inmates. Cost savings will be projected upon receipt of CMS confirmation and additional hospital data from the counties. It has not yet been determined if the State will incur

additional costs in relation to the initiative. It should be noted that Medicaid eligibility is determined at the county offices.

18b. Available information indicated that the Governor's FY 2014 Budget had assumed \$3 million in savings, associated with the Medicaid expansion, due to claiming federal Medicaid reimbursement for certain inmate hospitalizations exceeding 24 hours. Inmates who are low-income childless adults (most inmates) were ineligible for Medicaid prior to the Medicaid expansion under the ACA, but now would be considered "newly eligible" for Medicaid and their hospitalizations would be eligible for a 100 percent federal match.

- **Questions:** Please provide an updated FY 2014 estimate of the State savings associated with enhanced Medicaid reimbursement for inmate hospitalizations, as well as a FY 2015 estimate. How much of the savings reflect Medicaid reimbursement for those inmates who are "newly eligible" under the Medicaid expansion, and how much reflects inmates who were eligible under pre-ACA eligibility rules, for each year? Before the process for taking Medicaid applications for inmates was developed, where were inmate hospitalization costs budgeted (by agency and line item), and where are they budgeted now? To which correctional facilities and populations of inmates do these savings apply, and how are such savings allocated between the DHS and any other affected agencies (e.g., Department of Corrections)?

Answer: The state savings estimates for DOC inmates have been significantly reduced due to the following: To date, Medicaid eligibility was approved for only 40 inmates from a total of 516 inmate hospitalizations for SFY 2014; Medicaid currently has 15 applications that are being screened for eligibility; approximately 10% of inmates are not US citizens or refused to sign the Medicaid application.

SFY 2014 state savings estimate \$1,239,120

SFY 2015 state savings estimate \$2,264,030

Newly Eligible:

SFY 2014 state savings estimate newly eligible = \$958,968; pre-ACA eligible \$280,152

SFY 2015 state savings estimate newly eligible = \$1,975,474; pre-ACA eligible \$288,556

Inmate hospitalization costs have been and continue to be budgeted at DOC. Savings apply to all Medicaid eligible inmates that reside in a DOC correctional facility and have been transferred to a hospital for an inpatient stay.

19. At the January 2014 meeting of the Medical Assistance Advisory Council, DHS announced its intention to implement a telepsychiatry benefit in Medicaid, which would allow psychiatrists and psychiatric advanced practice nurses to provide services from a remote location over secure, two-way, interactive audiovisual connection. This benefit is advertised as a potential cost-saver, as it allows increased access to specialty psychiatric services, including medication management, that may be able to reduce reliance on emergency rooms and prevent the need for more acute care at a later date.

- **Questions:** When will the telepsychiatry benefit become available to Medicaid beneficiaries? Are any net State costs or savings related to the benefits expected?

Answer: Beginning January 1, 2014, Independent Clinics and Hospital providers with an approved policy and procedure plan to provide telepsychiatry services (approved by DMAHS and DMHAS or DCF) can bill immediately. The provider is paid the same rate as face to face services. For the State, there is no savings or cost. The State benefit is increased access to care for clients.

20. The NJ FamilyCare Advantage program is a buy-in program for health coverage through which a parent or caretaker whose family income exceeds 350 percent of the poverty level may purchase coverage under NJ FamilyCare for an uninsured child under the age of 19. Horizon Blue Cross Blue Shield of New Jersey, which offered and administered the program, has announced that it will no longer offer the plan effective March 31, 2014, citing subsidized health coverage available through the health insurance marketplace under the Affordable Care Act. Most families who previously purchased policies through NJ FamilyCare Advantage will be eligible to purchase private insurance on the health insurance marketplace, but premiums and cost sharing are much higher on the marketplace than in NJ FamilyCare Advantage. Although NJ FamilyCare Advantage is not directly administered by the State, the Commissioner of Human Services is statutorily required to establish the program pursuant to N.J.S.A.30:4J-12, subsection j.

- **Questions:** What is the department's intention with regard to NJ FamilyCare Advantage? If the program is to be discontinued, is legislation required to eliminate the statutory requirement to establish the program?

Answer: Horizon NJ Health has phased out NJ FamilyCare Advantage effective March 31, 2014 and members were redirected either to the Marketplace or NJ FamilyCare (as appropriate per ACA requirements). DHS consulted with the Attorney General's Office and, based on that consultation, DHS believes that the ACA has preempted NJSA 30:4J-12.

21. Under the ACA, states have the option to establish a Basic Health Plan, which would provide Medicaid-like coverage to individuals with incomes just above the Medicaid eligibility level (138-200 percent of the FPL) and who would otherwise be eligible to purchase coverage through their state's ACA health insurance marketplace. The hope was that the Basic Health Plan would reduce the cost of coverage for this highly price-sensitive population. It was also hoped that, by drawing plans into the program that also cover Medicaid and CHIP beneficiaries, the program would offer continuity of care for a population that is likely to "churn" into and out of Medicaid eligibility because of small fluctuations in income.

- **Questions:** Has any analysis of the costs and benefits of a Basic Health Plan in New Jersey been conducted? What conclusions have been drawn?

Answer: The final regulations on the Basic Health Plan (BHP) were just released by the Centers for Medicare and Medicaid Services (CMS) on March 7, 2014. This included the federal funding methodology for states to use in 2015, which is the first year a state can operate a BHP. New Jersey is in the process of reviewing the new federal regulations.

22. An August 2013 report by the U.S. Department of Health and Human Services' Office of the Inspector General (OIG) regarding state Maximum Allowable Cost (MAC) programs for prescription drugs in Medicaid found that New Jersey's MAC prices were 15.3 percent higher than the federal upper limit (FUL), as revised pursuant to the ACA. In general, MAC programs are intended to save money by: (1) setting reimbursement limits for multiple-source drugs not covered by the FUL program, and (2) setting reimbursement rates for multiple-source drugs lower than the FUL amounts. The higher MAC rate seems to suggest an opportunity to reduce Medicaid costs for prescription drugs by reevaluating the MAC program.

- **Question:** Has the department taken any steps to reduce prescription drug reimbursement rates in the MAC program as recommended by the OIG?

Answer: New Jersey's FFS program automatically takes advantage of lower FUL rates (in those cases where the FUL is lower than the State MAC) by using a "lesser of" methodology when paying all pharmacy claims. This is done while continuously monitoring the actual NJ specific cost of multi-source drugs through the collection of pharmacy invoices and setting State MAC prices at the lowest actual pharmacy cost plus 50%.

23. The Office of the State Comptroller (OSC) issued an audit report in July 2013 of United Healthcare Community Plan's Special Investigations Unit, the Medicaid MCO's contractually required fraud and abuse prevention mechanism. The report identified several factors that appeared to have contributed to a low rate of Medicaid recoveries by the MCO, including: a lack of full-time employees dedicated to investigating waste, fraud, and abuse; a lack of referrals from vendors and their subcontractors; and insufficient training for analysts. An October 2011 report found similar problems with Horizon NJ Health.

The 2013 report also indicated that, by July 2013, United had implemented or was in process of implementing OSC's recommendations.

- **Questions:** Can DMAHS verify that all Medicaid managed care organizations have the required number of full-time equivalent employees working on fraud, waste, and abuse prevention? What actions is DMAHS taking to ensure that other Medicaid managed care organizations are upholding their contractual obligations to minimize and recover improper payments?

Answer: The Medicaid MCO contract requires 1 FTE in the Special Investigations Unit (SIU) per every 60,000 members in each health plan. These requirements are monitored closely by NJ Medicaid Fraud Division (MFD). DMAHS works closely with MFD to assure that Medicaid managed care organizations are upholding their contractual obligations to minimize and recover improper payments. Working closely with MDF, requirements are added to the MCO contract to strengthen and assure against fraud, waste and abuse.

24. Section 3021 of the ACA established a Center for Medicare & Medicaid Innovation (CMMI) within the federal Centers for Medicare & Medicaid Services (CMS). CMMI has been conducting a federal State Innovation Models (SIM) Initiative, which provides up to \$300 million to support the development and testing of state-based models for multi-payer payment and health care delivery system transformation with the goal of improving health system performance for residents of participating states.

SIM is testing broad-based, innovative payment and service delivery models that have the potential to lower program costs for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), while maintaining or improving quality of care for program beneficiaries. As of March 2014, a total of 25 states have received SIM awards, in the following categories:

- Model Testing Awards (six states): \$33.1 million to \$45.2 million awarded per state.
- Model Pre-Testing Awards (three states): \$1.0 million to \$2.0 million awarded per state.
- Model Design Awards (sixteen states): \$0.8 million to \$3.0 million awarded per state.

CMS formally announced the SIM funding opportunity in July 2012 and applications were due in September 2012. Awards were announced in February 2013. Information provided by CMS in March 2014 indicated that another SIM funding opportunity is anticipated within the next year and that all states will be eligible to apply.

- **Questions:** Did DHS submit an application for the initial SIM funding opportunity in 2012? If so, did the State apply for a Model Design or a Model Testing Award, with what proposed strategy for health care delivery system transformation? If not, please explain why the department did not pursue the federal funding. Does DHS intend to submit an application for any subsequent SIM funding that may be offered in the near future?

Answer: DMAHS did not submit an application for SIM funding in 2012. The Division determined that it was counterproductive to take on an additional major initiative as it worked to implement the provisions of its 1115 Comprehensive Waiver. As appropriate and within resources, DHS/DMAHS continually seeks federal and other support for initiatives that benefit the State of NJ and Medicaid/NJ FamilyCare beneficiaries.

25. Schedule 1 of the FY 2014 Governor's Budget (page C-5) estimated School-Based Medicaid revenues at \$31.8 million in FY 2013 (revised) and \$31.8 million in FY 2014. The FY 2014 Appropriations Act also assumed \$31.8 million in School-Based Medicaid revenues.

The FY 2015 Governor's Budget (page C-5) indicates that actual School-Based Medicaid revenues were \$47.4 million in FY 2013, and estimates School-Based Medicaid revenues at \$49.9 million in FY 2014 and \$47.8 million in FY 2015.

- **Questions:** What accounts for the significantly greater than anticipated revenues in FY 2013, and the upward revision in the FY 2014 estimate? Why are School-Based Medicaid revenues expected to decrease by \$2.1 million in FY 2015, relative to the revised FY 2014 estimate?

Answer: The School-Based Medicaid (SEMI) program is implementing a revised claiming methodology based on cost settlements which is expected to increase revenues. The FY14 revenue estimate includes a one-time catch-up of two years' worth of cost settlement which is why the overall revenue estimate is higher in FY14 than FY15.

26. Schedule 1 of the FY 2014 Governor's Budget (page C-5) also estimated revenues associated with Early Periodic Screening, Diagnosis and Treatment (EPSDT) at \$1.4 million in FY 2013 and \$1.4 million in FY 2014. The FY 2014 Appropriations Act also assumed \$1.4 million in EPSDT revenues.

The FY 2015 Governor's Budget (page C-5) estimates EPSDT revenues at \$7.8 million in FY 2014 and \$7.8 million in FY 2015.

- **Questions:** What accounts for the upward revision in the FY 2014 estimate for these revenues, as compared with the original FY 2014 estimate?

Answer: There is an increase in revenue due to an increase in the number of districts participating. In the past, claiming for the administrative portion of School-based Medicaid was voluntary. Under a new SEMI claiming process, the information provided by districts as part of their SEMI claiming now includes their administrative costs.

DIVISION OF AGING SERVICES (DoAS)

27. New Jersey’s Comprehensive Medicaid Waiver authorizes implementation of the Managed Long-Term Services and Supports (MLTSS) initiative. Under MLTSS, 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 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 clients and clients with disabilities.

Implementation of MLTSS is anticipated to commence in FY 2015. The FY 2015 Governor’s Budget consolidates a number of previously separate line items from the Division of Aging Services and the Division of Disability Services into a new “Managed Long Term Services and Supports” appropriation (see page D-186), which is recommended to be \$281.2 million in FY 2015. As shown below, when excluding the consolidation of existing funds into MLTSS, the Governor’s FY 2015 Budget recommends an increase of approximately \$125 million in State funding associated with implementing MLTSS. The Governor’s FY 2015 Budget Summary (page 25) references this amount and indicates that the \$125 million is to “deliver high quality care through a new Managed Long Term Supports and Services system, allowing seniors to stay in their homes and communities rather than nursing homes.”

MANAGED LONG TERM SERVICES AND SUPPORTS: FUNDING (\$000)

Line item	FY 2014 Adj. Approp.	FY 2015 Governor’s Recommendation	FY 2014 to FY 2015 Difference
Global Budget for Long Term Care	62,656	0 <i>(Incorporated into MLTSS)</i>	(62,656)
Global Budget for Long Term Care (CRF)	37,850	0 <i>(Incorporated into MLTSS)</i>	(37,850)
Managed Long Term Services and Supports (MLTSS)	0	281,182	281,182
Funds Transferred from Division of Disability Services ¹⁾	55,306	0 <i>(Incorporated into MLTSS)</i>	(55,306)
TOTAL NEW FUNDING FOR MLTSS			\$125,370

¹As noted on page D-194 of the Governor’s FY 2015 Budget, funds from the following appropriations are to be transferred out of the Division of Disability Services 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, and Payments for Medical Assistance Recipients – Waiver Initiatives (CRF). The Governor’s Budget indicates that \$55.306 million would be involved in these transfers in FY 2015 (see page B-4, under the heading “Disability Services Shift to Managed Long Term Services and Supports”).

Information from footnote (c) on page D-185 of the Governor’s FY 2015 Budget indicates that projected FY 2015 MLTSS expenditures include start-up costs associated with MLTSS.

- **Questions:** Of the \$125 million anticipated in new State spending for implementing MLTSS, please provide the total dollar amount of exclusively one-time, start-up costs and a detailed description of the types of costs represented in that amount. Of the remaining dollar amount representing ongoing costs, please provide a detailed disaggregation of the types of costs represented among those costs, and indicate the total dollar amount representing FY 2015 MLTSS capitation payments for participating managed care organizations. If these costs are

offset by any anticipated savings related to MLTSS that are incorporated into the \$125 million increase, please also provide a description and the amount of any such savings.

Answer: Of the \$125 million anticipated in new State spending for implementing MLTSS, 5% is for one-time start-up costs primarily related to claim run-out costs (payment for home and community based waiver services provided during SFY14). Of the remaining costs, 20% is for administrative and operational costs within the managed care organizations (such as IT and fiscal agent changes and interfaces, provider network contract work, care management, and new long term service and support management functions) and the remaining 75% is for expanded services and new access to long term services and supports (a few types of expanded services include assisted living, home based supportive care, private duty nursing, chore services and home delivered meals).

28a. It is noted that “managing long-term care” was one of several Medicaid delivery system reforms associated with the Comprehensive Medicaid Waiver that were, in aggregate, originally anticipated to produce between \$16.0 million to \$40.0 million in State savings in FY 2012 (at the time, anticipated to be the Waiver’s first year of implementation), according to information provided to the Assembly Budget Committee in June 2011.² Based on the State’s Comprehensive Medicaid Waiver application and approval documents, it appears that “managed long-term care” is synonymous with the Managed Long-Term Services and Supports initiative.

It is also noted that the State’s September 2011 application for the Comprehensive Medicaid Waiver anticipated savings from managed long-term care (LTC) in every year of the program. For instance, the application stated that, “The savings incorporates a mandatory managed LTC program generating considerable savings that increase over time. The savings achieved can be significant. For purposes of the waiver, a modest savings range from approximately \$20 million in [demonstration year 1] to approximately \$220 million in [demonstration year 5] was assumed.” (These numbers represent combined State and federal savings.)

Accordingly, budget neutrality calculations³ in the State’s application suggest State savings of \$10 million in the first year of MLTSS, \$35 million in the second year, and \$60 million in the third year.⁴ The State’s application appeared to assume full implementation of managed long-term care, including the shift of Medicaid waiver home- and community-based services (HCBS) and Medicaid nursing facility (NF) services into managed care, beginning in Demonstration Year Two, stating that “effective July 1, 2012, the State will further amend its existing MCO contracts to manage all LTC services including HCBS and NFs for the elderly and physically disabled.” Thus, Demonstration Year Two in the State’s application appears to roughly correspond to FY 2015 under the current, revised MLTSS implementation schedule that anticipates the shifting of HCBS and nursing facility services into MLTSS during FY 2015.

In contrast to these predictions, the Governor’s FY 2015 Budget recommends \$125 million in new State appropriations for implementation of MLTSS (see Discussion Point 27 above).

² The information provided to the Assembly Budget Committee may be found here:

http://www.njleg.state.nj.us/legislativepub/budget_2012/DHS_follow_up_responses_medicaid_ABU_05242011.pdf.

³ Medicaid waivers under section 1115 of the Social Security Act are required to be “budget neutral” to the federal government, which means that, under the Comprehensive Waiver, federal Medicaid expenditures will not be more than federal spending would have been without the waiver. In this case, the same calculations show an anticipated State savings as well as federal savings.

⁴ A table representing these calculations is enclosed as Exhibit 1 at the end of this document for reference.

- **Questions:** Given that managed long-term care (i.e., MLTSS) was originally anticipated to produce State savings in each year of the Comprehensive Waiver, why does the Governor’s FY 2015 Budget recommend \$125 million in new State appropriations for implementation of MLTSS in FY 2015? Were these start-up costs originally anticipated in the September 2011 Comprehensive Waiver application submitted to the federal government? Given the delay in implementation of MLTSS from the timeframe originally anticipated in the Comprehensive Medicaid Waiver, please provide updated estimates of the net State fiscal impact (i.e., net costs or savings, by fiscal year) associated with MLTSS relative to what was projected in the absence of MLTSS. Noting that this up-front cost is greater than the cumulative State savings that were previously anticipated over the first three years of the program, is MLTSS expected to result in an overall net increase in State expenditures, rather than net State savings, over the remaining three years of the demonstration program? When will the program break even?

Answer: As part of the required federal reporting requirements, the State is updating the Comprehensive Waiver budget neutrality analysis, as appropriate, to reflect the new implementation schedule.

28b. The State’s Comprehensive Waiver application also indicated that the anticipated gross savings of \$20 million to \$220 million each year assumed the diversion of Medicaid enrollees away from nursing homes and into home- and community-based alternatives.

Evaluation data on page D-183 of the Governor’s FY 2015 Budget anticipate 13,000 clients served by Managed Long Term Services and Supports in FY 2015, and estimate gross FY 2015 expenditures of \$562.4 million. Footnote (c) on page D-185, regarding those data, indicates that “increased recipients from nursing home diversions have not been reflected in the number of clients served” under the Managed Long Term Services and Supports initiative.

- **Questions:** What amount of offsetting savings from nursing facility diversions, if any, are assumed in the anticipated gross expenditures for Nursing Home Services or for MLTSS in FY 2015 shown in the evaluation data on page D-183? What amount of State savings from nursing facility diversions, if any, are assumed in the recommended FY 2015 State appropriations for Payments for Medical Assistance Recipients – Nursing Homes or for Managed Long Term Services and Supports, representing what number of clients diverted? What amount of State savings from nursing facility diversions are anticipated in FY 2016, representing what number of clients diverted?

Answer: The nursing home line assumes diversions consistent with prior years (impacted by the Global Budget program and other nursing home alternative programs) as part of its overall trend. DHS did not take any further adjustments for diversions since the MLTSS program will be newly implemented in FY15. DHS will monitor the diversion impact from MLTSS during FY15 and build a new trend for FY16 based on actual data.

29. DHS convened a Managed Long Term Services and Supports (MLTSS) Steering Committee from March 2012 to June 2012, consisting of stakeholders such as consumer advocates, provider groups, managed care organizations (MCOs), and Program of All-inclusive Care for the Elderly (PACE) organizations, to assist with planning for the transition of nursing home residents from a Medicaid fee-for-service reimbursement system into MLTSS. In June 2012, the MLTSS Steering Committee submitted to DHS their final recommendations, which included an “any willing provider provision” and a recommendation to maintain the existing State case-mix reimbursement methodology for nursing homes for two years. Since the release of

these recommendations in June 2012, implementation of MLTSS for home- and community-based long-term care services and institutional (i.e. nursing facility) long-term care services was delayed to July 2014.

Available information suggests that there will be a two-year period of “any willing provider” and “any willing plan” policies during the roll-out of MLTSS implementation, beginning July 1, 2014.

- **Questions:** Please summarize the “any willing provider” and “any willing plan” policies: what do they require from the managed care organizations and from the providers, respectively? Which party (provider or MCO) would set the terms of the contract, which the other would be able to accept or reject? What specific types of long-term care providers will be subject to these policies? When will the “any willing provider” and “any willing plan” periods specifically begin and conclude?

Answer: Any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living provider (AL), community residential services (CRS) provider that serves residents with traumatic brain injury, or long term care pharmacy that applies to become a network provider and complies with the Contractor’s provider network requirements shall be included in the Contractor’s provider network to serve MLTSS members. In addition, if the Contractor wishes to have any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living provider (AL), community residential services (CRS) provider join its network, those providers will be instructed to complete the application form. This is known as Any Willing Plan. This provision is available for NF, SCNF, AL and CRS for two years beginning on July 1, 2014 and expiring on June 30, 2016. The aforementioned policies were discussed as part of the MLTSS Steering Committee, which has met officially eight times since March 2012, and is next scheduled to meet in April 2014. Four Subcommittees of the Steering Committee did meet between March and June 2012 to come up with formal recommendations, which were approved at the June 2012 meeting of the Steering Committee. In October 2012, the Department convened the Steering Committee to discuss the MLTSS Steering Committee recommendations agreed to by the State. At that meeting the Department detailed the more than 90% of the recommendations accepted by the State. In 2013, the MLTSS Steering Committee convened either face-to-face or by telephone three times to be provided with updates and provide input to the State on implementing MLTSS. In 2014, the MLTSS Steering Committee has already convened twice and is scheduled to meet a third time on April 28, 2014. The Department also provides regular updates to the Medical Assistance Advisory Council. The Department is committed to maintaining the MLTSS Steering Committee throughout the implementation of MLTSS, as required by the Special Terms and Conditions from the federal government.

30. Current Department of Health (DOH) regulations (N.J.A.C.8:33H-1.15) generally require nursing facilities to reserve 45 percent of their beds for Medicaid-eligible individuals. Without a requirement that Medicaid managed care organizations (MCOs) open their networks to any willing provider, a nursing facility could be excluded from managed care networks, effectively excluding it from the Medicaid program and causing it to be unable to meet its licensure requirements. Available information indicates that DHS anticipates reimbursement for existing Medicaid nursing facility residents to remain fee-for-service and that a two-year “any willing provider” period will be implemented, which would affect nursing facility services provided to new Medicaid clients through managed care (under the MLTSS initiative). These policies may help nursing facilities continue to comply with N.J.A.C.8:33H-1.15 in the short term.

In response to questions from the Senate Budget and Appropriations Committee in May 2013, DHS indicated that it was aware of the DOH licensing regulation at N.J.A.C.8:33H-1.15, and that it would continue

to monitor Medicaid occupancy and network adequacy for nursing homes and consult with the DOH in determining if any regulatory changes were needed in the future. DHS also reported that the average percentage of Medicaid occupancy in nursing facilities in the State was 68 percent.

- **Questions: Please provide an update as to whether any regulatory changes to N.J.A.C.8:33H-1.15 are anticipated in the next two fiscal years. What is the current estimated average percentage Medicaid occupancy in nursing facilities across the State?**

Answer: The Department of Human Services (DHS) has met with the Department of Health (DOH) regarding the 45% requirement for Medicaid occupancy in nursing facilities over the past several years. As DHS transitions into Managed Long Term Services and Supports for people in nursing facilities, DHS, with the assistance of DOH, will continue to monitor any potential regulatory changes. Given that the DHS has included an Any Willing Provider/Any Willing Plan provision in the contract with the Managed Care Organizations for the next two years, it is not anticipated that any regulatory changes will be needed in the foreseeable future. Currently, the average percentage of Medicaid occupancy is approximately 68%.

31. A revised language provision in the Governor's FY 2015 Budget (page D-188) addressing Medicaid reimbursement for nursing facility services provides that: "(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."

Informal information from the department indicates that these language provisions will be implemented as follows:

- Medicaid beneficiaries currently residing in nursing facilities will not be required to enroll in a managed care plan to continue to receive nursing facility services, 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 case-mix methodology in April 2014, which informal information from DHS refers to as the "default" rate); and
- 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 to receive nursing facility services. Facilities will either receive a reimbursement rate that has been negotiated with a managed care organization (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 on June 30, 2014 (fee-for-service rate last calculated through the case-mix methodology in April 2014).

Available information suggests that the above provisions will be incorporated into the State's contract with the Medicaid MCOs so that nursing facilities will not receive a reimbursement rate lower than the fee-for-service per diem rate that each received on June 30, 2014 for a period of two years, effective July 1, 2014, unless a nursing home negotiates a lower rate with an MCO.

- **Questions:** What specific requirements will the State include in its revised managed care contract regarding how nursing facilities are to be reimbursed? Does the anticipated two-year period for the “default” reimbursement rate remain valid? Please provide specific examples of circumstances where a nursing facility might receive a negotiated rate lower than the June 30, 2014 fee-for-service rate during the period of the “default” reimbursement rate. Because “any willing provider” arrangements typically allow MCOs to set the terms of a contract to be accepted or rejected by a provider, and because providers may not always be easily able to meet these terms, will it be possible for MCOs to waive certain onerous contract terms in exchange for a lower reimbursement rate during the first two years of the program?

Answer: The Department of Human Services (DHS) is ensuring that nursing facilities will be reimbursed as detailed in the budget. The “default” reimbursement rate will be maintained. The language to allow nursing facilities to receive a lower rate than the default rate was requested specifically by the Provider Transition Subcommittee during the MLTSS Steering Committee and subcommittee meetings. Some large corporations, which own nursing facilities, requested this provision to allow them to negotiate a volume-based rate with the Managed Care Organizations (MCOs). Specifically, it is possible that if the corporation wants to negotiate with the MCOs, then it will receive a higher number of admissions to all of its nursing facilities in exchange for agreeing to a lower rate. Given that the contract defines Any Willing Provider and Any Willing Plan, the providers have an opportunity to work with the MCOs to ensure appropriate contract terms.

32. Following the publication of initial FY 2014 nursing facility reimbursement rates for the period effective from July 1, 2013 to September 30, 2013, Myers and Stauffer, LC (the accounting firm under contract with DHS to set rates) issued revised July 1, 2013 rates in early 2014.

Available information indicates that, for the initial July 1, 2013 rates, Myers and Stauffer used total base State and federal appropriations of \$1,769,138,000 to calculate the “budget adjustment factor” used to adjust nursing facility reimbursement rates to limit expenditures to available resources. This amount of base appropriations excludes adjustments for out-of-State funding, certain nursing facility provider tax revenues, and resident contributions.

- **Questions:** Why were revised rates issued? What specific corrections or changes in the rate-setting assumptions or parameters are reflected in the revised rates? What was the total base FY 2014 State and federal appropriation (equivalent to the \$1,769,138,000 referenced above) used to calculate the revised July 1, 2013 rates? What equivalent total base FY 2015 State and federal appropriation is assumed to support the “default” FY 2015 fee-for-service nursing facility reimbursement rate in the Governor’s FY 2015 Budget?

Answer: When the July 1, 2013 rates were initially calculated toward the end of November, 2013, there was a concern that the rates did not contain the \$20 million (gross) in additional funding that was added during the FY14 Appropriations Act process. Only 28 NFs received a rate increases with none of the counties NFs receiving an enhanced rate. Upon review, it was found that the \$20 million was contained in the funding formula, but that an anomaly in the calculation occurred due to the fact that the four-year patient day trend, which is used in the formula by regulation, was considerably higher than the actual number of patient days. This anomaly resulted in lower than expected rates where the actual amount paid to NFs would have only resulted in a \$5 million increase. To be consistent with the legislative intent of the additional funding, DHS used a different calculation and used the average of the four-year trend as well as the FY13 actual number of patient days. This resulted in rates more accurately reflecting the budget increase. As a result, 171 NFs received rate increases (up from only 28 NFs receiving increases using just the 4 year trend). It should be noted that our rules permit the Department of Human Services (DHS) to make changes to rates when an inequity would result from strict adherence to the rules. In this case, it was believed that such an inequity

would exist if the NFs were denied a rate increase. As a result, 171 NFs, including two county NFs, received rate increases.

33a. A language provision in the FY 2014 Appropriations Act (see FY 2014 Appropriations Handbook, page B-99) provided that “no licensed facility in the adult Medical Day Care Program may serve or receive reimbursement for more than 200 Medicaid beneficiaries per day. Furthermore, no reimbursement will be provided for any claim in excess of a given facility’s licensed capacity as established by the Department of Health.”

A recommended revision to this language provision in the Governor’s FY 2015 Budget (page D-215) provides that “no licensed facility in the adult Medical Day Care program may serve or receive reimbursement for more than *200 participants per day* and, for facilities with a 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.”

- **Questions:** Would the revised language provision effectively limit adult medical day care facilities to serving no more than 200 individuals per day as a condition of participating in the Medicaid program, regardless of whether the individuals served are Medicaid clients or non-Medicaid (e.g., private paying) clients? If so, what is the policy rationale for broadening the language provision to include non-Medicaid clients? As several adult medical day care facilities currently have licensed capacities exceeding 200 slots, does DHS anticipate that the Department of Health (DOH) will be revising its licensing standards to correspond with the revised language provision? If so, what changes to the DOH licensing standards are anticipated by DHS?

Answer: The budget language was first included in the FY 2010 Appropriations Act and has remained in the budget under the Division on Aging through FY14. The language is being moved to the Department section of the budget since it impacts multiple Divisions and clarifies that, regardless of whether an individual is in fee-for-service or managed care, the facility can serve no more than 200 individuals per day.

33b. The language provision limiting adult medical day care facilities from serving or receiving reimbursement for more than 200 Medicaid beneficiaries per day first appeared in the FY 2010 Appropriations Act, along with a related language provision stipulating that “physical therapy, occupational therapy, and speech therapy shall no longer serve as a permissible criteria for eligibility in the adult Medical Day Care Program.”

Available information indicates that, at the time, these provisions were recommended by the Executive Branch to offset State costs associated with providing a per diem fee-for-service reimbursement rate of \$78.50 for Medicaid adult medical day care services, which was higher than the rate first proposed in the Governor’s FY 2010 Budget, and were intended to produce Medicaid savings by reducing improper utilization of adult medical day care services.

Subsequently, in FY 2012, most Medicaid adult medical day care services were shifted from fee-for-service delivery into Medicaid managed care. Under the latter arrangement, the State’s Medicaid managed care organizations (MCOs) contract with adult medical day care facilities to provide services at a negotiated rate. The MCOs also monitor clients’ need for services and impose various utilization controls.

- **Questions:** As the Medicaid MCOs currently review and manage the utilization for most Medicaid adult medical day care services, does the FY 2014 language provision limiting adult medical day care reimbursement to 200 Medicaid beneficiaries per day continue to produce measurable savings for the State? Please estimate the State savings attributable to that provision in FY 2014. Would additional State savings attributable to that provision be expected in FY

2015, as the language would be expanded to include non-Medicaid adult medical day services reimbursed by the State? Please estimate the State savings attributable to the revised provision in FY 2015.

Answer: The Department of Human Services did not adjust the FY15 budget for savings because the language simply clarifies previous budget language which has been in the Appropriations Act since FY 2010.

34a. 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.

- **Questions:** What accounts for the \$15.5 million downward revision in estimated FY 2014 PAAD rebate revenues, when compared to the original estimate? Given the lower than expected revenues in FY 2014, why are rebate revenues projected to increase by \$6.7 million (to \$39.2 million) in FY 2015, relative to the revised FY 2014 estimate?

Answer: The Governor's FY 2015 Budget estimate of \$39.2 million is based on recent actual rebate collections forecasted forward. The revised FY 2014 PAAD rebate estimate included in the Governor's FY 2015 Budget reflects lower than anticipated current year rebates, but also a one-time downward adjustment resulting from the fact that the FY 2013 accounting receivable in this account took longer than expected to satisfy.

34b. The Governor's FY 2015 Budget also indicates a \$14.2 million FY 2014 supplemental appropriation for the Pharmaceutical Assistance to the Aged and Disabled—Claims line item on page D-186. It is noted that a \$6.2 million supplemental appropriation, authorized by appropriations language, was required at the end of FY 2013.

- **Questions:** What have been the primary factors driving the need for FY 2013 and FY 2014 supplemental funding? Is a need for supplemental funding anticipated for PAAD in FY 2015?

Answer: The primary factor driving the need for FY 2013 and FY 2014 supplemental funding is lower than anticipated rebates. No additional resources are required for PAAD in FY15 since the rebate forecast has been updated per our response in #34a.

34c. Schedule 2 of the Governor's FY 2015 Budget (page C-13) estimates PAAD Drug Manufacturer Rebates of \$48 million in FY 2014 and \$42.5 million in FY 2015. Evaluation data on page D-183 estimate PAAD manufacturer rebates of \$32.5 million in FY 2014 and \$39.2 million in FY 2015.

- **Questions:** What accounts for the difference between the PAAD manufacturer rebates estimated for FY 2014 and FY 2015 in the Division of Aging Services evaluation data (page D-183) and the rebate revenues estimated on Schedule 2 (page C-13)?

Answer: Schedule 2 will be revised downward to reflect evaluation data estimates during the spring update of federal and non-State funds. This will not have a State General Fund impact as the evaluation data is reflective of the resources used to build the PAAD appropriation.

35. The FY 2011 Appropriations Act established the Community Based Senior Programs line items (one representing General Fund expenditures, and one representing the Casino Revenue Fund expenditures), consolidating several previously distinct line items for specific grant programs. At that time it was stated that eliminating special grants would enable other providers to access funds and would result in a more open and competitive bidding process. The items from the FY 2010 Appropriations Act that were consolidated in the FY 2011 Appropriations Act included the following:

- o ElderCare Initiative
- o Demonstration Adult Day Care Center Program – Alzheimer’s Disease
- o Purchase of Social Services
- o ElderCare Advisory Commission Initiatives
- o Alzheimer’s Disease Program
- o Adult Protective Services
- o Senior Citizen Housing – Safe Housing and Transportation
- o Respite Care for the Elderly
- o Congregate Housing Support Services
- o Home Delivered Meals
- o Home Care Expansion

- **Questions: Please provide a breakdown of funding in the Community Based Senior Programs accounts according to the programs supported by the accounts, by year, for FY 2011 through FY 2015. How have available funds been reallocated among the different programs?**

Answer: Since FY 2011, the budgets for the 11 programs, which were consolidated under the Community Based Senior Program line item, have remained consistent. However, when the last surviving participant under the Home Care Expansion (HCE) program passed away, \$71,000 in HCE funds were transferred to Congregate Housing Support Services. Last year, the Department transferred \$1 million in administrative funds from this account to address the increase in Adult Protective Services’ caseloads. This was an administrative efficiency savings when the Division was moved to DHS. Additionally, there are two reallocations reflected in the appropriation: the Department of Children and Families transferred \$378,000 of SSBG-like grants to DoAS and \$120,000 for a Area Agencies on Aging (AAA) Call Center that was reallocated from the 211 appropriation in the Division of Management and Budget; those grants are now included in the CBSP budget line item. The breakdown of funding is as follows:

Eldercare Initiative/JACC		\$10,027,000
Demonstration Adult Day Care Center Program-Alzheimer’s disease		\$500,000
Purchase of Social Services/SSBG		\$10,579,000
ElderCare Advisory Commission Initiatives		\$2,309,000
Congregate Housing	\$784,000	
Adult Protective Services	\$900,000	
State Home Delivered Meals	\$625,000	
Alzheimer’s Disease Program		\$3,632,000
Adult Protective Services		\$3,878,000
Senior Citizen Housing – Safe Housing and Transportation		\$1,726,000
Respite Care for the Elderly		\$5,359,000
Congregate Housing Support Services		\$2,077,000
Weekend Home Delivered Meals		\$1,020,000
Home Care Expansion (transferred to Congregate Housing)		\$0
SSBG Like Grant Programs (reallocated from DCF)		\$378,000
Call Center AAA (reallocated from 211 Approp)		\$120,000
Administrative		<u>\$4,041,000</u>
Total		\$45,646,000

36. The ACA's Balancing Incentive Program (BIP) allows qualifying states to receive bonus payments for increasing their share of Medicaid long-term care spending on home- and community-based services and reducing Medicaid long-term care spending on institutional care (i.e., care provided in nursing facilities, developmental centers, State psychiatric hospitals, etc.). If certain requirements are met, states will receive an increase of two percentage points in the federal reimbursement rate for any eligible expenditures from October 1, 2011, through September 30, 2015.

New Jersey received approval for participating in BIP in early 2013, so eligible Medicaid expenditures in the State will receive a 52 percent federal reimbursement rate, rather than the regular 50 percent rate, through September 30, 2015 (i.e., early FY 2016). New Jersey's original application for participation indicated that the enhanced federal reimbursement rate would apply to eligible State Medicaid expenditures on: home health services, personal care services, targeted case management, private duty nursing for children, PACE services, medical day care services, and other home- and community-based services. In New Jersey's original application for participation, the State anticipated a total of \$108.5 million in bonus payments over the program's duration.

- ***Question:*** Please identify accounts where BIP bonus payments allow for reduced State spending in FY 2014 and FY 2015, and the amounts of these reductions.

Answer: New Jersey anticipates earning approximately \$100M in BIP funding through September 2015. These funds will be used towards the implementation and transition phase for the newly created Managed Long Term Services and Supports program for Home and Community Based Services (HCBS) targeted to start on July 1, 2014.

DIVISION OF DISABILITY SERVICES (DDS)

37a. As recommended in the Governor's FY 2015 Budget, a significant portion of the services previously administered by, and budgeted within, the Division of Disability Services (DDS) will be transferred into the Managed Long Term Services and Supports initiative administered by the Division of Aging Services, as part of the State's implementation of the Comprehensive Medicaid Waiver. (Also see Discussion Point 27, above).

The transferred DDS services include Medicaid personal care assistant services and Medicaid home- and community-based services under three programs previously associated with separate Medicaid waivers: the Traumatic Brain Injury (TBI) program; the AIDS Community Care Alternatives Program (ACCAP); and the Community Resources for People with Disabilities (CRPD) program. DDS previously administered and funded these services under fee-for-service arrangements, but, once integrated into MLTSS, the services will shift to managed care delivery via the State's Medicaid MCOs.

- **Questions:** What administrative or oversight roles and responsibilities will DDS continue to perform regarding the services transferred into MLTSS? To clarify, what Medicaid services, if any, will remain under DDS administration? What non-Medicaid DDS services will be unaffected by the shift of services into MLTSS?

Answer: DDS will retain responsibility for the following Medicaid services, administration of the Medicaid PCA program for individuals in fee for service. The enrollment and eligibility screening function for NJ WorkAbility will remain with DDS, as well as the operational components of the NJ Personal Preference Program. It is also projected that DDS will provide extensive technical assistance to the MCOs on cases formerly held under the three waivers which are transitioning from the Division. We believe that this assistance will provide a historical and experiential context to ease the transition for the clients involved.

DDS will retain responsibility for the non-Medicaid Personal Assistance Services Program (PASP), the NJ Traumatic Brain Injury Fund, the Senior Community Independent Living Skills Program, Disability Health and Wellness Programs, and its comprehensive Information and Referral service. The Division will also continue its Institutional Discharge and Diversion Initiative, and its case management functions.

DDS also administers several grant funded projects related to disaster preparation for individuals with disabilities, domestic violence prevention for women with disabilities, and promoting access to food pantries. Finally, the Division operates the newly created SSBG funded Superstorm Sandy Modular Ramp Program. DDS is also serving as the DHS lead for Access and Functional Needs (AFN) for people with disabilities, as New Jersey evaluates its response to Super Storm Sandy and preparations into the future.

37b. As noted in Discussion Point 27, the Governor's FY 2015 Budget indicates that an anticipated \$55.306 million (State) is to be transferred from several appropriations within DDS to the Managed Long Term Services and Supports (MLTSS) line item in the Division of Aging Services. Total State Grants-In-Aid appropriations in DDS are only recommended to decline by approximately \$35.875 million, suggesting \$19.431 million in other growth, or 33 percent of the entire FY 2014 State Grants-In-Aid adjusted appropriation for DDS, that is not immediately apparent in the budget presentation. This may be driven in part by growth in the Personal Preference Program, noted in Discussion Point 38, below.

- **Question:** What accounts for the \$19.4 million increase in appropriations for DDS programs being transferred to MLTSS?

Answer: The majority of this growth is related to an anticipated shortfall in the FY14 Waiver and PCA lines (driven by the increased demand of the PPP program; see question 38 below). While the FY14 shortfall will be covered by other Medicaid balances in this fiscal year, appropriation growth is still needed in FY15 to cover projected costs.

38. The Personal Preference Program allows elderly and disabled adult Medicaid recipients to direct and manage their own Medicaid Personal Care Assistant services by receiving, and managing, a monthly cash allowance and working with a consultant to develop a Cash Management Plan identifying the services they need and the individuals and/or agencies they can hire to provide those services. (This is also referred to as a "cash and counseling" or "consumer-directed" approach.)

Informal information from the department suggests that the Personal Preference Program (which in FY 2014 is budgeted within the Payments for Medical Assistance Recipients – Personal Care appropriation) has experienced significantly higher utilization in recent years. This information is consistent with performance data from the Governor’s FY 2014 Budget (page D-168) and the Governor’s FY 2015 Budget (page D-163) indicating the utilization trends for the NJ Personal Preference Program:

Clients served in the NJ Personal Preference Program: FY 2012 to FY 2014

	FY 2012 actual	FY 2013 actual	FY 2014 revised
Clients	1,964	2,600	3,200

Available information suggests that this program will be incorporated into, and budgeted under, the Managed Long Term Services and Supports appropriation (see page D-186 of the Governor’s FY 2015 Budget) in the Division of Aging Services in FY 2015.

- **Questions:** What specific factors account for the recent growth in the Personal Preference Program? How much is budgeted for the program in FY 2014? How much funding is associated with the program in FY 2015? Will the integration of the program into MLTSS change, if at all, how clients access and utilize the program in FY 2015 and beyond? What role will managed care organizations play in managing the Personal Preference Program, and how will that role affect recipients’ ability to direct their own care?

Answer: The growth in the Personal Preference Program (PPP) can be attributed to two specific factors; 1) Recent CMS mandates that everyone qualifying for PCA services be given a choice of its delivery system, agency services or self-hire. With PCA moving to managed care, this mandate has been included in the quality functions required by the MCOs. The MCO’s are obligated to obtain client sign off denoting a choice of delivery method for everyone they evaluate for PCA. 2) In 2014, the PPP expenses were excluded from the capitation rate for the MCOs as PPP was not part of the PCA carve in.

Beginning in FY 2015, Personal Preference will be included as part of the capitation rate provided to the MCOs under MLTSS as the MCOs will be responsible for funding both agency and self-hire delivery systems for the PCA services.

As DHS moves to MLTSS, the Personal Preference Program responsibility will be shared between the MCOs and the Division. Clinical and Assessment Functions will be the sole responsibility of the MCOs and Operational and Administrative functions will remain with DDS. DDS will essentially manage the PPP program on behalf of the MCOs using funding provided to them under the capitated rate. This approach allows the state to assure that the program is consistently operated across all MCOs, and complies with CMS polices that the state maintain authority over its PCA delivery alternative. Other states including Massachusetts and Ohio have successfully implemented a similar

design in partnership with managed care organizations in MLTSS models.

DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)

39. In February 2013, the Governor announced the settlement of two lawsuits filed in 2005 and 2008 by Disability Rights New Jersey. The lawsuits contended that the State had failed to comply with the U.S. Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999), which required that residents with disabilities live in the least restrictive appropriate environment. The settlement agreement between the State and Disability Rights New Jersey requires the State to discharge approximately 600 individuals residing in State developmental centers to community placements during the period from fiscal year 2013 to 2017. It must also discharge a number of individuals equal to the number of new admissions of community placement-eligible individuals, up to 35 per year. According to performance metrics on page D-162 of the Governor's FY 2015 Budget, the department expects to have made 559 such placements from FY 2013 to the end of FY 2015. If few new admissions of community placement-eligible individuals have occurred, it would appear that the State is well ahead of the schedule required by the settlement agreement.

- **Questions:** How many community placement-eligible individuals were admitted each year to developmental centers between FY 2012 and FY 2014? Does the division expect to meet all of its obligations under the agreement to discharge developmental center residents to the community prior to FY 2017? Are any savings possible from the accelerated discharges, such as avoided costs related to consultants or monitoring? By the end of FY 2015, how many community placement-eligible individuals are expected to still be residing in developmental centers?

Answer: A total of 19 individuals were admitted to developmental centers between FY 2012 and FY 2014, of which 11 were court ordered to the Moderate Security Unit (MSU) at New Lisbon. There has not been a voluntary admission since December 2011 and there have been no court ordered admissions in calendar years 2013 or 2014. Of the 19 individuals admitted between FY 2012 and FY 2014, 8 have returned to the community, 1 was discharged to Ancora Psychiatric Hospital and 1 is deceased. Of the 9 remaining in developmental centers, 2 are community eligible, 1 is not community eligible per the private guardian, and 6 remain in the MSU and are not community eligible. The Division expects to meet its discharge obligations, at which point cost saving opportunities will be evaluated. By the end of FY 2015, approximately 230 community placement-eligible individuals are expected to be residing in the developmental centers.

40a. Pursuant to the binding recommendations of the Task Force on the Closure of State Developmental Centers, issued August 1, 2012, DHS plans to close North Jersey Developmental Center on July 1, 2014, followed by Woodbridge Developmental Center on January 1, 2015. Census at the two centers has steadily decreased since the Task Force's recommendations were issued, while census at other developmental centers has remained relatively steady.

- **Questions:** Please describe how DDD is managing census reduction at North Jersey and Woodbridge. How many residents have been, or will be, transferred to other developmental centers? How many have received, or will receive, community placements? How many have passed away or otherwise left DDD's care? What specific steps have been taken to expedite the development of new community placements in northern New Jersey to accommodate former residents of North Jersey and Woodbridge?

Answer: Housing development is ongoing for individuals who have chosen community placement. Developmental center transfers are evaluated monthly based on their ICF/ID licensed capacity. As of March 28, 2014, 120 individuals have been transferred from North Jersey

Developmental Center to other developmental centers (another 90 are planned), 89 have moved to community placements, 13 have passed away, and 1 was discharged from services. As of the same date, 82 individuals have been transferred from Woodbridge Developmental Center to other developmental centers (another 183 are planned), 35 have moved to community placements and 9 have passed away. Across all centers, 175 individuals have moved to the community in Fiscal Year 2014.

The Division has taken the following actions to expedite housing development in northern New Jersey:

- 1) Encouraged use of the Special Needs Housing Partnership (SNHP) – currently this program has 35 projects (137 beds) in various stages of development in northern New Jersey.
- 2) Created an enhanced SNHP funding option for Bergen and Passaic counties that will fund an additional 10 projects (40 beds), with an increased funding cap (up to \$650,000/home instead of \$500,000) to reflect the higher costs of acquisition and accessibility renovation in those counties.
- 3) Encouraged use of Sandy Special Needs Housing Fund to develop housing in impacted counties in northern New Jersey – the first two DDD projects to receive commitments through this program are located in Bergen County.
- 4) Facilitated partnerships between professional developers and experienced service providers for the development of new housing. By partnering with a professional developer, the service provider can access their development expertise, as well as the developer’s familiarity with a variety of financing sources, and can often work with multiple developers to have projects in development simultaneously. In FY 2014, 19 projects (74 beds) in northern New Jersey have been or are in development through this partnership model.
- 5) Provided “seed capital” of up to \$25,000 per bed for projects serving 3 or 4 Olmstead individuals. In FY 2014, there are 18 projects (73 beds) that have been developed or are in development in northern New Jersey using this capital.

40b. Prior to the current plans to close North Jersey and Woodbridge Developmental Centers, when DHS was originally planning to close Vineland Developmental Center, the division had outlined various initiatives to support employees affected by the developmental center closure in its *Blueprint for the July 30, 2013 Closure of Vineland Developmental Center*. These initiatives included providing support and assistance in identifying employment options through the establishment of a Career Development Center and the availability of online training through the College of Direct Supports.

- **Questions:** What are the division’s plans for providing support and assistance to affected employees of the North Jersey and Woodbridge Developmental Centers? What percentage of affected employees is expected to transfer into vacancies at other developmental centers, DDD Community Services, or DDD Central Office? As context for the impending closures, please provide updated data regarding: the number of staff currently employed at all seven developmental centers, by developmental center and by job title; and the average salary associated with each job title.

Answer: Retirement planning, job search, resume writing and interview assistance will be provided to staff through Employee Resource and Information Centers at North Jersey Developmental Center and Woodbridge Developmental Center. Employees will continue to have no-cost access to the College of Direct Support, an online training program that some community colleges accept as nine credits towards an Associate degree. The Division is actively working with staff and other divisions within DHS to identify employment and transfer opportunities in advance of the closure. State civil

service statutes, however, required a Department-wide staffing plan, and the exercise of civil service rights and transfers will encompass all divisions.

40c. The closures of North Jersey and Woodbridge Developmental Centers may eventually result in opportunities for the State to either repurpose the properties for other public uses or to sell the properties. For instance, in 2007, the State sold the 256.5 acre North Princeton Developmental Center property, including land and improvements (over 100 State buildings, largely in substandard or obsolescent condition), to Montgomery Township in Somerset County for \$5,950,000, as authorized pursuant to P.L.2006, c.51.

- **Questions:** What are the State's current plans for the disposition of the North Jersey and Woodbridge Developmental Center properties following their closures? Please provide the most recent estimates available of the potential market value of the North Jersey and Woodbridge properties and, as context, the potential market value of the five other developmental center properties, including the estimated value of each developmental center's land and improvements.

Answer: DHS has advised the New Jersey Department of Treasury of the intent to close North Jersey DC and Woodbridge DC, and once completed, the properties will be turned over to that department for disposition. Meetings have taken place with regard to repurposing these sites for potential local, county or state uses. Discussions will continue to focus on potential alternative uses for the vacated sites and avenues to keep jobs within the area. The potential sale of the properties also will be explored.

Vehicles, furnishings, office equipment and supplies at the sites are being transferred to other DCs as needs arise. Once the doors of the facilities are closed, the remaining equipment will be made available to other state offices.

Estimated building and land values are contained in the Division of Taxation's Property Tax List database (https://wwwnet1.state.nj.us/Treasury/Taxation/TYTR_TLSPS_WEB/TaxListSearch.aspx).

41a. As required by a language provision in the FY 2014 Appropriations Act (Appropriations Handbook, p. B-117) the Commissioners of Human Services and Labor and Workforce Development are required to submit, by January 1, 2014, a plan to the Joint Budget Oversight Committee (JBOC) for the transfer of sheltered workshop services from DHS to the Division of Vocational and Rehabilitative Services (DVRS) in the Department of Labor and Workforce Development. To date, however, a plan has not been received by JBOC.

In anticipation of the transfer of services, the Governor's FY 2015 Budget includes a shift of approximately \$5.5 million from DDD (DHS) to DVRS (pages D-201 to D-202 and D-231 to D-232). However, in response to questions from the Senate Budget and Appropriations Committee in May 2013, DHS indicated that, in FY 2014, it held approximately \$6.9 million in contracts with providers of sheltered workshops.

- **Questions:** By which date will a plan for the transfer of sheltered workshop services be submitted to JBOC, as required by budget language? Why is only \$5.5 million to be transferred from DDD to DVRS, rather than the full \$6.9 million? Will DDD continue to provide funding for any aspect of the sheltered workshop program? What role, if any, will DDD continue to play in providing or overseeing sheltered workshop services for DDD clients?

Answer: The Departments of Labor and Workforce Development (LWD) and Human Services worked together to draft a joint plan, as required by FY14 budget language. LWD submitted that joint plan on behalf

of both Departments to the Legislature in February, 2014. The dollar amount transferred reflects the cost of programs for the 710 individuals that will now be administrated by DVRS. The Division met with each provider individually to determine the actual amount spent on sheltered workshop services, as opposed to other disability services funded through the same contract. The sheltered workshop funds were transferred to DVRS with no reduction in capacity. Once the transfer is complete, DDD will no longer provide sheltered workshop services.

41b. Current DVRS rules require that individuals must meet at least 20 percent of the production rate of an individual without a disability to participate in supported employment services. Individuals who do not meet this standard have historically been referred to DDD. However, the transfer of funding described above may indicate that DDD will cease to provide any sheltered workshop services in FY 2015.

- **Questions:** Under the transition plan being developed by the Commissioners, how will individuals who do not meet the 20 percent standard be able to access sheltered workshop services? Who will be responsible for determining whether sheltered workshop services are appropriate for an individual who does not meet the 20 percent standard? On what basis would such a determination be made? How will future graduates and their families be made aware of opportunities to participate in sheltered workshops, if those services are not administered by DDD?

Answer: Labor and Workforce Development proposes to ensure that 21% of all sheltered workshop participants (currently 710 of the 3,378 total current participants) will not be required to meet the 20 percent production rate requirement. As in the past, individuals will be able to enroll in DVRS programs; although DDD will longer provide sheltered workshop services, DDD will continue to provide Career Planning, Individual Supported Employment and Group Supported Employment services.

42. The Community Care Waiver (CCW) allows the State to claim federal Medicaid matching funds for a package of services provided to enrolled individuals with developmental disabilities who are living in the community. The CCW was originally scheduled to expire on September 30, 2013, but has received short-term extensions. The most recent information indicates that the CCW is scheduled to expire on March 29, 2014. A CCW renewal application is currently pending federal approval; however, no information is available regarding the delay in that process.

- **Questions:** What is the current status of the CCW renewal application? What are the most notable proposed changes in the CCW program, as compared to the currently authorized program? Has the federal government raised objections to any specific elements of the renewal application? What is the current anticipated timeframe for approval?

Answer: The CCW renewal application has been extended until June 27, 2014. The notable changes include the expansion of eligible Medicaid groups to include NJ Workability; additional employment services and therapies such as Habilitative Occupational Therapy, Physical Therapy, and Speech and Language Therapy; and Behavioral Supports services as a result of stakeholder feedback. In addition, the renewal application informed CMS of DDD's intent to implement the New Jersey Comprehensive Assessment Tool (NJCAT) in order to determine an individual's functional eligibility and level of care determination.

43a. Under the Comprehensive Medicaid Waiver, the State is authorized to establish a Supports Program within the State Medicaid program, which would provide various employment and day habilitation services and

individual and family supports (e.g., adaptive technology, behavioral supports, respite, etc.) to individuals with developmental disabilities who live with family members or in their own homes and who are not receiving Community Care Waiver services. The Supports Program would closely resemble the current State-funded Family Supports Program, but would receive a 50 percent federal Medicaid match, instead of being entirely State-funded. The department's response to an FY 2014 OLS Discussion Point indicated that Supports Program enrollment was expected to begin in FY 2014, but to date enrollment has not begun.

- **Questions:** What accounts for the delay in the roll-out of the Supports Program? When will enrollment begin? What amounts of federal revenues, and corresponding State savings, are assumed from the Supports Program in the FY 2015 budget? Will the State be able to retroactively claim federal matching funds under the authority of the Supports Program for services provided before enrollment has begun?

Answer: The Supports Program implementation timeline has been adjusted to ensure that adequate systems development and testing occurs prior to the start of claiming. Supports Program enrollment and claiming will begin in the second half of FY 2015, with revenue projections reflected as of the Federal Funds update.

43b. In response to an FY 2014 OLS Discussion Point, the department indicated that, although the Supports Program enrollment process would take time (once enrollment began), there would not be a waiting list for Supports Program services, and that DDD anticipated providing Supports Program services to all of the adults currently on the Community Care Waiver (CCW) waiting list.

- **Questions:** How many total individuals are currently on the CCW waiting list? Of those individuals, please also indicate the number currently on: the Priority Waiting List; and the General Waiting List.

Answer: As of March 2014, there were 6,592 individuals on the CCW Waiting List (3,791 Priority, 2,801 General). Of those individuals currently on the list, 1,100 (428 Priority, 672 General), or 16.7%, are under the age of 21.

44. Children under age 18 with developmental disabilities are required to complete an eligibility determination process through the Division of Children's System of Care (CSOC) in the Department of Children and Families prior to receiving developmental disability services.

Available information indicates that these children are also required to complete a separate intake and eligibility determination process through DDD in the Department of Human Services (DHS) between the ages of 18-21 if they wish to be determined functionally eligible for adult DDD services (through DHS) beginning at age 21.

- **Questions:** Please explain the DDD intake and eligibility determination process for children with developmental disabilities who are transitioning from CSOC to DDD. How does the DDD eligibility determination process differ from the eligibility determination process for children when they first apply for services through CSOC? Except for instances when obtaining updated information regarding the person's condition is necessary, could the two divisions' processes be consolidated into a one-time process? What amount of State savings might be realized from efficiencies resulting from such consolidation?

Answer: The CSOC application is modeled on the DDD application and both Divisions use the same federal definition of a developmental disability. At age 18, when an individual enters the DDD eligibility process, CSOC shares their documentation, but a reevaluation remains necessary. Many

years may pass from the time an application is submitted to CSOC for a child, to the time an application is submitted for adult services with DDD – the elapsed time could be over a decade. It would not be appropriate, for the person or DDD, to rely on outdated information from an application submitted for a child. Individuals with developmental disabilities present differently from a clinical perspective when they are young, for example, age five or six years, than when they are older, at 18 years or above. Assessment tools used by clinicians vary based upon whether the individual is a young child or an adult, as does the framework for considering whether an individual has substantial functional limitations. Additionally, an individual's functional limitations may change over time from when they are a young child through adulthood. The current process minimizes the effort and expenditure needed, while ensuring an accurate assessment of an individual's support needs.

COMMISSION FOR THE BLIND AND VISUALLY IMPAIRED (CBVI)

45. According to performance data on page D-162 of the Governor’s FY 2015 Budget, 93.9 percent of Commission for the Blind and Visually Impaired (CBVI) clients in vocational rehabilitation programs had exited into employment in FY 2013. The same data indicate a revised FY 2014 estimate of 93.9 percent and an FY 2015 performance target of 93.9 percent.

Performance data on page D-167 of the Governor’s FY 2014 Budget indicate that 98.5 percent of CBVI clients in vocational rehabilitation programs had exited into employment in FY 2012. The same data indicate FY 2013 and FY 2014 performance targets of 100 percent on this same measure.

- Questions:** What accounts for the decrease in performance on this indicator from actual performance in FY 2012, and from expected performance in FY 2013 and FY 2014? What accounts for the apparent downward revision in the FY 2015 performance target for this indicator, as compared to the FY 2013 and FY 2014 performance targets? As context, what was the total (gross) funding expended on CBVI vocational rehabilitation programs in FY 2013? What is the total (gross) funding for such programs allocated in FY 2014, and recommended in FY 2015? Please also disaggregate the FY 2013, FY 2014, and FY 2015 amounts by State and federal dollars.

Answer: The Commission purchased a new client tracking system which was fully implemented during FY 2013. Data was rerun and the actual indicator in FY 2012 was 89.1%, not 98.5%. The actual indicator in FY 2013 was 93%. The targets for FY 2014 and FY 2015 of 93.9% are attainable.

The Federal standard for this performance indicator is 89%, but the agency typically serves consumers that meet the definition from the 90th percentile all the way to 100%, depending on the period of time measured.

	<u>FY 2013</u>	<u>FY 2014</u>	<u>FY 2015</u>
STATE	\$3,432,886	\$3,437,512	\$3,437,512
FEDERAL	<u>12,683,951</u>	<u>12,701,041</u>	<u>12,701,041</u>
GROSS	\$16,116,837	\$16,138,553	\$16,138,553

DIVISION OF FAMILY DEVELOPMENT (DFD)

46. The recently enacted federal farm bill, the “Agricultural Act of 2014,” Pub.L.113-79 included a new restriction on the Supplemental Nutritional Assistance Program (SNAP, formerly known as the Food Stamp program) that would require SNAP recipients to receive at least \$20.00 per year in utility assistance in order to qualify for additional benefits. Several states, including New Jersey, have provided SNAP recipients with minimal utility subsidies, as low as \$1.00 per year, in order to qualify them for the additional benefits. This practice has been referred to as “heat and eat.” At least four states (New York, Connecticut, Pennsylvania, and Oregon) have increased the minimum utility benefit to \$20.00 in order to avoid reducing SNAP benefits, generally by drawing down funding reserves already available in their utility assistance programs.

- **Questions:** If the State does not increase utility benefits to at least \$20.00, how many SNAP recipients will see a reduction in benefits? How much money would be lost to them, in aggregate? What would be the estimated State cost in FY 2015 of increasing utility benefits to at least \$20.00? Please coordinate your response with the Department of Community Affairs, if appropriate.

Answer: In response to federal legislation recently passed by Congress, DCA and DHS are currently reviewing this issue. No determination has been made regarding next steps. This review includes an analysis of the number of participants in the programs, as well as the cost of the benefits provided for the past several years. As soon as this information is developed, it will be shared with the Committee ensuring responsiveness to the questions asked.

47a. The Division of Family Development (DFD) is developing and implementing a new social service information system known as the Consolidated Assistance Support System (CASS), which will replace a system that has been in operation since the mid-1980s. CASS is intended to provide county welfare agencies with a comprehensive system for managing client information and determining eligibility for a number of programs in DFD and other DHS divisions, including: General Assistance, Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), child care assistance, Medicaid, and NJ FamilyCare.

In response to an OLS FY 2014 Discussion Point, DHS reported the status of CASS as follows:

- Phase 6 (Testing and Conversion) was expected to be completed by August 30, 2013.
- Implementation of CASS was scheduled for October 2013.
- The total contract cost with Hewlett Packard (HP) for developing CASS was \$107.5 million.

At the January 2014 Medical Assistance and Advisory Council meeting, DHS shared that CASS was still under design and development, with ongoing system testing, and that the department was working to finalize the implementation schedule.

- **Questions:** What is the current status of CASS with respect to its implementation date and its projected total cost? What portion of any costs exceeding the previously reported \$107.5 million are expected to be borne by the State during: i.) FY 2014; ii.) FY 2015; and iii.) the remaining duration of the project?

Answer: Phases 1 through 5.5 of the CASS Project have been completed. The current status of the project remains in Phase 6-Testing and Conversion.

The approved development & implementation contract increased from the previously reported \$107.5 million to approximately \$118.3 million, which includes an additional amendment (\$10.8M) that expanded the project to include functionality in support of the Federal Health Care Law. Of the \$10.8M, projected expenditures in FY 2014 amount to \$631,000, of which approximately \$69,000 is State funding. DHS is currently anticipating to expend the remaining \$10.1 million (approximately \$1.2 million State share) through FY 2015.

47b. The federal government generally provides 50 percent federal reimbursement for Medicaid administration costs. However, an enhanced 90 percent federal reimbursement has been provided for the design and development of new or improved Medicaid eligibility determination systems that states are developing to accommodate the Affordable Care Act's new modified adjusted gross income (MAGI) rules for Medicaid eligibility and to coordinate Medicaid coverage with the health insurance marketplaces. Available information indicates that DFD receives this 90 percent federal reimbursement for CASS design and development costs related to Medicaid.

In April 2013, the Centers for Medicare & Medicaid Services clarified that the costs involved in the ongoing maintenance and operations of such eligibility determination systems, once operational, may qualify for an enhanced 75 percent federal reimbursement upon the systems' compliance with certain federal standards and conditions. Qualifying costs include staff costs associated with processing Medicaid applications and renewals through the systems, performing eligibility determinations, and conducting eligibility-related case maintenance and customer service activities. The start date for the enhanced reimbursement would be October 1, 2013 or the actual start of the operations of the approved eligibility determination system, whichever is later.

- **Questions:** Does the State expect to receive the enhanced 75 percent reimbursement rate for eligibility determination activities once CASS is operational? If so, how much additional federal revenue is the enhanced reimbursement rate anticipated to generate, on an annualized basis? Of that additional revenue, what portion would be allocated to the county welfare agencies and what portion would be retained by the State? What amount of net State savings, if any, are anticipated in FY 2015 due to CASS becoming operational and the enhanced reimbursement being realized?

Answer: DHS is currently working with CMS to determine which costs are eligible for this enhanced match.

48. According to information provided by DHS, 7,000 children were on the waiting list for Work First New Jersey (WFNJ) subsidized child care services as of June 15, 2012. In response to a subsequent FY 2014 OLS Discussion Point, the department indicated that approximately 100 children were on the waiting list as of April 2013, and that those 100 children were projected to be placed within two months.

- **Question:** How many children are currently on the waiting list for WFNJ Child Care services? How many children, on average each month, are projected to be on the waiting list in FY 2015?

Answer: There is no current or projected child care waiting list.

49a. The appropriation for Work First New Jersey Child Care 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).

The overall appropriation for Work First New Jersey Child Care (page D-209) is recommended to increase by \$22.6 million in FY 2015, from \$294.8 million (gross) in FY 2014 (adjusted) to \$317.4 million in FY 2015, which includes a recommended \$14.5 million increase in State appropriations and an \$8.1 million increase in federal funds.

Evaluation data on page D-207 of the Governor’s FY 2015 Budget suggest that the expected FY 2014 cost per-child has increased significantly from the original FY 2014 estimates (presented on page D-214 of the Governor’s FY 2014 Budget) in nearly all child care categories:

Average Per-Child Costs of Work First New Jersey Child Care programs

Category	Original FY 2014 Per-Child Cost (FY 2014 Governor’s Budget)	Revised FY 2014 Per-Child Cost (FY 2015 Governor’s Budget)	Percent Change
Low income families in Child Care Assistance Program	\$4,343	\$5,088	17.2%
Children placed through protective services	\$5,504	\$6,967	26.6%
Active TANF recipients in work activity	\$5,365	\$5,866	9.3%
Transitional child care services	\$4,674	\$5,299	13.4%
Abbott Child Care Services	\$2,848	\$3,351	17.7%
Post Transitional Child Care	\$4,468	\$4,413	(1.2%)
Total child care payments for eligible families (across all categories)	\$4,402	\$5,154	17.1%

Source: OLS calculations of per-child costs, based on total expenditures and average monthly children reported in the Governor’s FY 2014 Budget (FY 2014 original estimate) and the Governor’s FY 2015 Budget (FY 2014 revised)

- **Questions:** What accounts for the apparently significant growth in per-child costs across nearly all categories of Work First New Jersey Child Care services? Why does the per-child cost growth for children placed in protective services exceed growth in other categories? What accounts for the exception of reduced per-child costs in post-transitional child care?

Answer: The original estimates for Work First NJ Child and Post Transitional Child Care services provided in the SFY 2014 Governors’ Budget were based on data derived from legacy child care systems. Current estimates are compiled by using data from the recently implemented eChildCare Time/Attendance/Payment system that accounts for the actual number of children being served and compares it against the actual cash payment to providers. Therefore, the SFY 2014 Budget estimates are not reliable when compared against the Revised SFY 2014 estimates due to the differences in these two systems.

49b. Information from the Executive indicates that DHS anticipates an FY 2014 lapse of \$14.5 million due to “WFNJ Child Care Trend.” As noted above, the FY 2014 adjusted appropriation for Work First New Jersey is \$294.8 million. Excluding the amount of the anticipated lapse, the remaining funds available from the FY 2014 appropriation would be \$280.3 million.

The FY 2015 recommendation of \$317.4 million, which includes a recommended \$14.5 million State increase and a \$8.1 million increase in federal funds, represents a 13.0 percent increase over the \$280.3 million in anticipated, unexpired funds from the FY 2014 appropriation.

According to evaluation data on page D-207 of the Governor’s FY 2015 Budget, total estimated FY 2014 expenditures on child care payments are revised to \$247.9 million. The same evaluation data projects estimated FY 2015 expenditures of \$257.5 million, representing a 3.9 percent increase over the revised FY 2014 expenditures.

- **Questions:** What anticipated trends in utilization or costs account for an anticipated lapse of \$14.5 million in FY 2014 and a recommended increase of \$14.5 million in FY 2015? As the 3.9 percent increase in estimated child care payment expenditures from FY 2014 to FY 2015 is significantly lower than the 13.0 percent increase in funding from the unexpired FY 2014 appropriation to the FY 2015 recommended appropriation, can the FY 2015 recommended appropriation be reduced?

Answer: DFD was able to utilize unspent FFY 2013 Federal Child Care resources to offset a portion of the SFY 2014 child care expenditures. The use of these unspent funds resulted in a projected \$14.5 million surplus at the end of the SFY 2014. By lapsing the \$14.5 million, no unspent FFY 2014 federal funds remain to offset SFY 2015 expenses. The annualization of the waiting list reduction and continued growth in the number of children served necessitates that the \$14.5 million be replaced in SFY 2015 so all child care obligations can be met. Reports generated by the eChildCare time and attendance payment system enables DFD to more accurately project future funding requirements. Overall, Child Care evaluation data projections show an increase of approximating \$10 million from FY 2014 to FY 2015.

50. The following caseload and funding trends are observed for the Work First New Jersey – Temporary Assistance for Needy Families (TANF) program, which provides cash assistance to very low-income parents and children through the Work First New Jersey program.

AVERAGE MONTHLY RECIPIENTS	FY 2011 Actual	FY 2012 actual	FY 2013 actual	FY 2014 revised	FY 2015 estimate
WFNJ-TANF (total)	105,647	107,189	101,937	91,291	92,774
% change from previous year	---	1.5%	(4.9%)	(10.4%)	1.6%

Source: Evaluation data from Governor’s Budgets for FY 2013-FY 2015.

Based on the above data, it is noted that, between FY 2011 and FY 2014, the WFNJ –TANF caseload is projected to have decreased an average of 4.6 percent per year, assuming that the revised FY 2014 caseload projection remains valid.

- **Questions:** What factors have been contributing to decreasing WFNJ-TANF caseloads since FY 2012? Why is the trend of decreasing WFNJ-TANF caseloads projected to reverse itself, with slight growth in FY 2015 compared to FY 2014?

Answer: There are multiple factors that may be contributing to the decrease in the TANF caseload. The Temporary Assistance for Needy Families (TANF) program is time-limited to a lifetime of 60 months. Some of the decrease in the caseload could be due to the time-limit terminations. Another factor to the decrease could be regular case closures if a family is no longer in need of assistance. A third factor could be an improving economy whereby family units are better able to

support themselves without the need for public assistance. The slight growth in FY 2015 is projected due to the unknown impact of the termination of extended unemployment benefits in December 2013, as there is often a time lag before an impact is seen in public assistance.

51. The following caseload and funding trends are observed for the General Assistance cash assistance program, which provides cash assistance to very low-income single adults and couples without dependent children through the Work First New Jersey program.

AVERAGE MONTHLY RECIPIENTS	FY 2011 actual	FY 2012 actual	FY 2013 actual	FY 2014 revised	FY 2015 estimate
General Assistance (total)	55,812	47,179	41,167	34,447	31,296
<i>% change from previous year</i>	---	<i>(15.5%)</i>	<i>(12.7%)</i>	<i>(16.3%)</i>	<i>(9.1%)</i>

Source: Evaluation data from Governor’s Budgets for FY 2013-FY 2015.

Based on the above data, it is noted that, between FY 2011 and FY 2014, the General Assistance caseload (including “employable” and “unemployable” recipients) is projected to have decreased an average of 14.8 percent per year, assuming that the revised FY 2014 caseload projection remains valid.

In response to OLS FY 2014 Discussion Points, the division highlighted several factors that have contributed to the ongoing decreases in General Assistance (GA) 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 since FY 2011: Implementation 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.
- **Questions: What have been the most significant factors contributing to the continuing decrease in General Assistance caseloads during the current fiscal year? Why is the trend of decreasing General Assistance caseloads projected to slow somewhat in FY 2015?**

Answer: The General Assistance program has undergone several significant changes in recent years that have caused the caseload to decrease. The most significant change is the implementation of the 28-day protocol which requires all new applicants to participate in job search activities. Another significant factor in GA caseload trend reduction is the adherence to time limits for GA recipients. The third most significant factor contributing to the reduction in GA caseload is due to the work of the compliance teams. The compliance teams review cases to ensure recipients meet all requirements for eligibility. The compliance team reviews result in active cases being closed and also prevent ineligible recipients from opening a new case and receiving benefits.

For SFY 2015, DFD does not anticipate that caseload will continue to decline at the same levels as in previous fiscal years. The original effect of these programs assisted in identifying and terminating

clients that were ineligible for assistance. As these programs progress, new client applications are rigorously scrutinized to ensure that only those individuals truly in need will receive program benefits and/or training. The impact of the compliance teams include both cost reductions and cost avoidance.

52a. Performance data on page D-162 of the Governor's FY 2015 Budget indicate that General Assistance Compliance Teams generated \$1.6 million and \$2.5 million in FY 2013 State savings associated with General Assistance (GA) cash assistance and GA Emergency Assistance, respectively. Available information indicates that the savings are generated from GA case closures or application denials based on ineligibility for benefits discovered through the Compliance Teams' case reviews. The performance data indicate that about 27,500 case reviews were conducted in FY 2013.

The performance data also indicate that the GA Compliance Teams are expected to generate \$2.5 million in GA cash assistance and \$1.8 million in GA Emergency Assistance savings in FY 2014, associated with an anticipated 25,000 case reviews. In response to an FY 2014 OLS Discussion Point, the division indicated that the total operating cost for the compliance teams during FY 2012 was \$500,849.

- **Questions:** How many GA Compliance Teams were operating in FY 2013, at what total operating cost? In FY 2014, at what total operating cost? How many GA Compliance Teams are anticipated to be operating in FY 2015, at what total operating cost? Why are the Compliance Teams expected to realize greater FY 2014 savings from GA cash assistance, but reduced FY 2014 savings from GA Emergency Assistance, when compared to FY 2013?

Answer: Currently there is one compliance team tasked with reviewing General Assistance and all Emergency Assistance. The team is comprised of 14 staff and one (1) supervisor and the personnel cost for all team members is \$1.285 million for SFY 2014. The compliance team is projected to close more GA assistance cases in FY 2014 (2,000) than were closed in FY 2013 (1,732) which accounts for the increase in cash assistance savings. However, FY 2014 projections indicated that a lower percentage of the GA cash assistance cases being closed also included a GA Emergency assistance payment; therefore, a lower GA EA savings is expected to be realized.

52b. In response to an FY 2014 OLS Discussion Point, the division indicated that Supplemental Security Income (SSI) and Temporary Assistance for Needy Families (TANF) Compliance Teams were anticipated to be operational and to generate total savings of \$4.8 million in FY 2014.

- **Questions:** How many SSI Compliance Teams and TANF Compliance Teams were operating in FY 2014, at what total operating cost for each type of team? How many of both types of Compliance Teams are anticipated to be operating in FY 2015, at what total operating cost for each type? Please provide FY 2014 performance data for the SSI and TANF Compliance Teams that are comparable to data reported for the GA Compliance Teams, including, by program (i.e., disaggregating SSI and TANF): the estimated annual number of cases reviewed; the estimated annual number of cases reviewed per worker; the estimated number of cases closed or denied based on review; and the total anticipated savings.

Answer: During FY 2014, new five (5) member Emergency Assistance (EA) compliance team have been tasked with reviewing both SSI and TANF Emergency Assistance cases throughout the State. For this review, four (4) staff began reviewing EA cases in September 2013 with a fifth staff member added in January 2014. The estimated personnel cost for SFY 2014 is \$303,000. The team size is expected to remain the same during SFY 2015 with annualized personnel costs estimated at \$431,000. For the period of September 1 through December 31, 2013 the 4 member team was able to review 388 Emergency Assistance cases. Of the 388 cases reviewed, 65 were denied or closed. The average cost of each of these cases was \$1,128 per month. DFD estimates that by closing these cases it would save a total of \$586,000 in SSI (\$235,000) and TANF (\$351,000) EA costs. Only one quarter of

data is available at this time, therefore, DFD is waiting on additional data collection to establish caseload review and cost savings estimates

52c. Available information suggests that, in some counties, the activities of the GA Compliance Teams may have been associated with delays in the processing of county-approved GA applications. Anecdotal reports indicate that, in some cases, there may be two to three Compliance Team reviewers assigned to review all of a county’s GA applications, which may number several hundred each month. In turn, this may potentially create delays in approving valid applications and providing individuals with assistance.

- **Questions:** How many Compliance Team reviewers are typically assigned to each county, for what period of time? What performance data does the division collect regarding the average time for a GA Compliance Team to complete application reviews? Please provide any such data available for FY 2013 and FY 2014. Has the division observed any difficulties with the Compliance Teams reviewing applications on a timely basis? If so, what steps have been taken to address those challenges?

Answer: Originally initiated with a team of five (5) people, currently there is one overall GA compliance team with 14 staff and one (1) supervisor. It is difficult to provide a standard time period in any county welfare agency (CWA) since the review timeframe is dependent upon the volume of cases and the scope of the corrective regulatory compliance action identified in each location. There are typically no less than two (2) reviewers in a county and the timeframe duration ranges from 2-12 months.

Cases are given to the State reviewer who identifies errors and returns the cases to the CWA worker for correction. The delay is often caused by the late submission of the cases by CWA staff to the team for review or re-review; therefore, resulting in a delay in final approval.

The State reviewers average 15 cases per day and return cases within 1-4 days (with the latter only in extreme cases) for further action by CWA staff.

53. The appropriation for Payments for Cost of General Assistance (page D-209) supports the provision of General Assistance cash assistance to very low-income single adults and couples without dependent children through the Work First New Jersey program.

The overall appropriation for Payments for Cost of General Assistance is recommended to decrease by \$14.9 million (State), from \$65.2 million in FY 2014 (adjusted) to \$50.3 million in FY 2015 (page D-209 of the Governor’s FY 2015 Budget). Evaluation data on page D-206 estimate FY 2015 expenditures of \$50.3 million on General Assistance for employable and unemployable recipients (adjusting for refunds to assistance), which are also \$14.9 million below the originally estimated FY 2014 expenditures of \$65.2 million (see page D-213 of the Governor’s FY 2014 Budget).

However, based on information from previous Budgets, and as indicated in the table below, the division appears to have originally overestimated the FY 2012 and FY 2013 expenditures on General Assistance, and the original FY 2014 estimate is also above the revised projection. The pattern of lower than expected expenditures appears correlated with lower than expected caseloads:

Fiscal Year	Average Monthly Recipients: Original Estimate	Average Monthly Recipients: Actual	Expenditures: Original Estimate	Expenditures: Actual	Expenditures: Percent change from original to actual
2012	60,489	47,179	\$91,869,974	\$78,509,301	(14.5%)

2013	45,696	41,167	\$74,474,674	\$68,958,371	(7.4%)
2014	38,464	34,447 (revised estimate)	\$65,245,854	\$56,262,376 (revised estimate)	(13.8%)

Source: Evaluation data from Governor's Budgets for FY 2012-FY 2015.

- **Questions:** As the division has consistently overestimated General Assistance expenditures since FY 2012, are actual FY 2015 expenditures likely to be less than estimated? Can the FY 2015 appropriation be reduced, if lower than expected caseloads are assumed?

Answer: DFD uses several years of historical caseload and cost data to develop current and future General Assistance caseload and cost projections. In addition, DFD makes adjustments to these estimates based upon proposed or recently implemented programmatic changes. Some examples of these changes are the addition and expansion of a GA Compliance review team and the implementation of the 28-day Protocol. Although estimates for the impact of these and other changes are included within our projections, the size of the program and the lack of historical data related to these recent changes impede our ability to more accurately predict total expenditures and caseload statistics.

With respect to the SFY 2015 appropriation, we do not anticipate lower than expected caseloads.

54. The appropriation for the General Assistance Emergency Assistance Program (page D-209) supports the provision of certain emergency benefits to very low-income single adults and couples without dependent children through the Work First New Jersey program. These benefits include 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.

The overall appropriation for General Assistance Emergency Assistance is recommended to decrease by \$11.8 million, from \$66.6 million in FY 2014 (adjusted) to \$54.7 million in FY 2015 (page D-209 of the Governor's FY 2015 Budget). Evaluation data on page D-206 estimate FY 2015 State expenditures of \$54.7 million on General Assistance Emergency Assistance, which are \$11.8 million below the originally estimated FY 2014 State expenditures of \$66.6 million (shown on page D-213 of the Governor's FY 2014 Budget).

As indicated in the table below, the division appears to have originally overestimated the FY 2012 and FY 2013 expenditures on General Assistance Emergency Assistance, and the original FY 2014 estimate is also above the revised projection. The pattern of lower than expected expenditures appears correlated with lower than expected caseloads:

Fiscal Year	Average Monthly Recipients: Original Estimate	Average Monthly Recipients: Actual	Expenditures: Original Estimate	Expenditures: Actual	Expenditures: Percent change from original to actual
2012	7,976	7,280	\$81,739,005	\$81,007,181	(0.9%)
2013	7,021	6,304	\$77,448,651	\$71,385,992	(7.8%)
2014	5,848	5,346 (revised estimate)	\$66,553,515	\$60,658,924 (revised estimate)	(8.9%)

Source: Evaluation data from Governor's Budgets for FY 2012-FY 2015.

- **Questions:** As the division has consistently overestimated General Assistance Emergency Assistance expenditures since FY 2012, are actual FY 2015 expenditures likely to be less than estimated? Can the FY 2015 appropriation be reduced, if lower than expected caseloads are assumed?

Answer: DFD uses several years of historical caseload and cost data to develop current and future GA-EA caseload and cost projections. In addition, DFD makes adjustments to these estimates based upon proposed or recently implemented programmatic changes. Some examples of these changes are the addition and expansion of an EA Compliance review team and the implementation of the 28-day Protocol. Although estimates for the impact of these and other changes are included within our projections, the size of the program and the lack of historical data related to these changes impede our ability to more accurately predict total expenditures and caseload statistics.

With respect to the SFY 2015 appropriation, we do not anticipate lower than expected caseloads.

DIVISION OF MANAGEMENT AND BUDGET

55. The Governor's FY 2015 Budget recommends \$22,000 for the United Way 2-1-1 System, a decrease of the \$490,000 originally appropriated in FY 2014 (see FY 2014 Appropriations Handbook, page B-115). Footnote (b) on page D-214 indicates that the FY 2014 adjusted appropriation and FY 2015 recommended appropriation reflect the transfer of funding to four other divisions in DHS. The 2-1-1 system is a 24/7 telephone hotline and website that provides information and referral services for people who need assistance navigating the health and human services systems, government assistance programs, and local community resources.

- **Questions:** How much total funding is allocated to the 2-1-1 system in FY 2014? In FY 2015? In which specific line items is this funding located in the Governor's FY 2015 Budget?

Answer: As referenced in footnote b on page D-214, the United Way 211 appropriation was reallocated to the Divisions of Disability Services, Family Development and Mental Health and Addiction Services (\$348,000 @ \$116,000 each). As such, the DHS portion of the United Way 211 contract will remain stable for FY 2014 and FY 2015 at \$370,000.

In FY2014, \$120,000 for a similar hotline program was reallocated to DHS from DCF. It was placed in the United Way 211 appropriation for FY 2014, but was reallocated to the Division of Aging Services.

EXHIBIT 1. COMPREHENSIVE MEDICAID WAIVER APPLICATION: ANTICIPATED STATE SAVINGS FROM MANAGED LONG-TERM CARE (included by OLS in discussion point questions)

The State’s Comprehensive Waiver application estimated the Managed Long Term Services and Supports (MLTSS) expenditures below within calculations intended to demonstrate the Waiver’s “budget neutrality” with regard to federal expenditures. As noted above, Medicaid waivers under section 1115 of the Social Security Act are required to be "budget neutral" to the federal government, which means that, under the Comprehensive Waiver, federal Medicaid expenditures will not be more than federal spending without the waiver. In these estimates, the “LTC/Transitioned HCBS” population represents elderly and disabled Medicaid clients receiving home- and community-based services or nursing facility services (the same general population and services involved in the MLTSS initiative).

Federal Budget Neutrality Calculations from New Jersey’s September 2011 Comprehensive Medicaid Waiver Application

	Demonstration Year 1 (originally anticipated to be October 2011-Sept. 2012)	Demonstration Year 2 (originally anticipated to be October 2012-Sept. 2013)	Demonstration Year 3 (originally anticipated to be October 2013-Sept. 2014)
Without Waiver LTC/Transitioned HCBS			
Total share	\$3,297,312,236	\$3,785,803,816	\$4,099,878,007
Federal share	\$1,648,656,118	\$1,892,901,908	\$2,049,939,004
State share (a) (OLS calculation: Total share less federal share)	\$1,648,656,118	\$1,892,901,908	\$2,049,939,003
Without Waiver Pre-Transitioned HCBS			
Total share	\$217,030,940	---	---
Federal share	\$108,515,470	---	---
State share (b) (OLS calculation: Total share less federal share)	\$108,515,470	---	---
With Waiver LTC/Transitioned HCBS			
Total share	\$3,277,312,236	\$3,715,803,816	\$3,979,878,007
Federal share	\$1,638,656,118	\$1,857,901,908	\$1,989,939,004
State share (c) (OLS calculation: Total share less federal share)	\$1,638,656,118	\$1,857,901,908	\$1,989,939,003
With Waiver Pre-Transitioned HCBS			
Total share	\$217,030,940	---	---
Federal share	\$108,515,470	---	---
State share (d) (OLS calculation: Total share less federal share)	\$108,515,470	---	---
State savings (OLS calculation: State share without waiver (a + b) less State share with waiver (c + d))	\$10.0 million	\$35.0 million	\$60.0 million