

**Discussion Points****DEPARTMENT OF HUMAN SERVICES - GENERAL**

1. The FY 2009 recommended budget reduces the number of State employees through an Early Retirement Initiative (ERI) and layoffs. A department's ability to hire employees to fill these vacant positions will be limited. The impact these personnel actions will have on the department's programs and services is not clear.

- **Questions: How many employees are eligible for the ERI or may be laid off, by division? To the extent that new employees cannot be hired to fill the vacated positions, what services or programs does the department intend to reduce or eliminate? How will the reductions affect the department's monitoring and oversight of contracts and its efforts to maximize federal reimbursements?**

*Answer:* The administration's ERI proposal does not include the Department in the eligible pool of employees because of the backfill cap requirement. As a result, the Department has not engaged in this planning process.

2. The Governor's recommended budget provides nearly \$60.9 million for FY 2008 and FY 2009 community placement costs for persons with developmental disabilities and mental illness.

Provider agencies have testified and provided information to the Legislature regarding recruitment and retention difficulties which compromise service delivery. Departmental licensing and inspection reports also indicate that agencies require additional staff.

- **Question: Is a significant expansion of community programs attainable given these personnel and recruitment issues?**

*Answer:* DMHS contract agencies are experiencing challenges with both staff turnover and recruitment for existing community mental health programs as well as those new programs/services created through the Governor's Mental Health Task Force and Olmstead initiatives. Particular difficulty exists in acquiring Nursing personnel, although salary structures at many community providers contribute to hiring delays in clinical, outreach and in those key administrative positions needed to support revenue and other business functions. The provider community reports that turnover in entry level service positions (residential, outreach, case management) can approach 30% per year. Such rates affect continuity of care for enrolled consumers. With regard to new initiatives, we have noted that challenges in hiring key clinical and service support positions often delays program implementation.

To combat these delays we have prepared and are preparing RFPs/RLIs now in anticipation of the FY 09 appropriation. We will expect to release these solicitations soon and to make awards before July 1, which will of course be contingent upon the final Appropriation Act containing resources equal to the Executive Recommendation.

In addition, programs in DDD have had delays in opening due to difficulty in hiring direct care staff for the new programs. An increasingly more common scenario is for a home to only be licensed for two people instead of four, until the agency can hire enough staff to serve four people. Also, agencies have more success in hiring and retaining staff due to the more desirable benefits.

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3. In FY 2008, the department will incur over 2.8 million hours of overtime and expend upwards of \$83 million for overtime at the State developmental centers and psychiatric hospitals. (See Background Paper on p. XX.)

The FY 2009 recommended budget includes \$2.8 million in overtime savings through implementation of an electronic Cost Accounting Timesheet System (eCATS). The department has utilized other software programs to better manage and control overtime, the most recent being Inovar. These software programs have met with limited success in controlling overtime.

- **Question: As other software technology efforts to manage and control overtime have met with limited success, how is eCATS a significant improvement over previous software programs to reduce overtime costs?**

*Answer:* The savings is based on \$1.8 of staff attrition and \$1 million of overtime savings. The Innovative Resource Management (INOVAR) software program currently being used by the State hospitals, is a scheduling program implemented to better manage the direct care staff's schedules on a 24/7 basis and will interface with the new Timetrack and eCATS system.

Timetrack consists of a fingerprint reading device (time clock) essentially serving as the sign in/out records. Use of this system is expected to reduce incidental overtime and unintentional errors resulting from manual sign in/out times.

4. Schedule 1 does not reflect any School Based Medicaid revenues for either FY 2008 or FY 2009. Available data indicate the State may realize upwards of \$14 million (State) in revenues from the program in FY 2008.

- **Question: Why are no School Based Medicaid revenues reflected in Schedule I?**

*Answer:* School based Medicaid claims continue to be audited by the DHHS Office of the Inspector General and the Centers for Medicare and Medicaid Services. Additionally, proposed federal regulations will reduce the level of federal reimbursement for these services. The federal audits have raised concerns about the claims used for federal funding. The Department of Human Services is working with the Departments of Treasury and Education, the State's contractor and the responsible federal agencies to correct any concerns and collect the appropriate amount of federal reimbursement. In the meantime, it was determined that current revenue projections for this item may be at risk and should not be reflected in the budget.

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

5. The Department of Health and Senior Services, in cooperation with the Division of Mental Health Services, requested applications from hospitals to develop 83 closed beds for patients in need of involuntary commitment to reduce admissions to State and county psychiatric hospitals. Many of these beds will likely become available during the latter half of FY 2009.

The FY 2009 recommended budget does not reflect a significant reduction in admissions to the four adult State hospitals: FY 2008 - 2,900 and FY 2009 - 2,850.

- **Question: Do the FY 2009 State psychiatric admissions data take into account the additional beds to become available during FY 2009?**

*Answer:* The DOHSS Certificate of Need call for Short Term Care beds will result in the approval of as many as 81 new STCF beds by the first quarter of FY '09. While the implementation schedule of new beds likely to be awarded is not yet known, it is expected that most of the new beds will be operational by June 2009. As such until the conclusion of the CN process we will not be in a position to project impact on State/County hospital census and budgets.

6. Approximately \$210 million is available towards the construction of a new Greystone Park Psychiatric Hospital and related projects. As of December 2007, it appears that total expenditures will be between \$190 - \$200 million.

- **Questions: How much unexpended funds will be available once the project is completed? How will these unexpended funds be used?**

*Answer:* The bond proceeds from a 2003 and 2005 issue totaled \$195.361M, interest originally anticipated was \$4.470M, and \$.595M was made available from Treasury for pond improvement, for a total available resource of \$200.426M.

The potential excess net interest earnings, and presently reserved contingency funds is \$12.187M. Potential plans for surplus include paying down some portion of the bond debt, acquiring maintenance contracts on new hospital systems such as the HVAC, costs associated with maintaining and closing the old building, providing for the space needs of the Greystone Park Association, the Northern Region office, State Union's space, and additional hospital storage. Any balance remaining after this will be used to pay down the debt.

7. Recent newspaper reports on patient care at Ancora Psychiatric Hospital resulted in Legislative hearings. Ancora is also inspected by other outside entities such as the joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the federal Centers for Medicare and Medicaid Services (CMS).

- **Questions: Has JCAHO, CMS or the U.S. Department of Justice conducted any inspections of Ancora since the articles were published? If yes, what were their findings? Did Ancora pass previous inspections by JCAHO and CMS? If previous inspections identified patient care problems, what corrective actions were taken and why do patient care problems still exist?**

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*Answers:* (1) The Dept. of Justice has not conducted any inspections at APH, but JCAHO and CMS have. Both JCAHO and federal-level CMS surveyors were at the hospital simultaneously during the week of April 7th, 2008, to conduct their unannounced triennial reviews. The hospital received "Full Accreditation" from JCAHO, and the same from CMS.

(2) Both agencies cited a number of deficiencies, but both indicated that the hospital met at least the minimum requirements for full accreditation. Both teams of surveyors expressed high satisfaction with the hospital's current effort to reduce census to below-capacity levels, to increase the amount of program hours, and to reduce the levels of violence, and strongly cautioned the hospital to continue implementation of the improvement plan, as future surveys will monitor for compliance.

(3) Both JCAHO and CMS have surveyed the hospital (all unannounced visits) a number of times over the past two years. In fact, CMS surveyors have been there 17 times since April 2006. Each survey has resulted in a decision that while the hospital continues to meet at least the minimum requirements for full accreditation/certification, some deficiencies exist.

(4) For each deficiency, a Plan of Corrective Action is developed, and submitted to CMS/JCAHO for review/approval. Then, on subsequent surveys, the hospital's implementation of the Plan of Correction is assessed. The DMHS and APH have reduced to census which is now below 700, added nursing and other clinical staff and made improvements to the therapeutic environment. Plans exist for additional hours of active treatment, the creation of a treatment mall, the creation of at least one training-focused ward, and the implementation of the "Nurse Directed Care Model".

8. The FY 2009 recommended budget reduces funding for the Governor's Council on Mental Health Stigma from \$350,000 to \$240,000. However, annualized FY 2008 expenditures are estimated at about \$110,000.

- **Question: Can the \$240,000 appropriation be reduced?**

*Answer:* No, the funding commitment is unchanged. The Council's Executive Director as well as support staff costs have been appropriately moved to the Divisions salary account. The remaining balance will fund a number of anti-stigma education and public awareness events. Given that the costs of such events do not occur in a uniform manner throughout the year - in fact, most events in FY 2008 will be occurring in the last quarter, straight-line or annualized expenditure projections for this account don't result in an accurate projection of total anticipated costs for the fiscal year. Consequently we believe that the entire recommended funding level for FY 2009 can and will be expended to support the key community partnerships being forged and to meet the potential for future anti-stigma initiatives these partnerships are now positioned to yield.

9. The FY 2008 budget recommends approximately \$40.4 million for Olmstead Support Services. Information is not readily available as to the services to be provided and the cost of the services.

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- **Question: Of the \$40.4 million recommended, how many clients will receive and how much is to be expended on the following mental health services: emergency/screening, outpatient, partial care, residential, supported housing, supported employment, etc.?**

*Answer:* The FY 08 appropriation of \$22.136M, the deferred portion of FY 08 costs recommended for FY 09 of \$3.247M and the FY 09 recommendation of \$15M total \$40.383M. The resources and the amount of funding dedicated to each area are as follows:

|                                   | Funding   | Clients Served |
|-----------------------------------|-----------|----------------|
| Housing and related               | \$34.568M | 1,211          |
| Pre-screening crisis intervention | \$2.0M    | 417            |
| STCF Beds                         | \$2.3M    | 1,200          |
| Employment related services       | \$700K    | 162            |
| Training                          | \$531K    | N/A            |
| ICMS                              | \$284K    | 100            |

10. As of December 2007, approximately \$1.8 million of the FY 2007 Community Care appropriation was still encumbered.

- **Question: Are all encumbered funds still valid? Can any encumbered funds be lapsed?**

*Answer:* On January 2, 2008 there was \$1.783M of FY 2007 Community Care account funds still encumbered. As of March 25, 2008, the amount of remaining encumbered funds had already been reduced to \$642K or less than three tenths of one percent of total FY 2007 Community Care account funding. This balance is still valid and cannot be lapsed. The remaining encumbered funds are being held open to process remaining payments due on several community mental health provider agency contracts, as well as county mental health board/administrator allocations for which we are still awaiting final expenditure details or are holding payment until required reports/responses are received.

11.a. Executive Order No. 77 (2005) directed the division to develop a pilot program of Operational Incentives to enable certain providers to "retain 100 percent of the current contracts' net savings identified from contract deficiencies," subject to reasonable restrictions and limits on earned incentives. In FY 2007, approximately \$2.9 million in incentive funds were distributed to 29 agencies.

- **Question: How much will be distributed in FY 2008**

*Answer:* For FY / CY 2006, \$2.9 million in incentives were earned and retained by 29 provider agencies. For FY / CY 2007, approximately \$2 million in incentives were earned and retained by 20 provider agencies. 12 of the 20 had also earned incentive awards for 2006. This year is incomplete, since it does not include any of the CY 2007

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providers as yet given that their final expenditure reports are not due until April 30, 2008.

11.b. Incentive funds are generated when an agency underspends its contract or when an agency realized more third party revenues, particularly Medicaid, compared to the prior year.

As discussed in a Background Paper (p. XX) the exclusive use of financial variables in determining the amount of incentive funds to be distributed may be problematic: It rewards agencies when under spending their contract results from personnel recruitment problems the agency has no control over and it rewards agencies for increases in third party revenues that may have been initiated by the State. The distribution of incentive funds does not take into account improvement in client services and client outcomes.

- **Question: Are any changes to the distribution of incentive funds envisioned to focus the distribution on improved client services and improved patient outcomes?**

*Answer:* The criteria for earning operational incentive for FY 08 for one of our services known as Program of Assertive Community Treatment, (PACT) includes not only the provision of a specified level of service outputs in terms of units and consumers served but also, for the first time incorporates the rehabilitative outcome variables of consumer independence in managing psychotropic medication, consumer participation in competitive employment or in an educational program, and reduction in consumer inpatient psychiatric hospital utilization.

DMHS intends to continue to develop clinical/rehabilitative outcomes for all program elements and incorporate performance against specified benchmarks in the determination of whether an operational incentive has been earned by each provider.

The present EO and policy finances the earned incentive from each individual provider's own surplus i.e. if the provider delivers exemplary service but accrues no surplus they would not earn an incentive. Another policy change under consideration would be to de-link "surplus" contract funds to some degree from the individual provider accruing the surplus. This would allow a pooling of such surpluses which could be awarded based on exemplarily performance regardless of whether the provider who delivered the exemplary service had a surplus in their contract for that year.

12. The federal government adopted interim final rules affecting case management services (December 2007). One of the adopted rules would prohibit Medicaid reimbursement on a per diem, weekly or monthly basis. Rather, reimbursement would be on a fee-for-service basis. This change could reduce federal reimbursement for PACT services and increase State expenditures.

- **Question: Is the \$15.3 million in PACT funding adequate in view of new federal Medicaid reimbursement requirements?**

*Answer:* At present only the Targeted Case Management (TCM) optional Medicaid service requires unbundled rates effective 3/3/08. The DMHS acquires Integrated Case Management Services using the Medicaid TCM option and already employs an unbundled reimbursement rate methodology. PACT services are covered under the Medicaid program using the Rehabilitation Option, not the TCM Option.

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We do believe it prudent however to prepare for an eventual extension of the requirement that is currently only in the TCM rule, to rehabilitative services which for DMHS would include PACT. To that end we are assuring our data systems are set up to collect information regarding units of service in such a manner as when correlated with cost information will allow us to calculate unbundled reimbursement rates and make changes to the Medicaid State Plan as may be required. At this point it is premature to calculate potential impact until we have completed collection and analysis of the data regarding units of service.

13. The division awarded UMDNJ a \$1.8 million contract "to improve the quality of clinical care administered to adult psychiatric patients ....' Among the services UMDNJ provides are: introducing best practices; case consultations; staff training; mentoring/co-leading projects; educational presentations; treatment team consultations; and performance improvement projects. The contract does not specify any standards UMDNJ must meet.

- **Question: How many case consultations, staff training, performance improvement projects, etc., will UMDNJ be required to conduct as part of the contract? How will the division assess whether UMDNJ's services improve patient care?**

*Answer:* The Goals and Deliverables for FY 08 emphasized in the UMDNJ affiliation contract agreement focus on workforce development, Treatment Team development, and Active Treatment.

- Workforce Development -- Training consisted of 29 Grand Round sessions offered to 218 medical staff (medical physicians and psychiatrists). UMDNJ provided 18 other types of training to clinical disciplines, teams, as well as case consultations. Training in this area consisted of 401 sessions/meetings held and 1556 employees received trainings thus far this year.
- Treatment Team Development -- In this area, there were eight (8) types of training offered. There were 1452 training sessions/meetings held and 162 + staff were trained thus far this year.
- Active Treatment -- There were five (5) types of programming offered, with 217 sessions/meetings held, and 91 + staff received training in this category thus far this year.

There are some improved patient care outcomes that are observable e.g., implementation of performance-improvement projects at the hospitals, awareness of evidenced based practices and concepts. As we work on the deliverables for the FY 09 contract there is increased emphasis not only on quantified outputs but also on objective and quantifiable assessment measures and outcomes.

14. State Aid reimbursement to the six county psychiatric hospitals decreases from \$122.0 million to \$119.1 million. State Aid reimbursement to counties would be reduced from 90% to 85%, saving about \$6.3 million and increasing county costs by \$6.3 million. Overall, about 650 patients will receive services at the various county hospitals.

An additional 83 closed beds in general hospitals for patients in need of involuntary commitment to reduce admissions to State and county psychiatric hospitals is to be developed. Of

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the 83 beds, 13 beds are to be in counties that maintain a county psychiatric hospital. Many of these beds will likely become available during the latter half of FY 2009.

- **Question: Do the 650 patients at county psychiatric hospitals reflect the diversion of patients to the new inpatient beds?**

*Answer:* The DOHSS Certificate of Need call for Short Term Care beds will result in the approval of as many as 81 new STCF beds by the first quarter of FY '09. While the implementation schedule of new beds likely to be awarded is not yet known, it is expected that most of the new beds will be operational by June 2009. As such until the conclusion of the CN process we will not be in a position to project impact on State/County hospital census and budgets.

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

15. Since August 2005, the Division of Criminal Justice has been in negotiations with Price Waterhouse regarding the firm's role in the Mt. Carmel Guild Medicaid accounting fraud. To date, no settlement has been reached.

- **Questions: What is the current status of these settlement negotiations? If the case was settled, how much did the State receive?**

*Answer:* The Division of Criminal Justice has closed its investigation. The Department is pursuing administrative remedies. Since the case is in litigation, there are no settlement negotiations with Price, Waterhouse.

16. The federal Office of Inspector General (May 2006) reported that \$51.3 million in federal Medicaid matching funds for school-based health services were unallowable. The State provided additional information in support of the expenditures.

- **Question: What is the current status of the \$51.3 million disallowance?**

*Answer:* The final audit report has been published by the OIG recommending CMS recover \$51.3 million FFP. The State's contractor has submitted additional documentation to support some claims questioned in the OIG audit report. This documentation has been submitted to CMS for review. The outcome of the CMS review is pending.

17. The federal government has undertaken a major initiative to reduce improper payments in Medicaid and the SCHIP programs (i.e., NJ FamilyCare). New Jersey was one of the first states selected for review.

- **Question: If findings are available, what level of improper payments are present in the Medicaid and NJ FamilyCare programs?**

*Answer:* New Jersey was among the second tier of states selected for review. No specific state information is available from the first tier. The Payment Error Rate Measurement (PERM) is still in process for three areas: claims, medical review, and eligibility. Each area is in various stages of completion so findings are not yet available.

18.a. Proposed federal regulations would more closely align the Medicaid definition of "outpatient hospital service" with the Medicare definition. This could reduce Medicaid reimbursement for such services.

- **Question: If adopted, what impact will the proposed regulation have on Medicaid reimbursement to hospitals?**

*Answer:* This would require a change in reimbursement methodology, thereby lowering the rates paid to hospitals for these services. Pending federal legislation would impose a moratorium and delay the effective date of this and other proposed Medicare regulations.

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18.b. Proposed federal regulations would no longer permit the Medicaid program to reimburse Graduate Medical Education costs incurred by teaching hospitals.

- **Question: What impact will the proposed regulation, if adopted, have on Medicaid revenues and on hospital revenues?**

*Answer:* With this proposed regulation, Medicaid would be prohibited from making payments for teaching hospitals. The proposed state fiscal year 2009 budget includes \$50 million for Graduate Medical Education (\$25 million state/\$25 million federal) which is a \$10 million reduction from state fiscal year 2008. Pending federal legislation would impose a moratorium and delay the effective date of this and other proposed Medicare regulations.

19. In an attempt to reduce Charity Care and expedite enrollment of uninsured persons into Medicaid/NJ FamilyCare, State law requires county welfare agencies to out-station personnel at hospitals designated by the Commissioner of Health and Senior Services to accept and process applications for Medicaid/NJ FamilyCare by uninsured persons who utilize hospitals.

As indicated in a Background Paper (p. XX), five counties do not out-station personnel at hospitals in their respective counties. Also, the assignment of personnel to hospitals by county welfare agencies appears unrelated to the amount of charity care a hospital provides.

- **Questions: For purposes of out-stationing county welfare agency employees, have all hospitals that receive charity care been "designated" by the commissioner? If so, why have five counties not out-stationed personnel to hospitals in their county? How can the Departments of Health and Senior Services and Human Services ensure better compliance by the counties as to the number of personnel out-stationed at specific hospitals?**

*Answer:* The intent of outstationed workers is to initiate access to appropriate medical assistance on site thereby reducing inappropriate charges to Charity Care. Since the state's outstationing regulation was enacted in 1991, prior to the expansion of Medicaid/NJ FamilyCare, a review of the outstation activities is needed and is currently in process. Smaller counties and low volume hospitals have workers on call and send workers as needed.

A recent survey was conducted at the request of DMAHS and the CWA Directors to review outstationing activities in order to address issues such as the increase in the number of sites needing outstationed workers and the change in the scope of work as DMAHS moved to an on-line application for the NJ FamilyCare population.

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Through this survey, DMAHS identified issues for the CWAs as well as the outstationing sites. For example:

- lack of communication between the provider staff and the outstationed worker
- lack of access to the eligibility file at some sites
- insufficient CWA staffing
- high turnover of provider staff and the need for training

As a result of the survey, the CWA Directors and staff at DMAHS are reevaluating the role of the outstationed worker in meeting the needs of the clients and the outstation sites.

20. Pursuant to P.L.2005, c.237, Federally Qualified Health Center (FQHCs) receive \$40 million annually from the 0.53% assessment on hospital revenues. (These funds are classified as Other Funds.) In addition, FQHCs receive \$5.5 million in General Funds for other program activities.

As discussed in a Background Paper, p. XX, transferring \$1.0 million in FQHC funds from the Department of Health and Senior Services to the Division of Medical Assistance and Health Services to facilitate a one-time adjustment to the Medicaid reimbursement rates would generate an additional \$1.0 million in federal Medicaid reimbursement, subject to federal approval.

- **Questions: Can \$1.0 million be transferred to the Medicaid program to increase FQHC Medicaid reimbursement in order to generate an additional \$1.0 million in federal revenues for FQHCs?**

*Answer:* Yes, subject to federal approval, \$1 million could be transferred to the Medicaid program to increase FQHC Medicaid reimbursement.

21.a. The FY 2008 appropriations act assumed \$50 million (State share) in additional recoveries related to a reduction in fraud. The department identified \$31 million in recoveries: Claimcheck software - \$1 1.0 million; HMO recoveries - \$15 million; and Pharmaceutical Medical Exception - \$5.0 million.

- **Questions: Is the \$31.0 million estimate still valid? How will the remainder of the budgeted recoveries be realized in FY 20081**

*Answer:* The Division of Medical Assistance and Health Service's State Fiscal Year 2007 budget was reduced by \$50 million in anticipation of savings to be achieved through the Governor's Fraud, Waste and Abuse plan. The Governor's plan was successful and savings achieved as evidenced by the Division's ability to close-out the State Fiscal Year in balance. The savings continued into SFY08. In addition to the ClaimCheck Software, HMO recoveries, and Pharmaceutical Medical Exception, savings were achieved through:

- Awarding new third party liability contract- assuring that Medicaid is the payer of last resort
- Joining in large national Medicaid settlements
- Maximizing Medicare coverage prior to Medicaid payment for services (Part A and B buy-in)

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- Continuation of two disease management programs

21.b. The FY 2009 recommended budget assumes \$25.0 million (State) in additional Medicaid anti-fraud efforts. The specific initiatives to be undertaken are not identified.

- **Question: What specific anti-fraud efforts are to be undertaken to achieve an additional \$25.0 million in fraud savings?**

*Answer:* To achieve an additional \$25 million in fraud savings the Division anticipates implementing the following activities:

- Contract with forensic accountants and auditors to audit high cost providers
- Expand use of claims editing
- Increase TPL activities
- Increase provider credentialing efforts

22. The FY 2009 recommended budget would reduce Medicaid reimbursement to hospitals by \$30 million (gross): Graduate Medical Education (GME) payments - \$10.0 million (gross); and Hospital Relief Offset Payments (HROP) - \$20.0 million (gross).

In FY 2008, 25 hospitals received \$60 million (gross) in GME payments ranging from \$4,000 (Kessler) to \$8.6 million (Newark Beth Israel) and 33 hospitals received \$203.0 million in HROP ranging from \$240,000 (Mountainside and Newton Memorial) to \$25.1 million (Bergen Regional).

(It is noted that some of the hospitals scheduled to receive GME or HROP closed or are scheduled to close. Payments to such hospitals will be redistributed to other hospitals.)

- **Question: Please provide a breakdown as to the amount hospitals will receive in receive GME and HROP in FY 2009?**

*Answer:* In the current SFY08 cycle, thirty-eight (38) New Jersey hospitals receive supplemental payments totaling \$263 million for Graduate Medical Education (\$60M) and for providing certain services to low-income populations through the Hospital Relief Subsidy Fund (HRSF - \$203M). When these supplemental payments are combined with the direct rate payments, some New Jersey hospitals are actually receiving payments and subsidies that approximate the full cost of care. These reductions lower the GME and HRSF payments to a total of \$233 million. Even with the SFY09 proposed \$30M reduction to these subsidy payments, full cost coverage is attained by some hospitals.

23. The FY 2008 appropriations act assumed that competitive bidding of transportation and durable medical equipment services would produce about \$0.6 million in savings. The division recently withdrew its Request for Proposals (RFP) for transportation services and a revised transportation RFP was reissued during April 2008.

- **Question: Does the \$57.0 million recommended appropriation for Transportation Services incorporate potential savings from the transportation RFP?**

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*Answer:* Yes, the SFY09 budget request does assume \$0.6 million in savings for the competitive bidding of Transportation and Durable Medical Equipment services.

24. Managed care providers in the Managed Care Initiative must meet various performance standards with respect to the provision of health care services. Though overall performance has improved, according to available reports, performance is still below the standards specified in the contract.

- **Questions: In FY 2007 and FY 2008, how much will be recovered from managed care providers for not meeting contract performance standards? Are there instances in which it may be less expensive for managed care providers to pay the penalty than to increase performance levels? If so, should penalties be increased?**

*Answer:* The amount collected in sanctions/damages for FY 2007 was \$484,000 and collections to date for FY 2008 is \$3,100,000.

The Division has been more aggressive in applying damages this fiscal year. We monitor closely to ensure that HMOs are improving in areas of deficiency.

Staff are re-evaluating the entire contract.

25.a. Pharmaceutical savings of \$4.8 million are anticipated through cooperative drug purchasing (with other State programs). Several years ago, a similar initiative was proposed, but never implemented.

- **Question: As the State's prior attempt at cooperative drug purchasing was not successful, what is the basis for the State's assumption that it can save \$4.8 million?**

*Answer:* Purchasing power is leveraged by combining drug spending with other states.

25.b. Pursuant to proposed budget language the criteria for pharmacies to receive an impact allowance is to be revised. This would save \$0.4 million.

- **Question: What is the revised qualifying criteria for the impact allowance?**

*Answer:* In many cases, since the start of Medicare Part D, Medicare is the primary payor. In those cases in which Medicare is primary and the State drug program is secondary, the claim would not be counted as Medicaid or PAAD high volume.

In addition, as pharmacist consultation is required by law, this part of the dispensing fee will be eliminated as it is not necessary to provide an additional fee to pharmacies for providing this service.

25.c. Additional rebates from pharmaceutical manufacturers of \$19.3 million are anticipated. Available data indicate that the total amount of uncollected rebates for periods prior to June 30, 2007 totals about \$19 million (gross), or \$8.5 million State.

- **Question: What is the basis for the \$19.3 million (State) in additional rebates?**

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*Answer:* This initiative would enforce the language of Family Health Care Coverage Act of 2005 which requires drug manufacturers to pay rebates on prescription drugs for the General Assistance population and would require edits in place to deny claims for pharmaceuticals from those manufacturers who have not adhered to paying rebates. The rebates collected are to be used to partially offset Family Care (SCHIP) costs for the parent population due to the expansion as part of the bill. Based on the invoiced amount of the last four quarters, assuming a 90% collection rate, the Division would be able to collect an additional \$8.15 million annually as well as \$8.15 million retro for the past year for a total of \$16.3 million.

This initiative requires additional efforts in dispute resolutions with pharmaceutical manufacturers. The Division estimates an additional \$3 million in state funds can be collected through additional focus in this area.

26. During 2006, the division implemented a pilot project known as "step therapy" involving a certain class of drugs known as "proton pump inhibitors" (PPI). Under the pilot project an over-the-counter medication such as Zantac (Ranitidine) or Prilosec (Omeprazole) must be used first before a prescription for a generic or brand name drug can be prescribed for certain gastrointestinal conditions. The pilot project would determine whether "step therapy" was cost-effective and whether the pilot project should be extended to other classes of medications.

- **Questions: Was the step therapy initiative involving PPI cost effective? If yes, how much did the pilot project save? Will step therapy be expanded to other types of medical conditions?**

*Answer:* In 2006, the division offered to reimburse for over-the-counter medication as an alternative to legend drugs – both require a prescription. Clients were well maintained on drugs like Prilosec but because that drug (and others) went to OTC, prescribers were switching medications because the client could not afford to pay for OTC drugs. This initiative allowed clients to remain on Prilosec (for example) and Medicaid reimbursed for the drug. This pilot was successful and will be expanded. This initiative was extended to antibiotics and preliminary results indicate this pilot will achieve cost savings.

27.a. Budget language authorized the division to initiate disease management programs. Two disease management programs have been implemented: One Statewide program focuses on mental illness and a second program limited to Hudson County focuses on diabetes. Both programs are funded by the drug industry.

- **Questions: What is the current status of these disease management programs with respect to their cost effectiveness?**

*Answer:* The behavioral pharmacy disease management program was launched in May 2006 with \$1.150 million in funding from Eli Lilly. To date, sixty-two prescribers have participated in the peer consultation and education sessions on alternatives to current prescribing practices. In reviewing drug class utilization, findings indicate that prescribers have decreased the number of mood stabilizer prescriptions in both the pediatric and adult population in accordance with the behavioral pharmacy management program developed by Comprehensive NeuroScience, Inc. (CNS). The Division is

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currently working with CNS to quantify the fiscal impact on Medicaid service utilization. We will be happy to share the results from the program on an ongoing basis.

The second fee-for-service disease management program at the Division was also funded by Eli Lilly in the amount of \$.5 million. It began in October 2006 and seeks to manage the care of Medicaid clients in Hudson county receiving services through our fee-for-service delivery system with one or multiple chronic diseases such as asthma, chronic obstructive pulmonary disease, diabetes, and congestive heart failure. As of February 29, 2008, 545 Medicaid clients participated in the program through APS Healthcare. The number of emergency room visits for the participating clients decreased by 3-10% over one year depending on the primary diagnosis, i.e., asthma, diabetes, etc. The Division saves over \$6,000 per person per year for each enrolled member of this disease management program.

Eli Lilly has provided the funding to extend both of these programs for another year. There is no administrative cost to the state for these programs.

27.b. As part of their contract with the State, managed care organizations must operate disease management programs.

- **Questions: With respect to the five managed care organizations, what specific disease management programs do they operate? How many clients are enrolled in the various disease management programs? What were the total operating costs and savings associated with the disease management programs operated by the managed care organizations?**

*Answer:* Under the Department of Banking and Insurance, utilization reviews include a disease management requirement. The Department mandates care management for all enrollees with special health care needs to assure that enrollees receive needed services in a coordinated, effective, and timely manner.

However, although not mandated, all five of the contracted HMOs (AmeriChoice, AMERIGROUP, Health Net, Horizon NJ Health, and University Health Plans) have elected to provide organized DM programs to encourage preventive care and improve health outcomes. DM programs include asthma/ chronic obstructive pulmonary disease (COPD), diabetes, heart disease (coronary artery disease (CAD), congestive heart failure (CHF), hypertension, HIV/AIDS, and high-risk pregnancy, among others. Each HMO makes a decision on which DM programs to utilize based on their member case mix, i.e., the kinds of illnesses and severity of medical problems prevalent among the members.

Members voluntarily enroll in disease management programs, and may participate as they choose, going in and out of programs at will; their conditions may change in acuity, all of which makes it difficult to definitely say how many beneficiaries are in the programs. While there may be reductions in expenditures in some areas, such as Emergency Department visits and inpatient hospitalizations, there are increases for medications, outpatient visits to specialists, homecare visits, and diagnostic testing, and the associated expenditures. The specific DM programs that the HMOs operate are:

Discussion Points (Cont'd)

|                                | Diabetes  | Asthma  | Congestive Heart Failure   | Hypertension   | High-risk Pregnancy   | HIV-AIDS  |
|--------------------------------|---|---|--|--|---|---|
| <b>AmeriChoice</b>             | Yes<br><br>Managed:<br>In house<br><br>Enrolled:<br>Approx. 330                             | Yes<br><br>Contract<br>Targets members over 5 years old who have had an ER visit or hospitalization related to their asthma w/in the past 6 months.<br><br>Enrolled:<br>670 | Yes<br><br>Managed:<br>In-house<br><br>Enrolled:<br>90                                       | No   | Yes<br><br>Managed:<br>In-house   | Yes<br><br>Managed:<br>In-house                         |
| <b>Amerigroup</b>              | Yes<br><br>Managed:<br>In house for all ages  | Yes<br><br>Managed:<br>In house and for Chronic Obstructive Pulmonary Disease (COPD)<br>Asthma: all ages<br>COPD: 30 YO+<br><br>Decrease 497 ER visits since 10/06          | Yes<br><br>Managed:<br>In house for Coronary Artery Disease (CAD) for members 18 YO+         | Yes<br><br>Managed:<br>In house for CAD for members 18YO+                                    | Yes<br><br>Managed:<br>In house for all pregnant women<br><br>12.5% fewer NICU days in 2007 | Yes<br><br>Managed:<br>In-house for all ages            |
| <b>Health Net</b>              | No  | Yes<br><br>Contract (under review)  | No   | No   | Yes<br><br>Managed:<br>In house for all pregnant women                                      | No  |
| <b>Horizon NJ Health</b>       | Yes<br><br>Managed:<br>In house for members 2 years old and older<br><br>Enrolled:<br>7,239 | Yes<br><br>Managed:<br>In-house for members 2 years old and older<br><br>Enrolled:<br>43,150  | Yes<br><br>Managed:<br>In-house for members 18 years old and older<br><br>Enrolled:<br>1,239 | Yes<br><br>Managed:<br>In-house for members 18 years old and older<br><br>Enrolled<br>11,103 | Yes<br><br>Managed:<br>In-house for all pregnant women                                      | Yes<br><br>Managed:<br>In-house                         |
| <b>University Health Plans</b> | Yes<br><br>Managed:<br>In-house   | Yes<br><br>Contract and includes COPD. All ages<br><br>Enrolled:<br>984   | Yes<br><br>Managed:<br>In-house  | Yes<br><br>Managed:<br>In-house  | Yes<br><br>Managed:<br>In-house   | Yes<br><br>Managed:<br>In-house<br><br>Enrolled:<br>291 |

28. P.L.2005, c.156 directed the department to apply for a federal waiver to cover the adults without dependent children with incomes up to 100% of the Federal Poverty Level. Approval of a waiver would reduce State expenditures for General Assistance Medical Services.

- **Question: What is the status of the waiver application?**

**Discussion Points (Cont'd)**

*Answer:* The Division of Medical Assistance and Health Services (DMAHS) filed a detailed concept paper with CMS on November 30, 2005 setting out the identity of the population to be covered, the scope of the benefits package, the eligibility criteria, the manner of phase-in, the source of funding, estimates of costs, a description of the provider types, the length of the project and a detailed recitation of the public process which the State will engage in with consumers, advocates and stakeholders. It was reviewed by both CMS Region II staff as well as CMS's central office staff in Baltimore. Upon completion of that review, CMS staff met with DMAHS staff to discuss the various terms and conditions of the proposed waiver and asked DMAHS to submit an additional in-depth filing covering the various aspects of the expansion. The pending change in Federal administration is impacting the consideration of this waiver.

29. Available data indicate that between July - February 2008 average enrollment in NJ FamilyCare (Plans A - D) was about 116,300, compared to FY 2007 average enrollment of 126,600.

- **Questions: What accounts for the enrollment reduction of over 10,000 children? Were any children terminated from the program due to non-payment of premiums or because actual family income was greater than had been reported?**

*Answer:* The Division reached a total of 592,000 children in June, 2007 for a net increase of 34,000 for the 18 months since Governor Corzine's 50,000 Child Initiative (January, 2006). Child terminations for children who were eventually deemed ineligible or non-responsive have led to an actual 9,000 child decrease in enrollment for SFY08. As of February, 2008, the Division has approximately 583,000 children enrolled. As these terminations are complete, the Division anticipates this trend to reverse and has budgeted for an increase in child enrollment throughout SFY09.

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

30. The FY 2008 appropriations act provided \$3.5 million in additional funds to the Personal Assistance Services Program to eliminate the 150 person waiting list.

- **Question: What is the status of the appropriations? Will the entire waiting list be eliminated by the end of FY 2008?**

*Answer:* We have increased outreach to the counties to advise them of the additional funding for FY 2008. PASP is administered through the counties and the waiting lists are maintained by the individual county (21) PASP sites. They are responsible for eliminating their individual waiting lists through placing people on service or determining that the services are no longer needed. It is still being reduced every day but there were a number of potential recipients on the individual county lists and county staff have to go back, contact the individuals, re-determine both interest and eligibility, help them develop an individualized service plan and start services. They are identifying individuals on their waiting list who remain interested and eligible. All of the funding will be needed to assume the elimination of the waiting list by the end of the year.

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

31. Pursuant to State law, clients that receive services from the division are reviewed as to their income and their expenses. Based on this review, a co-payment is determined that clients, their guardians or representative payees are to pay for services. Co-payments are used to support or expand services to persons with developmental disabilities.

There has been an ongoing problem with some guardians or representative payees of clients who refuse to pay for such services. The division was in contact with the Social Security Administration to have the guardians or representative payees replaced to ensure payment.

- **Question: How many clients are currently not paying their co-payment? How much revenues are being lost through non payment? Have efforts to replace guardians and representative payees been successful?**

*Answer:* After an analysis of our banking system data, it was determined that approximately 273 consumers were not contributing to their cost of care. Of this group, only 106 were determined to be potential contributors. The remainder of this group was eliminated due to other factors, such as death, discharge, and the Division becoming the payee of unearned benefits. These 106 consumers represent approximately \$366,000 of revenue on an annual basis.

The efforts to replace a representative payee have proved to be only marginally successful. In most cases, Social Security feels that if a representative payee spends funds on appropriate services for the benefit recipient, they are unlikely to order a change in representative payee-ship regardless of payment history to the Division.

A pending lawsuit on this issue (L.B. vs. Grant) was recently decided; the court decided the issue was not ripe for judgment.

32. Significant reductions in State appropriations are recommended for the following developmental centers: New Lisbon - \$10.2 million; North jersey - \$10.2 million; and Woodbine - \$5.2 million.

As overall staffing at the developmental centers is largely unchanged, there is no ready explanation as to what these reductions represent or the extent to which services at the centers may be affected.

- **Question: What accounts for reductions in State appropriations at New Lisbon, North jersey and Woodbine? How will these reductions affect the provision of services?**

*Answer:* The Department is able to take advantage of prior year federal recoveries allowing for the reduction in state appropriations at these three facilities. There is no impact on services.

33. As discussed in a Background Paper (p. XX) it may be possible to obtain \$300,000 in federal Community Care Waiver reimbursements for two group homes on the grounds of the

**Discussion Points (Cont'd)**

Woodbine Developmental Center if certain administrative actions are taken. At present, costs associated with the two group homes do not qualify for any federal reimbursement.

- **Question: As the clients in the two group homes cannot be placed into an existing or a new community program because of behavioral and sexual issues, is it feasible for the division to operate the two group homes as community programs to obtain federal CCW reimbursement and reduce the overall operating costs of the group homes, which are 100% State funded?**

*Answer:* The Division is of the opinion, at this time, that most of these consumers won't meet the ICF-MR level of care and would not be eligible for the waiver.

34. The division has leased approximately 8,100 sq. feet of office space near the Hunterdon Developmental Center for many years. The current lease costs about \$130,000 annually, and over the years more than \$2.0 million has been spent on leased space.

The division indicated that purchasing and installing trailers for administrative space, as an alternative to the above leasing arrangement, is cost effective and would be explored.

- **Question: What is the status of this project to purchase and install trailers at Hunterdon as an alternative to the current leasing arrangement?**

*Answer:* Future space needs will be accommodated by using vacated space.

35. To comply with Department of Justice requirements, an independent monitor reviews the division's progress at improving services at both the New Lisbon and Woodbridge Developmental Centers.

- **Question: What is the cost of the independent monitoring reviews? Are costs monitored for reasonableness, e.g. are hotel/motel costs reimbursed at the rate charged to government agencies as opposed to the higher non-government rate?**

*Answer:* The monitor, The Columbus Organization, has a contract with the Division of Law (DOL). The Division of Developmental Disabilities is responsible for reimbursing the DOL. The monitor and his or her consultants, including all expenses, shall not exceed \$200,000 per fiscal year. The Office of Fiscal Resources in the DOL only provides payment vouchers to the Division in connection with the services performed.

36.a. In FY 2007, approximately \$268.7 million in federal Community Care Waiver (CCW) revenues had been anticipated. Actual FY 2007 federal CCW revenues were \$281.5 million.

- **Question: What accounts for the \$12.8 million increase?**

*Answer:* The actual FY07 amount reflected in the budget includes some prior year revenue. The Division's anticipated CCW revenue for services provided in FY07 is \$267.8 million. To date, CCW collections for FY07 total \$250.7 million in NJCFS. Of this amount, the CCW claims located in the Data Warehouse equal approximately \$248 million (without administrative claims). This level of collection is prior to the finalization of the cost reporting process.

**Discussion Points (Cont'd)**

36.b. Revised FY 2008 estimates for the CCW program indicate \$280.7 million in federal revenues; however, available Medicaid data indicate that only \$260 million in federal CCW revenues may be realized.

- **Question: Will \$280.7 million in CCW revenue be realized?**

*Answer:* Our anticipated FY08 CCW revenue is currently \$279.6 million.

36.c. Federal CCW revenues of \$303.8 million are estimated in FY 2009, an 8.2% increase over revised FY 2008 estimates.

- **Question: What is the basis for the \$23.1 million increase?**

*Answer:* The basis for this increase in FY09 is the federal revenue resulting from additional funding for Olmstead related appropriations.

37.a. The FY 2008 appropriations act provided \$69.7 million for Private Institutional Care. Revised data indicate that expenditures will exceed \$75.7 million. The number of persons receiving such services is relatively unchanged at around 700.

- **Question: What accounts for the increase' in program costs?**

*Answer:* As the Private Institutional Care expenditures grew, the appropriations did not keep pace. The Division shifted funding from other residential programs to cover costs. In part, this represents a technical reallocation and also children who aged out of educational entitlement but remained out of state.

37.b. For several years, the division has attempted to reduce the number of Private Institutional Care placements. These efforts were not successful.

- **Question: What specific programs are being undertaken in FY 2009 to reduce the cost and the number of clients in such placements?**

*Answer:* The Division is now using the Developmental Centers (for adults only) and Emergency capacity to avoid out of state placements. Additionally, the Assistant Commissioner must approve any out of state placement after an exhaustive review of all other in-state opportunities.

Additionally, the Division has (1) initiated the Child In-State Placement Enhancement Pilot (C-PEP) to build in-state community based capacity and (2) initiated discussions with provider agencies who have multi-state capacity to identify transfer opportunities back into New Jersey.

We also instituted an adult pilot project with one provider to bring clients back to New Jersey.

**Discussion Points (Cont'd)**

38. The FY 2008 appropriations act assumed that about 1,300 clients would receive Skill Development Home services. Revised data indicate that fewer than 1,200 will receive such services.

- **Question: What accounts for the reduction in the number of clients receiving Skill Development Home services?**

*Answer:* The Division has experienced a loss of providers in this area.

39.a. The FY 2008 appropriations act assumed that about 7,400 persons would receive Croup Home services. Revised estimates indicate that 6,400 will receive such services.

- **Question: What accounts for the reduction in the number of clients receiving Group Home services?**

*Answer:* The Division has not experienced a reduction in the level of contracted group home services. The Division restated capacity to show only contracted beds. Previous to this presentation, statistics included other contracted services that support group home operations.

39.b. Though fewer clients will receive Group Home services in FY 2008 than had been anticipated, per capita costs have increased between 15% and 82%:

Group Home - \$75,500 compared to \$86,800.

Supervised Apartment - \$59,900 compared to \$70,500.

Supported Living - \$28,100 compared to \$51,000.

- **Question: What accounts for the increase in per capita costs?**

*Answer:* As a result of the restatement of capacity, the expenditure level per client has also been recalculated.

40. The FY 2009 budget recommends \$30.1 million (gross) for Olmstead Residential Services. No data are provided as to the number of clients that will receive services, the types of services to be provided or the cost of the services.

- **Question: How many clients will receive services? What services are to be provided? What is the expected average cost of the services?**

*Answer:* The Division expects to serve 125 consumers with this appropriation. The plan was based on the Division's "Path to Progress," which is available at <http://www.state.nj.us/humanservices/ddd/nofa.htm>. Currently, the average cost of services for new consumers is approximately \$160,000 annually.

41. As of December 2007, about 650 persons were involved in the Real Life Choices (RLC) program. The Governor's FY 2009 recommended budget anticipates enrollment to increase to 750 persons.

**Discussion Points (Cont'd)**

Under RLC, a client is assigned one of four budgets based on the need: Level I - up to \$14,300; Level II - up to \$23,500; Level III - up to \$36,500; and Level IV - up to \$63,500. Data are not routinely available regarding the number of clients in each of the four levels, or average expenditures within each level.

- **Question: With respect to the 650 persons currently involved in RLC, how many clients are in each of the four levels? What are average expenditures per person in each of the four levels?**

*Answer:* Real Life Choice includes (1) individuals on the Community Services Waiting List (CSWL) and (2) individuals aging out from their educational entitlement who are in need of day activities. There are 4 Real Life Choice levels for those on the CSWL: Level 1 is up to \$23,742, Level 2 is up to \$38,162, Level 3 is up to \$48,822, and Level 4 is up to \$67,053. For those aging out of their educational entitlement, there are 3 transition levels: Level 1 is up to \$16,480, Level 2 is up to \$21,630, and Level 3 is up to \$26,780.

Of the 659 consumers participating in the RLC program as of February, 2008, there are 101, 129, 143, and 112 in RLC Levels 1 through 4, respectively. Additionally, there are 61, 47, and 32 in levels 1 through 3 for transitioning individuals. The remaining 34 consumers are in the planning stages.

42. The FY 2008 appropriations act provided about \$148.8 million (gross) for Adult Activity Services. Revised data indicate costs of about \$165.3 million (gross). Per capita costs have increased 11.5%, from \$16,500 to \$18,400.

- **Question: What accounts for the increase in program costs?**

*Answer:* There was a redistribution of Olmstead and initiative funding to the Adult Activities account. These funds were initially funded in the residential account and are now correctly reallocated.

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

43. During 2006/2007 a review determined that CBVI expended 100% State funds to reimburse for certain vision related procedures for clients who were Medicaid eligible. CBVI was to develop a system that would identify clients who were Medicaid eligible so that the clients could be referred to a Medicaid provider to obtain vision related services.

- **Question: Has this system been implemented? If yes, how many clients are being referred to Medicaid providers? How much has CBVI saved as a result of such referrals?**

*Answer:* The FY 2009 waiver for Consultant Services will include modification to the Commission's Client Tracking System that will track Medicaid eligible consumers. As of March, 2008, 1,122 Commission clients are in managed care and 1,306 clients are receiving fee for services. At this time, the Commission cannot identify any potential savings.

44. Nearly \$0.6 million in capital funds for Emergency Equipment Upgrades - I. Kohn Rehabilitation Center are unexpended.

- **Question: Can these unexpended balances still needed or can they be lapsed?**

*Answer:* \$497,000 of FY 2008 Capital funding for the Joseph Kohn Rehabilitation Center can be lapsed. Life Safety Issues project completed in FY 2006. \$100,000 needed for projected use in FY 2009 for a security monitoring system. No additional projects anticipated in FY 2009-2010.

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

45. Budget language requires that "any change ... in the standards upon which or from which grants of categorical public assistance are determined, first shall be approved by the Director of the Division of Budget and Accounting."

Effective January 2008, the division excluded as a resource the value of all vehicles, excluding recreational vehicles, in determining eligibility for public assistance and food stamp benefits.

- **Questions: Was this policy change approved by the Director of the Division of Budget and Accounting? If not, will the policy be withdrawn pending such approval? How many additional households are expected to qualify for public assistance and food stamp benefits, respectively, as a result of this policy?**

*Answer:* The policy change was approved by the Director of the Division of Budget and Accounting. We estimate that an additional 42 TANF cases, 44 General Assistance cases, and 428 Food Stamps cases would now qualify for public assistance as a result of this change, or less than a 0.1% caseload increase in the TANF, GA or Food Stamps programs.

46.a. The federal Deficit Reduction Act increased state work participation rate (WPR) requirements in the Temporary Assistance to Needy Families (TANF) program to 50%, and changed the basis upon which the caseload-reduction credit is calculated. Beginning in FFY 2007, the caseload-reduction credit will be based on caseload changes between FFY 2005 and FFY 2006. For New Jersey, failure to meet the WPR requirement could result in a \$20.2 million reduction in federal TANF funds and a potential increase in State expenditures of \$40.2 million according to Federal Funds Information for States (Issue Brief 06-04).

Available data indicate that in federal FY 2007, the State's 34.6% WPR appears to be 2.9% below the State's adjusted 37.5% WPR (50% - 12.5% caseload reduction credit). The State may be able to offset any federal penalties through a variety of methods.

- **Question: Will the State be able to offset any federal penalties?**

*Answer:* New Jersey will be able to take advantage of other caseload credits available to us in federal FY 2007 that will enable us to meet our 50% state work participation rate (WPR) requirement. As a result, we do not expect to be issued any penalties associated with the WPR in federal FY 2007 nor incur a reduction in our federal TANF block grant funds.

46.b. A review of WPR data indicate that the following counties with caseloads of 1,000 or more contribute to the State's being unable to meet the WPR requirement: Atlantic (26.4%), Bergen (32.7%), Camden (26.6%), Cumberland (24.2%), Mercer (31.1%), Middlesex (24.6%) and Passaic (27.9%).

- **Question: What specific problems contribute to the low work participation rates in these counties? What financial penalties or financial incentives are available to increase the work participation rates in these counties?**

**Discussion Points (Cont'd)**

*Answer:* The WPR data referred to in the discussion portion of the question is based upon outdated reports. Information for February of 2008 was provided to the Legislature in the OLS responses previously submitted by the Department of Labor and Workforce Development.

Our initial analysis indicated that this drop is due to a combination of factors:

- Before August 2007, clients' hours were reported in a way that was labor intensive, error prone, and often resulted in clients being credited with scheduled hours of activity, rather than their actual hours. The implementation of the federally-required electronic timesheet system is technically more efficient and accurate, but it is a major change for users and has proved challenging for some resulted in some hours not being captured,
- Clients who attend an activity are not attending for enough hours to meet the standard for the participation rate, and,
- Clients are simply not attending their mandated work activities.

Program and policy changes to increase our participation rate in some instances required legislation and in almost all instances, required significant changes to information systems. Because of this, many changes could not be implemented as quickly as we would have liked.

The statewide participation rate based on the new federal counting rules for February 2008 is 18%. New Jersey will qualify for caseload credits which will help us meet our goals. While the exact amounts of these credits are not calculated until the end of the year, we expect that these credits will help us meet the required participation rate by September 2008.

In an effort to increase participation, staff from the Departments of Human Services and Labor and Workforce Development has been providing intensive technical assistance to every county. The Department of Labor and Workforce Development issued corrective action letters to 15 counties with suggestions to improve performance. We are also engaging our community vendors to begin a process in May of 2008 to outreach to clients that are not in a work activity to encourage participation, or begin the sanction process.

In July of 2007, the Legislature passed P.L. 2007, c. 97, to streamline the process for sanctioning clients that are not in a work activity. We will be implementing the new practices this July, which will help increase the participation rate. The new sanction policy will require more outreach to clients, but sanctions will be imposed more quickly. The concept of a streamlined sanction process is to bring clients into compliance with the WFNJ program to assist them in becoming self-sufficient, while at the same time contributing to the participation rate. Statewide sanction training will be held in April to prepare staff for the new sanction regulations. Counties need time to adjust to the new TANF rules, which were only finalized in February of 2008.

Fiscal sanctions for underperformance have been considered by other states. New Jersey has not pursued fiscal sanctions at this time

**Discussion Points (Cont'd)**

46.c. During Spring 2007, regulations were adopted to establish a pilot project to allow welfare recipients who work a minimum of 30 hours per week to retain more of their earnings by increasing the earned income disregard. The division had estimated that about 2,400 cases would be affected by the program. The incentive would increase State welfare expenditures by about \$3.3 million annually.

- **Question: How many recipients are taking advantage of the incentive? Has there been an increase in the number of hours affected recipients are working? If not, should the pilot project be continued?**

*Answer:* While the pilot began in Spring of 2007, state legislation was enacted in July of 2007 to make the new disregard policy permanent. This legislation also reduced the number of hours required to be eligible for the expanded disregard from 30 per week to 20 per week. As of March 2008, **2,372 WFNJ/TANF cases** were in receipt of the 75% earned income disregard. Initial analysis of the impact of the enhanced disregard on the Work Participation Rate (WPR) indicates that more than half of all countable work activities are attributable to cases in receipt of the 75% disregard. The overall net impact of the policy is estimated to increase NJ's WPR by approximately one third over what would be expected had the policy not been implemented.

47.a. The division is in the process of implementing a new Automated Child Support Enforcement System at a cost of upwards of \$70 million (gross).

- **Question: Is available funding adequate, or will additional funds be required to complete the project?**

*Answer:* The New Jersey Kids Deserve Support (NJKiDS) system is fully funded over its six year developmental and operational period. Total estimated NJKiDS developmental costs of \$77 million are being offset with 66% federal matching funds. The non-federal share of costs are offset using earned child support incentive revenue also provided from the federal government through 2011, eliminating any reliance on State General Fund support. We do not anticipate any additional funds will be necessary to complete the NJKiDS project at this time.

47.b. The new child support system is to be implemented during 2008. Monitoring reports submitted to the federal government indicate that insufficient State personnel have been assigned to the project and that understaffing could have a negative impact on implementation.

- **Question: Is implementation on schedule? Have the personnel issues been resolved?**

*Answer:* The project is on schedule to be implemented statewide by June 2009. This includes a pilot in Ocean County scheduled for October 1, 2008 with full statewide rollout completed by June 2009.

Given the complexity and scope of this project, finding the required skill sets and experience amongst state staff, and the state's hiring freeze makes recruiting challenging. However, we have received approval to augment state staff utilizing our existing NJKiDS Quality Assurance contract vendor for \$12.1 million which has helped the project move forward at the current rollout structure.

**Discussion Points (Cont'd)**

48. A Request for Proposal to develop and implement a new welfare/food stamps computer system known as the Consolidated Assistance and Support System (CASS) is currently under review. No contract has been awarded, in part, because of concerns as to whether adequate numbers of State personnel would be available to support the project.

- **Questions: What is the status of CASS project? What is the projected gross cost to implement CASS?**

*Answer:* The CASS Evaluation Committee prepared a formal Evaluation Report which documented their justification for selecting the winning bidder for the project. This report was sent to the Department of Treasury, Division of Purchase & Property for their review and approval prior to the issuance of a formal Intent to Award letter. Final approval from the Department of Treasury to proceed with this procurement process is expected shortly. Pending their approval, the CASS Committee Evaluation report will be forwarded to our Federal sponsors who have 60 days to review and issue approval of their recommendation. Upon receipt of federal approval, the contract will be awarded to the selected bidder.

New Jersey procurement regulations prohibit the release of actual any cost information for the CASS Project prior to the formal awarding of the contract.

49. The division provides approximately \$3.5 million in State funds for the TANF Initiative for Parents (TIP) program. The program assists new parents with children under 12 months of age to improve their parenting skills and encourage their child's well being and health development.

No federal Medicaid reimbursement is apparently obtained for the program even though the TIP services appear to qualify for federal Medicaid reimbursement pursuant to N.J.A.C.10:77-5.1 et seq.

- **Questions: Is federal Medicaid reimbursement being obtained for TIP? If not, why not?**

*Answer:* Federal Medicaid reimbursement is not being obtained for the TIP program, as it is paid for using all Federal TANF funds. The TIP program is successful and a child abuse preventive initiative shared with the Department of Children and Families that prepares new mothers to return back to work.

50.a. Effective September 2007, families residing in Abbott Districts with incomes greater than 300% of the Federal Poverty Level (3 person household - \$52,800 and a 4 person household - \$63,600) are not eligible for free wrap-around child care services and are required to pay for such services.

- **Questions: To date, how many families have been affected by this requirement, in total and by municipality? How much has been collected as a result of this co-payment policy?**

**Discussion Points (Cont'd)**

*Answer:* The actual households impacted by the income limit are unavailable since there is no data regarding those who previously would have applied but, due to the income limit, did not.

The only change to Abbott implemented in September 2007 was the establishment of the maximum income limit. There was no co-pay established. As a result, those with income's above 300% of the FPL were required to pay the full costs of Abbott services rather than share in the costs on a sliding income-based co-pay scale. Information is not available by municipalities.

50.b. The proposed FY 2009 budget would further reduce the income eligibility for free wrap around child care services from 300% to 250% of the Federal Poverty Level (3 person household - \$44,000 and a 4 person household -\$53,000).

- **Questions: How many additional families are expected to be affected by this requirement, in total and by municipality?**

*Answer:* We estimate statewide that a total of 1,344 children will no longer be eligible for free child care wrap-around services as a result of lowering the family income eligibility threshold from 300% to 250% of the Federal Poverty Level (FPL). This new income threshold will be identical to the Family income eligibility threshold that is applicable to the non-Abbott School Districts. Information is not available by municipality.

51. New Jersey was one of several states that participated in a federal pilot study to determine the error rate in the federal Child Care and Development Block Grant, one of the main funding sources for child care.

Preliminary findings indicate that: child care payments exceeded documented needs; the incorrect household size was used; family income may not have been verified resulting in lower co-payments or the provision of services to families that may not be financially eligible; the wrong fee schedule may have been used to determine co-pays; and that data was incorrectly entered into the computer systems.

- **Question: What was the approximate dollar value of incorrect child care payments as a result of these errors?**

*Answer:* Preliminary findings indicate that that 28 of the 150 records selected randomly had one or more errors possibly involving an improper payment. The total value of payments made to the sampled cases for the review month was \$45,807, of which \$6,042 or 13% were made due to possible error. We are presently analyzing these results to determine the validity of the federal payment findings. No penalties associated with findings.

52. The FY 2008 appropriations act increased funding for the Substance Abuse Initiative by \$19.4 million, to \$38.2 million, based on a projected increase in the number of persons being referred, assessed and receiving treatment services.

**Discussion Points (Cont'd)**

Available data, however, do not reflect any significant increase in the number of persons being served by this program: In FY 2007, 9,100 persons were referred for services, 7,000 persons were assessed and 5,400 persons were referred to treatment. In FY 2008, available data indicate that 8,700 people will be referred for services, 6,900 persons will be assessed and around 5,800 persons will be referred for treatment.

- **Questions: As the overall number of persons being served by the program has not increased significantly, how much unexpended funds will the account have? Why has the number of persons participating in the program not increased to the anticipated levels?**

*Answer:* Regarding not meeting the anticipated participation in FY 2008, it is thought that the FY 2006 recipient counts reflected a large influx of DYFS recipients who were required to receive substance abuse services as part of their reunification plan under Child Welfare Reform. This influx was reflected as part of the future trend. However once the initial population was absorbed into the caseload, the trend normalized. A reduction was addressed in the budget.

53.a. The FY 2009 recommended appropriations for Work First New Jersey - Client Benefits of \$1 16.2 million (gross) assumes average monthly caseloads of 96,700. During FY 2008, caseloads have ranged from 98,700 to 102,400.

- **Question: In view of current caseloads, is the 96,700 estimate too low? If the FY 2009 estimate is too low, what are the implications for the FY 2009 recommended budget?**

*Answer:* Given recent caseload trends, we believe that the 96,700 number is realistic. As always we will monitor caseloads closely as additional information becomes available.

53.b. The FY 2009 recommended appropriation for Work First New Jersey - Emergency Assistance of \$71.3 million (gross) assumes an average monthly caseload of about 14,700. During FY 2008, caseloads have ranged from 14,700 to 16,400.

- **Question: In view of current caseloads, is the 14,700 estimate too low? if the FY 2009 estimate is too low, what are the implications for the FY 2009 recommended budget?**

*Answer:* Given recent caseload trends, we believe the 14,700 average monthly recipients are realistic. As with TANF, we will continue to monitor caseloads closely as additional information becomes available.

53.c. The FY 2009 recommended appropriation for the General Assistance Emergency Assistance and Payments for the Cost of General Assistance assumes monthly caseloads of 7,200 and 41,000 persons, respectively. Current FY 2008 caseloads in the two programs are at or above FY 2009 caseload estimates.

- **Question: In view of current caseloads in the two programs and the downturn in the economy, are FY 2009 enrollment estimates in the two programs too low? If the FY**

**Discussion Points (Cont'd)**

**2009 estimate is too low, what are the implications for the FY 2009 recommended budget?**

*Answer:* Given recent caseload trends, we believe 41,000 and 7,200 recipients for GA and GA-EA respectively are realistic. As with all State Aid programs, we will continue to monitor caseloads closely as additional information becomes available.

## Discussion Points (Cont'd)

## DIVISION OF ADDICTION SERVICES

54.a. In FY 2008, additional funds were appropriated to the division to hire nine employees to improve the division's monitoring and oversight of contracts. The FY 2009 recommended budget eliminates over \$0.5 million in funded vacancies, including some positions intended to improve financial oversight.

- **Question: What impact will this reduction have on the number of positions assigned to contract monitoring related activities?**

*Answer:* The reduction in staff may result in DAS moving from biennial to triennial licensure monitoring and from annual to biennial monitoring of contracts. It may require DAS to explore the use of deemed status.

DAS has also revised its financial audit process to account for more program procedure audits than General Ledger auditing (for example) and now routinely includes program staff in developing auditable events.

Many of the changes DAS is undergoing are focusing on quality and productivity of contracts. The single most important change is the movement towards fee-for-service. The larger the portion of our contracts and providers participating in a FFS network, the less staff DAS will require to write contracts. These staff can be repurposed as field monitors. Finally, we are examining best practices from throughout the country in order to refine our contract monitoring activities.

54.b. In FY 2007, the division initiated seven provider audits and completed two.

- **Question: How much, if any, funds were recovered as a result of these audits? How many audits were initiated in FY 2008 and will be initiated in FY 2009?**

*Answer:* All agencies have a single audit. The OIG report recommended a list of high risk agencies for outside audit. The division recovered \$130,000 of funds from FY 07 audits. DAS expects to initiate 6 audits in FY08. DAS is in the process of developing a potential list of agencies for audits for FY09. Audits are not the sole strategy that DAS is utilizing to increase accountability. As a result of the OIG report, DAS initiated a "360 Contract Review" process in FY 2007. This process provides Division management, program, fiscal, and support staff with the opportunity to conduct a thorough, integrated, and multidimensional review of all service contracts executed by DAS. The process entails the development and analysis of fiscal, program, licensure, and performance information on each contracted agency into a single report which is reviewed by management, program, and fiscal staff who are responsible for implementing corrective action steps as needed to address deficiencies identified as a result of the review.

55. The division indicated that it did not have systems in place to identify whether a person receiving services from the division was also receiving substance abuse services provided by other divisions or departments.

**Discussion Points (Cont'd)**

- **Question: What controls are in place to minimize the possibility of providers being reimbursed twice for the same client?**

*Answer:* DAS is increasing Fee-for-Service reimbursement for its services. This will enable electronic cross matches using a unique client identifier with Medicaid and other agencies to identify potential billing issues for clients receiving DAS services. DAS has more than \$30 million in Fee-for-Service programs and will be increasing this amount in the coming year.

The Encounter Module has been established within the NJ Substance Abuse Monitoring System (NJ-SAMS) and will be rolled out with the Needle Exchange Treatment Initiative (NETI) and Co-Occurring Fee-for-Service Voucher Programs. This new data component will help prevent double billing across DAS funded initiatives.

56. The department was attempting to secure federal Medicaid administrative reimbursement for certain administrative costs incurred by non-hospital based substance abuse agencies.

- **Question: How much federal Medicaid administrative reimbursement was received in total, and how much was distributed to substance abuse agencies?**

*Answer:* The claim is still under preparation. The first claim is expected to be filed by the end of this fiscal year and it is anticipated to yield approximately \$900,000 in total. Once the funds are received, a distribution (25%) will be made to the participating agencies.

57. The division conducts various surveys on substance abuse issues related to the State's population in general and specific segments of the State's population. The federal government conducts similar surveys, e.g., State Estimates of Substance Use from 2005 - 2006, National Surveys on Drug Use and Health (2008) and Health, United States, 2006. In general, federal survey findings are similar to the division's survey findings though the federal surveys may not be statistically valid on a state or a county level.

- **Question: How much State funds are expended to conduct the division's surveys? In view of the State's fiscal problems, are the federal survey findings sufficient for the division's planning purposes to justify the elimination of the State surveys?**

*Answer:* No state funds are expended on any survey conducted to determine need assessments. There are no Federal need assessment surveys that provide data on a county level and therefore, none that can help us with our needs assessment and county planning process. These data are used to drive resource allocations. We utilize Federal block Grant funding for the surveys that provide county specific data. Although no state funds are used in these surveys, the surveys are federally mandated.

58.a. The FY 2009 budget recommends \$4.0 million for a new program, Union County Inmate Rehabilitation Services. Little information is available regarding the program, though it appears similar to an Essex County program funded by the division.

- **Question: Will this program be operated by the county or a private vendor? Will the provider be licensed by the division? Will the program be required to provide**

**Discussion Points (Cont'd)**

**statistical data on clients receiving services through the division's data system, NJ SAMS?**

*Answer:* This program will be operated by a private vendor and it will anticipate an annual level of service of 225 inmates and will require \$4m from the proposed FY09 budget. This program is located at two different sites in Union County. Program performance will be monitored by the Union County Department of Corrections.

58.b. The FY 2009 budget recommends \$23.0 million for two substance abuse treatment programs in two counties: Essex - \$19.0 million and Union - \$4.0 million. Similar programs may operated in other counties.

- **Question: How many counties operate programs similar to those operated by Essex and Union Counties? What is the cost of programs operated by the other counties? Why is State funding provided to only two counties while programs in other counties are not supported by the State?**

*Answer:* All counties have the ability to contract with such programs with non-DAS dollars. The counties aren't operating these programs, they contract with the programs. DAS is not a party to the contract with the county and the program. Therefore, it is unknown how many counties actually operate or contract with such programs or the cost associated with operations or contracts.

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

59.a. The FY 2009 budget recommends \$290,000 for Services to Deaf Clients, the same as in prior fiscal years. Between FY 2005 and FY 2007, Services to Deaf Clients program expenditures were \$143,000 - to \$240,000. FY 2008 expenditures are projected at around \$220,000.

- **Question: Based on current and prior year expenditures, can FY 2009 recommended appropriations be reduced?**

*Answer:* The Division of the Deaf and Hard of Hearing's FY09 recommended appropriations can not be reduced.

DDHH is working closely with the Offices on Aging and the AARP and other community group to provide awareness about hearing loss and services available to them from the DDHH. We anticipate that as Senior Citizens become aware of the resources available to them from the DDHH, funds will need to be allocated to serve this population.

Additionally, DDHH is working closely with the Department of Labor's Division of Vocational Rehabilitation Services (DVRS) to secure a contract which would result in three regional sites where consumers who are deaf and hard of hearing may seek assistance in securing employment. The sites will allow employers and employees to experience the latest technology such as Videophones, Captel phones, Assistive Listening Devices, telecommunications and other related equipment.

Other existing DDHH programs which have been successful will be expanded, such as the Equipment Distribution Program, Open-Captioning plays at NJ theatres, the Assistive Listening Technology Loan Program and public announcements that enhance awareness of hearing loss.

DDHH's ability to continue to support existing programs, as well as the new initiatives mentioned above, will require that we maintain our current budget.