

**Discussion Points**

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**DEPARTMENT OF HUMAN SERVICES – GENERAL**

1.a. The following Schedule 1 revenues were less than the amounts anticipated in the FY 2006 appropriations act:

REVENUE	FY 2006 APPROP. ACT (000)	FY 2006 ACTUAL (000)	SHORTFALL (000)
Early Periodic Screening Diagnosis and Treatment	\$4,000	\$1,807	(\$2,193)
Medicaid Uncompensated Care – Acute	\$286,955	\$280,367	(\$6,588)

In FY 2005, these revenues were also less than the amount reflected in the FY 2005 appropriations act.

- **Question:** What accounts for these shortfalls?

**Answer:** The Department of Treasury has a consultant to prepare claims for this program and identify difficulties collecting the necessary information from school districts, reducing the amount claimed for Early, Periodic Screening, Diagnosis and Treatment activities.

In fiscal year 2006, Claims for Medicaid Uncompensated Care – Acute were reduced after reconciling of estimated and actual claims for FY2005. Estimated claims submitted in fiscal year 2005 were overstated by approximately \$7.7 million.

1.b. The Comprehensive Annual Financial Report for the Fiscal Year Ended June 30, 2006 (CAFR) indicates that the State realized the following Patients’ and Residents’ Cost Recoveries: Development Disabilities - \$9.8 million and Psychiatric Hospitals - \$77.4 million.

However, the FY 2008 recommended budget, Schedule 1, reflects these amounts: Developmental Disabilities - \$15.9 million and Psychiatric Hospitals - \$69.4 million.

- **Question:** What accounts for differences in reported revenues?

**Answer:** The difference in the reported amounts of revenue is due to how accounts are consolidated in each document. Any other differences may be due to rounding (The CAFRA report doesn’t round their numbers).

1.c. The FY 2008 recommended budget, Schedule 1, reflects a \$110 million increase in Medicaid Uncompensated Care – Acute revenues: FY 2007 revised - \$140.5 million and FY 2008 - \$250.0 million.

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- **Question:** What accounts for the \$110 million increase?

**Answer:** The federal Office of the Inspector General (OIG) has issued several audit reports recommending recovery of FFP. The potential impact of these audit findings has been reflected as a reduction of anticipated revenue to the State in fiscal year 2007.

1.d. The FY 2007 appropriations act reflected \$3.5 million in School Based Medicaid revenues. As revised in the FY 2008 recommended budget, Schedule 1, no School Based Medicaid revenue are anticipated.

- **Question:** What accounts for the reduction in FY 2007 School Based Medicaid revenues?

**Answer:** The federal Office of the Inspector General (OIG) issued an audit report questioning some claims for school based Medicaid services and recommending recovery of FFP. The potential impact of this audit finding has been reflected as a reduction of the anticipated revenue to the State in fiscal year 2007.

2. 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 since August 2005. To date, the issue has not been settled.

- **Question:** How much does the State seek to recover? What is the status of the negotiations?

**Answer:** Negotiations between the Division of Law and Price Waterhouse Cooper (PWC) continue. As a matter of practice, the Division of Law has asked the Department not to reveal the amount that the State seeks to recover from PWC until the matter is closed.

3. In FY 2006, approximately 109.4 million kilowatt hours (kWh) of electricity was used by the State developmental centers (71 million kWh) and psychiatric hospitals (38.5 million kWh). These facilities have considerable vacant land that may be suitable for solar energy development by the State in conjunction with private developers. The Department of Military and Veterans Affairs is developing a 600,000 kWh solar energy project on approximately 1.75 acres at a net cost to the State of about \$1.3 million. This cost might be further reduced through the sale of Solar Renewable Energy Credits.

- **Question:** Has the department discussed with the State Board of Public Utilities the development of vacant institutional property for alternative energy such as solar?

**Answer:** The Department is working with John Rhodes, Director of Energy Savings, his staff from Treasury's Office of Energy Savings and the ombudsman from the

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State Board of Public Utilities. Together with other State Departments, we are working on a program to increase energy efficiency, reduce energy usage and lower energy costs at all DHS institutions. Solar energy is just one of the clean energy technologies under consideration.

4. In federal FY 2006, the State was eligible to receive a maximum of \$606.4 million in federal Disproportionate Share Hospital (DSH) revenues for Inpatient Hospital and Mental Health services. The State realized about \$574 million in federal DSH funds, about \$32 million less than the maximum. The \$32 million shortfall is related to the Inpatient Hospital component of DSH.

- **Question: What accounts for the \$32 million shortfall in DSH funds?**

**Answer:** State expenditures for DSH eligible activities did not meet or exceed the DSH limit for federal fiscal year 2006. The DSH limit for federal fiscal year 2004 was increased by about \$84 million FFP. Since then, the Department has worked to identify additional claiming opportunities. DSH claims for the current federal fiscal year are expected to equal the available allotment.

5. The Nursing Incentive Program in the Divisions of Developmental Disabilities and Mental Health Services is discontinued, saving \$400,000.

- **Question: In view of the difficulties State institutions have in hiring and retaining nursing personnel, why is the program being eliminated?**

**Answer:** Considerable progress has been made in DMHS in the last two years in hiring RNs. There has been a net gain of approximately 50 RNs which was in part, but not solely attributable to this incentive program. We believe that a focused approach is necessary to identify factors contributing to hiring difficulties that are unique to each hospital and then to take remedial steps accordingly. In DDD, the Scholarship program was deemed to be more effective. Therefore, due to limited funding available in the budget, this program was eliminated.

6. The FY 2007 appropriations act assumed the following savings: Management Efficiencies - \$50 million; Information Technology Efficiencies - \$20 million; and Procurement Efficiencies - \$15 million.

Though savings were reflected in the Interdepartmental Accounts section of the budget, the various department were to provide the monies to reimburse the Interdepartmental Accounts? in direct correlation with identified efficiency improvements.

- **Question: What was the department's share of the Management Efficiencies, Information Technology Efficiencies and Procurement Savings? What specific efficiencies was the department able to achieve? Are these efficiency savings continued in FY 2008?**

**Answer:** The DHS share of the efficiency reductions was approximately \$11 million, which is permanently reduced from the FY2008 base. Savings are being

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derived mostly through excess turnover due to the delay in backfilling non-exempt positions. Overtime is expected to decrease due to hiring actions in critical areas. Nursing incentive funds were eliminated, as discussed in question 5 above. Information Technology hardware and software purchases have decreased pending the outcome of the OIT consolidation.

**DIVISION OF MENTAL HEALTH SERVICES**

7. The FY 2008 recommended budget includes \$350,000 for the Governor's Council on Mental Health Stigma. As of this writing, less than \$50,000 of the FY 2007 appropriation has been expended.

- **Question:** Can the appropriation be reduced?

**Answer:** No, the appropriation cannot be reduced. A permanent Executive Director for the Council was hired in mid-December 2006, the Council has not been able to move as quickly as had been hoped. However, with the assistance of a full time Executive Director, the Council expects to shortly begin its activities to advance the mission of the council.

8. Of the \$11.8 million recommended for Personal Services, \$330,000 is allocated for the Office of Disaster Mental Health, but the amount spent on the office is not identified.

- **Question:** How much will be expended on the Office of Disaster Mental Health?

**Answer:** DMHS is currently projecting to fully spend the State appropriation during FY 2007 on the salaries of the seven (7) members of this office intended to be supported by this lump sum allocation within the salary account appropriations.

9. 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 efficiencies," subject to reasonable restrictions and limits on earned incentives.

- **Question:** Of FY 2006 appropriations, how much Operational Incentives were providers allowed to retain?

**Answer:** Of 120 DMHS contracts with preliminary settlements done for 2006, there were 25 with operational incentives awarded, with a total value of \$2.085 million. The smallest incentive award was \$2,202, and the largest was \$321,722, with the average incentive award at \$83,404.

10. The FY 2008 recommended budget includes \$1.8 million for Jail Diversion Projects in Atlantic, Essex and Union counties. An additional \$0.7 million is recommended to expand the program.

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This program provides services to persons with mental illness who might otherwise be placed in a county jail. Though the State funds the entire cost, counties realize all the savings by avoiding an admission to the county jail.

- **Question:** Has there been consideration of having counties share in the program's costs, particularly if the program is expanded?

**Answer:** The Division is exploring the possibility of this idea in developing the RFP and evaluation criteria for the planned FY '08 expansion of this service by perhaps giving greater weight in the final award decisions to proposals which reflect a county's willingness to cost share for this service.

11. FY 2008 State Aid reimbursement to the six county psychiatric hospitals would increase by \$13.8 million, from \$108.2 million to \$122.0 million.

With the exception of some units at Bergen Regional, the CY 2007 rates established for the county psychiatric hospitals increased by less than 10%. Two smaller facilities had no rate increase. In addition, the census at the six county hospitals is unchanged at around 600 patients daily.

- **Question:** What accounts for the appropriations increase?

**Answer:** The Governor's recommended State Aid increase for FY '08 reflects further anticipated rate increases to be effective January 1, 2008. The rate changes at Bergen Regional Medical Center, are significant. Bergen's billable census accounts for 30% of the total billable census for all six hospitals combined, therefore exclusion of the Bergen rate increases suggests lower costs.

12. The Psychiatric Hospital budgets include nearly \$9.3 million in federal funds that are to be used for Personal Services. However, Personnel Data does not reflect any "federal positions."

- **Question:** Why are these positions not reflected in the personnel data?

**Answer:** New Federal Title XIX funds earned through claims for Medicaid Administrative Costs, are being shown as a funding source for the hospitals' administrative positions. These Federal dollars offset the cost of the State positions.

13. Available information is that a new Greystone Park Psychiatric Hospital will be operational during the July – September 2007 period and that construction costs will be significantly less than the \$204.1 million in funds available for construction.

- **Question:** What is the NJ Economic Development Authority's current estimate as to the construction costs of the new Greystone?

**Answer:** While current Economic Development Authority (EDA) cost reports project a construction cost estimate (CCE) for the new Greystone Psychiatric

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Hospital at approximately \$200.5 million, design change orders and compliance with various code inspections should bring the work total much closer to the full funding availability. In addition, current projections anticipate the move of consumers to the new hospital in mid-October.

14. To reduce the census of Ancora Psychiatric Hospital, the division is examining whether a South Jersey hospital can accept patients for longer treatment periods as an alternative to being admitted to Ancora. Numerous issues are being examined, such as: the number of beds, facility renovations costs, staffing requirements and overall program costs, the amount of Medicaid reimbursement such a facility would generate, etc.

- **Question:** Have estimates been developed as to the capital and operational costs associated with the project, the amount of Medicaid reimbursement that may be realized and the amount of State funds required to implement such a program?

**Answer:** The Division has examined admissions patterns and patient lengths of stay at Ancora Hospital. A significant percentage of consumers are admitted to Ancora directly from Screening Centers without the benefit of a stay in a Short Term Care Facility. Additionally, approximately 12-15% of all Ancora discharges occur within 35-50 days of admission. These facts suggest that the development of additional Short Term Care Facility beds and community hospital based intermediate inpatient care would provide greater opportunities for consumers to be served locally and would reduce admissions pressures on Ancora and the State Hospital system.

The Division is working with DMAHS and DHSS on the development of additional Short Term Care Beds as an initial priority. Efforts to identify program, cost and facility parameters for the development of intermediate length of stay community based inpatient beds has begun, but is not expected to be completed until FY '08.

**DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES**

15.a. The FY 2007 appropriations act included budget language limiting new provider enrollment to “new providers whose services are deemed necessary to meet special needs....”

- **Question:** How many providers, by type, have been denied and approved to participate in the Medicaid program?

**Answer:** The Division continues to enroll new providers. It is no longer, however, an automatic process. New providers are reviewed to determine the need for additional providers in that geographic area or other special need exceptions. The chart below shows the number of providers denied and approved to participate in the Medicaid program as well as total provider enrollment as of June, 2006, March, 2007, and the net increase in SFY07 to date.

<b>Provider Type</b>	<b>Applications</b>	<b>Applications</b>	<b>Applications</b>	<b>Applications</b>
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	<b>Received</b>	<b>Approved</b>	<b>Denied</b>	<b>Under Review</b>
<i>Pharmacy (received before moratorium, processed after July 1)</i>	48	37	11 ( denials not related to moratorium)	0
<i>Pharmacy (received after moratorium)</i>	54	15 (including 13 Transfers of Ownership)	18	12 Out of State Pharmacies  9 Undergoing Credentialing
<i>Durable Medical Equipment</i>	41	5 (Transfers of Ownership in process)	0	36
<i>Chiropractors</i>	5	0	0	5
<i>Podiatrists</i>	27	0	0	27
<i>Partial Care</i>	0	0	0	0

*The 9 pharmacies undergoing credentialing have already been enrolled for PAAD, Senior Gold and Medicare wraparound.*

15.b. The FY 2008 appropriations act assumed \$50 million (State share) in additional recoveries. To generate these additional recoveries, staff are required to review reports and follow-up with clients and providers. However, between December 2005 and December 2006, the division’s full-time employee count was reduced from 580 to about 540, meaning that fewer staff are available to investigate and follow-up on fraud related matters.

- **Question:** Will \$50 million in recoveries be realized? Are additional Staff needed to realize these recoveries?

**Answer:** The Division anticipates a balanced budget in SFY07, in large part due to the commitment the Division has made to prevent and recover Medicaid overpayments to providers. To achieve this balanced budget, the combination of both recoveries and cost avoidance is expected to make significant progress towards the \$50 million during SFY07.

Despite the reduction in staff size, the Division has made significant progress at improving fraud, waste, and abuse prevention efforts including staff training, staff restructuring, and operational changes. In conjunction with these changes, Program Integrity staff has made significant progress at utilizing data to detect and recover overpayments as well as improved the management of cases. The Division has made the prevention, and detection of fraud, waste, and abuse a Division-wide priority, not just that of the Office of Program Integrity.

The most significant savings are a result of four items:

- 1) Provider moratorium- The Division elected to limit the number of new providers. Only providers who meet special needs criteria or are transfers of ownership will be enrolled. In an effort to take inventory and review the quality of

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existing providers, the Division elected to place a moratorium on new provider enrollment (pharmacy, durable medical equipment, partial care, podiatrists and chiropractors). The Division has not received any complaints from the clients on access to care. We are still working to assess the full impact of the moratorium.

1993 VS. 2007					
MONTH OF:	PRESCRIPTIONS	FEE FOR SERVICE		PRESCRIPTIONS PROVIDERS	PRESCRIPTIONS PER PROVIDER
		ELIGIBLES	PER ELIGIBLE		
February, 1993*	896,010	259,900	3	1,886	475
January, 2007	1,024,776	196,192	5	1,941	528

\*Prior to the start of Medicaid Managed Care

2) "ClaimCheck" - ClaimCheck is a claims software product utilized by the Division's fiscal agent UNISYS that will automatically audit and adjust professional billing errors to avoid overpayments. This new product, scheduled to be implemented in May, 2007, is anticipated to save \$3 million State share in SFY 2007 and \$11 million in State funds during State Fiscal Year 2008.

3) HMO Recovery - The Division is in the process of recovering over \$15 million State share of incorrect maternity payments from the 5 participating HMOs. The SFY 2007 recovery is a result of payments made to HMOs without approved encounter claims; payments made to HMOs that proved to be duplicated invoice payments; and claims paid to HMOs that were duplicated fee-for-service payments.

4) Pharmaceutical Medical Exception Program- Under the contract with the Division, UNISYS created a medical exception unit comprised of clinical staff. In consultation with the State, certain medications require prior approval by the MEP unit before a pharmacist is permitted to dispense and be reimbursed for the medication. This program has proven to be extremely successful in preventing fraud and improving medical management. The Division anticipates savings \$5 million in SFY 2007 as a result of this improved efforts.

While the Division has made significant reform in this area it has not implemented additional system enhancements, since these functions will transfer to the Office of Medicaid Inspector General during FY2008.

15.c. As a result of UMDNJ's double billing for physician services, the division was to undertake additional hospital audits and adopt additional auditing protocols.

- **Question:** How many additional audits were undertaken? How much has been recovered?

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**Answer:** DMAHS has initiated an in-house desk review of all 74 general acute care hospitals to isolate potential duplication of physician billing. The order of more in depth field reviews of the hospitals was prioritized in terms of total Medicaid physician cost. DMAHS outreached, met with, and has begun reviews at 17 hospitals. DMAHS continues to work with these hospitals to isolate possible overpayments and initiate recovery, if necessary.

The analysis thus far does not seem to suggest widespread abuse or patterns of intentional billing duplication.

15.d. The FY 2007 appropriations act assumed that competitive bidding of transportation and durable medical equipment services would save \$0.6 million

- **Question: Have Requests for Proposals been issued for such services? Have the bids that have been submitted indicate that such savings will be realized?**

**Answer:** The Transportation RFP has been received by Purchase and Property and is pending final approval. The process experienced delays with CMS that we believe have been resolved and should no longer hold up publication of the RFP. The Durable Medical Equipment RFP is in its second draft. The Department has had meetings with Purchase and Property and it is anticipated that the DME RFP will be approved shortly after the Transportation RFP. Although no bids have been submitted, the Division fully anticipates that these savings will be achieved; however, those savings will be realized in SFY08.

16.a. Proposed capitation rates for managed care providers in the Managed Care Initiative would increase 3.0%, effective July 2008.

A Wall Street Journal article indicated that managed care organizations, including some which contract with the State, may be inappropriately charging off corporate administrative costs on to the State.

- **Question: What specific actions have been taken to reduce the possibility of a managed care provider charging inappropriate corporate costs to the program?**

**Answer:** To reduce the possibility of managed care provider charging inappropriate costs to the program, the Division edits the HMO's 3rd party contracts to ensure administrative costs are excluded from medical expenses and reported as subcontractor expenses in the administrative section of the income statement. Appropriate, cost neutral adjustments are made between medical and administrative for capitation rate development.

In addition, the Medicaid contract requires the HMO to forward a copy of their general ledger that reconciles to the administrative totals in the income statement which is then audited for expenses that are disallowed from cap rate development. These include but are not limited to: cost plus fees for Corporate Overhead

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Charges, Amortization of Goodwill, Lobbying expenses, Trademark Licensing fees, sanctions, and state taxes included in the administration category.

In the 3 years since the inception of this type of auditing, the Division has removed, on average, a net amount of about \$7 million per year when developing the annual capitation rates.

16.b. 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.

- **Question:** How much in penalties has been collected from managed care providers who do not meet contract performance standards?

**Answer:** The Division has worked with the HMOs on improvement strategies and the HMOs have increased their resources and efforts to improve performance to reach targeted goals. As a result of these efforts, the total amount collected from managed care providers decreased from \$1.740 million in SFY05 to \$760,000 in SFY06, a decrease of \$980,000, or 56%. It is too early to have complete data for SFY07, but the Division continues to monitor the HMOs as well as impose and collect the appropriate sanctions as necessary.

17.a. Proposed budget language (D-215) eliminates language that pharmacies be reimbursed for brand name drugs and nutritional supplements on the basis of Average Wholesale Price less 12.5%. Instead reimbursement would be in accordance with the federal Deficit Reduction Act (DRA).

The DRA specified the manner in which states were to reimburse pharmacies for (most) generic drugs, but reimbursement for brand name drugs and nutritional supplements was left up to the states.

- **Question:** How are pharmacies to be reimbursed for brand name drugs and nutritional supplements effective July 2007?

**Answer:** It is our intent to continue the reimbursement of all drugs and nutritional supplements at AWP – 12.5% until the Average Manufacturers Price is published and supported by CMS. At that point, generic drugs will be paid in accordance with the DRA.

17.b. Pharmaceutical manufacturer's rebates are expected to increase by over \$23.1 million, from \$111.3 million (FY 2007) to \$134.4 million (FY 2008).

- **Question:** As most Medicaid recipients either participate in the federal Medicare Part D program or obtain prescription drugs through managed care programs, why are pharmaceutical manufacturer's rebates expected to increase?

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**Answer:** Historically, the Division has realized 16% to 20% in rebates on pharmaceutical expenditures. The Division saw a decrease in the SFY07 rebate amounts as a result of the first full fiscal year of reduced rebates since the implementation of Medicare Part D. Although many Medicaid recipients receive their prescription drugs through Medicare Part D or Managed Care, a significant amount of pharmaceutical costs continue to be paid through Fee-For-Service. In SFY08, the Division anticipates an increase in the rebate amount as the pharmaceutical costs for those clients who continue to obtain their drugs through Medicaid Fee-For-Service increase and it is reflected in the SFY08 Budget accordingly.

18. To assure compliance with the terms and conditions of the ACS State Healthcare Health Benefits Coordinator contract, the division implemented a monitoring plan. The first review was completed around May 2006. Additional reviews may have been completed since then.

Under the contract, 15% of every invoice is retained and may be released after three months after the contractor's performance is reviewed. In addition, "damages" may be assessed if standards are not met with respect to the call center, timeliness and accuracy of NJ FamilyCare eligibility and HMO enrollment.

- **Question:** Is ACS meeting contract standards with respect to: (a) eligibility services and enrollment services; (b) the assignment of premiums; (c) the generation of correct premium notices; and (d) the collection and non-collection of premiums? How much, if any, invoice payments have been withheld from the contractor to date?

**Answer:** The Office of Contract Compliance monitors the ACS contract very closely and is constantly reviewing eligibility determinations, listening to phone calls to the HBCs, and monitoring all phases of the operation.

The contract requirement is an eligibility error rate of 5%. ACS is meeting contract standards in respect to eligibility and enrollment services.

The contract requires the Division to withhold 15% retainage of each monthly invoice, which averages about \$216,000. After 3 months, a month's retainage is released so we are continuously holding 3 months retainage. During the first year, we withheld several months bill payments while problems were resolved and have since made payments on these bills once the Division was satisfied that any pending issues were resolved. To date, no penalties have been imposed as ACS is now satisfying all contract requirements.

19. Additional funds were provided in the FY 2007 appropriations act to enable an additional 50,000 children to be enrolled in NJ FamilyCare. The Budget in Brief (p. 30) states that "this initiative is on track."

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Available data indicate that between July – December 2006, the number of children enrolled in NJ FamilyCare (A – D) increased by about 2,000 (net), from 124,700 to 126,600.

- **Question:** As enrollment has increased by only 2,500 (net) between July 2006 – January, 2007, how is the “initiative on track” to enroll 50,000 by the end of FY 2007?

**Answer:** The Governor directed an increase of 50,000 additional children from January, 2006 to July, 2007 in the NJ FamilyCare program, which covers both Medicaid and SCHIP programs. In the fall of 2006, the Division had seen a reduction in the growth of the number of children enrolled in the SCHIP and Medicaid program. A large part of this slow-down is due to requirements of the Federal Deficit Reduction Act (DRA) of 2005 which mandates verification of US citizenship and proof of identity. Between new and renewal applications, this requirement has produced a substantial backlog of applications of over 10,500 children.

Despite this backlog, since the time of the Governors January, 2006 initiative to enroll 50,000 children by July, 2007, the Division has increased enrollment by over 31,000, from approximately 558,000 (January, 2006) to 589,000 children (February, 2007) between Medicaid and SCHIP and with recent trends growing, anticipates reaching 45,000 by July, 2007.

20. 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.

- **Question:** What is the waiver application’s status?

**Answer:** The Division has had preliminary discussions with the Governors Office and the Center for Medicare and Medicaid Services (CMS) related to the application of a federal waiver to cover adults without dependent children up to 100% of the Federal Poverty Level. The Division continues to explore this waiver as part of a larger Medicaid Health Care Reform initiative. We do anticipate pursuing this initiative more aggressively over the next several months.

21. 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 was to provide additional information in support of the expenditures.

- **Question:** What is the 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 the claims questioned in the OIG audit report. This documentation has been submitted to CMS for review. The outcome of the CMS review is pending.

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22. The FY 2007 appropriations act provided \$4.7 million for Personal Care Salary Increase.

In past years, provider agencies have not have distributed funds allocated by the Legislature to increase the salary of direct care employees. Instead, provider agencies used all or part of the monies to offset other employee costs, such as health care insurance, etc.

- **Question:** What actions did the division take to insure that \$4.7 million was used to increase the salary of direct care workers as intended by the Legislature?

**Answer** Each Medicaid PCA provider agency is required to submit a signed "Attestation Form" agreeing to use the increased Medicaid PCA reimbursement for "compensation" to the homemaker/home health aides in their employ. Without the attestation on file, the PCA provider is not reimbursed at the higher rate. Spot check audits will be used to determine compliance with this requirement.

23. The FY 2008 recommended appropriation for Personal Care is reduced \$16.0 million (gross), from \$151.3 million to \$135.3 million, based on current expenditure and utilization patterns.

The number of persons utilizing Personal Care services has remained relatively constant at between 22,000 – 23,000 monthly. Similarly, the number of units of services being provided has remained between 1.2 million – 1.7 million monthly. Barring a significant reduction in either the number of persons receiving services or number of units of service being provided, it is unclear how expenditures will be reduced in FY 2008.

- **Question:** As overall utilization has remained fairly stable in both FY 2006 and FY 2007, what accounts for the \$16.0 million reduction in FY 2008 appropriations?

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**Answer:** The reduction was made in anticipation of additional savings from the initiative to prior authorize services. We will continue to monitor caseload trends and address changes if needed.

24.a. In CY 2006, a contract was awarded for fiscal and support services related to the Cash and Counseling program. Under the terms of the contract, Section 3.4, the division is to monitor and evaluate the contractor's performance in various specified areas.

- **Question:** Has any formal monitoring of the contractor's performance been conducted? Is the contractor meeting the contract's terms and conditions?

**Answer:** The first formal monitoring of the contractor is scheduled for July 2007. Monthly, the contractor submits to the Division a detailed report of the work completed against the various price lines in the contract. These are verified by Division staff against our own internal records before payment is authorized. The contractor has met the terms and conditions of the contract.

24.b. The contractor's administrative expenses cannot exceed 10% of the total program budget for each year. Further, while the contractor may bill participants for various administrative expenses, the amount billed to participants must be "modest."

- **Question:** Are the contractor's administrative expenses within the 10% limit? What is the amount being charged program participants and is this amount "modest"?

**Answer:** The contractor's administrative expenses have never exceeded the 10% allowable maximum during the term of this, or the prior contract we had with them for this service. The amounts billed to participants include a \$.95 charge for each check issued (payroll or otherwise), \$28.00 for "stop payment" on checks (fee bank charges contractor) \$10.00 for brokering worker's comp coverage and \$15.00, 45.00 or 60.00 for employee background checks – depending on extent of the check to be made. We believe these fees are modest and realistic.

**DIVISION OF DEVELOPMENTAL DISABILITIES**

25.a. Schedule 2 estimates that federal Title XIX ICF/MR (ICF-MR) revenues will increase by about \$15.9 million, from \$314.6 million (FY 2007) and \$330.5 million (FY 2008).

Actual Medicaid billings (through December 2006) indicate that FY 2007 federal ICF-MR revenues may be as much as \$350 million (cash basis). Also, during the FY 2004 – FY 2006 period, ICF-MR revenues increased between 10.2% - 16.3% annually over the prior fiscal year.

- **Question:** Are FY 2008 federal ICF-MR revenue understated?

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**Answer:** The Division believes that the ICF amount of 330.5m is an accurate projection. Our estimates indicate that we should generate approximately \$289m for '06. Our '07 estimate stands at \$315m. By applying the same increase % between '06 and '07 to estimate the '08 amount, the result is \$330.5m.

25.b. Schedule 2 estimates that federal Title XIX Community Care Waiver (CCW) revenues will increase by about \$4.6 million, from \$268.8 million (FY 2007) and \$273.4 million (FY 2008).

Actual Medicaid billings (through December 2006) indicate that FY 2007 federal CCW revenue is around \$250.0 million (cash basis).

- **Question:** Will the FY 2007 federal CCW revenues be realized? And if not, what is the basis for the \$273.4 million?

**Answer:** The Division believes that the FY 2007 projected CCW claim amount of \$268.8 million will be realized.

The FY 2007 base claim amount, increased for annualization of FY 2007 new program starts and the Governor's recommended 2% January 1, 2008 COLA, suggests an FY 2008 projected claim that meets the \$273.4 million expectation.

26. Nearly three years ago, the division began discussions with the federal government regarding the restructuring and expansion of the Community Care Waiver.

- **Question:** What is the status of the new waiver request?

**Answer:** Waivers are a multi-year process and are not formally submitted until all issues are resolved with CMS. The current waiver does not expire until FY08. Issues arising from the Olmstead project and additional concerns expressed by CMS must be addressed prior to formal submission of the waiver. The Department very recently placed the Division under Assistant Commissioner Kenneth W. Ritchey who comes with significant experience with a multiple waiver structure in Ohio. The Division is currently evaluating the multiple waiver option to determine the next step.

27. Evaluation Data (D-223) indicates that Private Institutional Care (PIC) costs increased 11.3% in FY 2006 and will increase 22.3% in FY 2007. Program costs are not expected to increase in FY 2008.

- **Question:** Based on prior years' experience, is the FY 2008 recommended appropriation realistic?

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**Answer:** Placements in PIC throughout the year are generally the results of emergencies that cannot be served in state or DCF placements of children in DDD contracted facilities. For FY07, the Division shifted available funding to cover the costs of the PIC placements as necessary as PIC appropriations were not sufficient to cover total costs. The Division is working to avoid future costs of out of state placements and bring individuals currently residing in out of state placements back to New Jersey.

28. The FY 2007 appropriations act provided funds for Cerebral Palsy of Middlesex County (\$500,000). As of this writing, these funds are in "reserve" and not available for expenditure.

- **Question:** What is the status of this appropriation?

**Answer:** The funds were released from reserve and paid to the agency on 2/21/07.

29. As of December 2006, approximately 550 persons were involved in the Real Life Choices (RLC) program. The Governor's FY 2008 recommended budget anticipates enrollment to increase to 750 persons, with a corresponding expenditure increase from \$19.2 million to \$24.3 million.

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. However, data are not routinely provided as to the number of clients in each of the four levels or average expenditures within each level.

- **Question:** With respect to the 550 persons currently involved in RLC, and with respect to the 750 persons that are expected to participate in RLC during FY 2008, how many are in each of the four levels? During FY 2006, what was the average expenditure per person in each of the four levels?

**Answer:** People on the priority Community Services Waiting List (CSWL) are offered the option of self-directing services and supports while living at home. This defers a residential placement. It is expected that the distribution of the individuals across the levels will be similar to the current percentages. As of the end of February 2007, the number of individuals participating in the Real Life Choices program was as follows:

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Individuals in Real Life Choices by Level

Level	1	2	3	4	Total
Number of Individuals	138	145	153	114	550

Average expenditures of plan participants during a 12 month plan term beginning or ending in FY 2006.

Average Spending of Individuals in Real Life Choices by Level

Level	1	2	3	4
Average Spending	\$10,233	\$18,629	\$25,727	\$43,505

30. To comply with agreements with the U.S. Department of Justice, the FY 2007 appropriations act assumed that the census at the New Lisbon and Woodbridge Developmental Centers would be reduced by 50 and 39 clients, respectively. Between July 2006 – January 2007, the census at the two facilities declined by 10 and 3 clients, respectively.

- **Question:** Will the FY 2007 census reduction objectives be achieved? If they are not achieved, what actions may the U.S. Department of Justice against the State?

**Answer:** In order to reach census reduction objectives in accordance with the Settlement Agreements reached with the U.S. Department of Justice in 2006, the Division, through a Request for Proposal process, contracted with two agencies to provide Independent Support Coordination teams to plan for and move individuals from Developmental Centers to the community. The agencies should be operational by July 2007.

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

There is sufficient vacant land at both the developmental center and the adjacent correctional facility to enable a 8,100 sq. foot trailer (or trailers) to be installed. The Department of Corrections has indicated that an 8,100 sq. foot trailer or trailers can be purchased and installed (with utility hookups) for about \$550,000. Thus, in about four years, the State would begin savings at least \$130,000 in rent annually.

- **Question:** Would the lease or purchase and installation of trailers for administrative space be more cost effective in the long term than paying rent?

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**Answer:** Purchasing and installing commensurable trailers with utility hookups and meeting all the needs as stated in the SPR and scope of work, as well as meeting ADA guidelines appears to be cost effective and will be explored.

32. Division policy requires that certain “respite placements” that extend beyond 30 days are to obtain a Medicaid number in order to obtain federal Medicaid reimbursement.

During January 2007, there were at least five clients in respite with lengths of stay exceeding 30 days. It is not clear whether the division has or is attempting to obtain federal ICF-MR reimbursement of approximately \$18,000 per month for such patients, or whether the cost is supported with State funds.

- **Question:** Is the division obtaining federal Medicaid ICF-MR reimbursements for respite placements whose length of stay exceeds 30 days? If not, why not?

**Answer:** The Division requires all respite placements over 30 days be admitted as interim placements to the developmental center. At that time, eligibility for claiming is determined and federal ICF-MR reimbursement is claimed for those eligible individuals.

**COMMISSION FOR THE BLIND AND VISUALLY IMPAIRED (CBVI)**

33.a. There are approximately 1,000 CBVI clients who are Medicaid eligible. Historically, CBVI has provided these clients with various medical services, such as eye examinations, eye classes, psychological counseling, cataract extraction, etc., at State expense. Over a two-year period, over \$200,000 in medical services were authorized.

CBVI is in the process of reviewing and resubmitting paid medical claims to Medicaid to obtain federal Medicaid reimbursement.

- **Question:** What is the status of CBVI’s resubmission of claims to Medicaid?

**Answer:** The Commission is working with DMAHS to identify the eligibility of these services for Medicaid funding and will claim all eligible costs.

33.b. Medicaid is in the process of enrolling certain disabled recipients, including persons who are blind, into managed care. Procedures need to be in place to enable CBVI staff to refer Medicaid clients to the appropriate managed care program for health care services currently provided and paid for by CBVI.

- **Question:** What procedures have been or will be proposed to prevent CBVI from paying for medical services on behalf of clients who are Medicaid eligible?
- **Answer:** To ensure that Commission clients who are Medicaid eligible are referred to Medicaid we plan to do the following: Develop a MIS report for supervisors

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identifying those clients on our tracking system who receive SSI/SSA, In Service Training to supervisors and staff for correct status tracking of SSI/SSA. Also, a Representative from the Social Security Administration is scheduled to address staff via video conference on June 13, 2007 about SSI/SSA eligibility.

34. Personnel Data indicate that the number of Administration and Support Services staff is being reduced from 58 to 37 in FY 2008.

- **Question:** What impact will this staffing reduction have on the commission's oversight and monitoring of programs?
- **Answer:** Currently, the Commission has 58 FTE's in Administrative and Support Services positions. The Commission along with DHS Budget and OMB Budget are working together on this issue and the data will be revised if needed. The Commission's current Administrative and Support Services staff provides oversight and monitoring of all its programs.

**DIVISION OF FAMILY DEVELOPMENT**

35. a. The Governor indicates that a \$6.0 million FY 2007 supplemental appropriation is required to develop the new child support enforcement system. These monies are to develop computer interfaces with systems of the Administrative Office of the Courts (AOC) and the Division of Family Development.

The initial Request for Proposal (RFP) (March 2005), upon which a contract valued at over \$70 million was awarded, required the new child support system to interface with other computer systems operated by the State, including systems maintained by the AOC (Appendix A).

- **Question:** As the RFP required interfaces with existing State computer systems, including those operated by the AOC, why are supplemental funds required? How much additional federal reimbursement would the \$6.0 million in State funds generate?

**Answer:** Supplemental funds are required due to discovering that a robust interface between DFD and AOC is needed to develop the most efficient system to serve the child support clients. Currently, AOC and DFD have two separate computer systems, which do not interface, causing duplication of data entry onto both of these systems for Case Initiation and Establishment. This is the critical entryway for establishing all child support cases onto NJKiDS, which in FFY 06; our total caseload equaled over 362,000 cases.

At the time the RFP was written, the full scope of additional work necessary on both DFD and AOC computer systems to reduce duplicate data entry to streamline and interface these two systems was not fully known. We received conditional federal approval of the interface concept in March 2007 and final approval is forthcoming upon submitting further detailed information to ACF. The use of state funds will be

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matched at the federal financial participation rate of 66%. To date, we are in the process of seeking project federal approval and will provide an update once approved.

35. b. Work First New Jersey – Technology Investment appropriations of \$60.6 million (gross) are recommended.

**Question:** What specific projects will be undertaken and at what cost?

**Answer:** The specific projects to be undertaken in FY 2008 and their associated costs are as follows:

NJKIDS (ACSES Reengineering) (\$29.7 million) is a federally mandated project to significantly improve the current child support enforcement system in terms of cost, benefits and risks utilizing the latest technologies. Since the contract for the implementation vendor has become effective March 1, 2006 and the vendor has begun the implementation of the plan, the following has occurred:

- An Executive Oversight Board (EOB) and Project Management Team (PMT) representing all partnership agencies have been formed for governance over the project. Both groups meet, at minimum, monthly to ensure that the project is on schedule and meeting the requirements set out in the RFP.
- In addition, there is a separate Quality Assurance contract that will oversee the project and reports independent of the Implementation Contractor to the State's Project Management.
- The federal Office of Child Support Enforcement (OCSE) has also required and established an Independent Validation and Verification (IV&V) contract with the audit firm KPMG to ensure that the project is on schedule and meets the requirements as set out by the state and federal governments. KPMG conducts and IV&V review once every six months.

Accomplishments to date include:

- Project Management Plan completed and accepted – Aug 06
- Completion of Joint Application Design (JAD) sessions – Dec 06
- Implementation of Joint Solution Design Sessions – March 07
- Completed Migration of code from MI and MA from Oracle Forms to JAVA J2EE – Dec 06
- Analysis of data in current system for data clean-up purposes – Sept 06-ongoing
- Development of training strategies and identification of training sites – Sept 06-ongoing
- Implementation of an Application Impact Analysis to assess impact on local office operations from current system to new system – April 07 – ongoing

To date, total of \$17.3 million has been spent on the NJKiDS project which will be operational statewide in 2009. This compression will also provide a more

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comprehensive single release and will provide for earlier improved benefits to clients and cost savings to the State.

The Consolidated Assistance Support System (CASS) project (\$17.8 million) is also a federally mandated project that provides for the integrated support of all public assistance programs supervised by the Division, utilizing the latest in open systems technology.

- The RFP to acquire the CASS Implementation Contractor was released on August 15, 2006 and the procurement process is ongoing.
- Following an evaluation of bidders' qualifications to develop CASS, two of the six bidders who responded to the RFP were determined qualified to submit draft technical proposals.
- Anticipate contract award by July 2007.

The estimated design, development and implementation timeframe is three years.

The remaining \$13.1 million is dedicated to operations and infrastructure issues such as document imaging (\$4.1 million) and operational support including maintenance (\$9.0 million).

Implementation activities are expected to begin by late 2007.

36. a. The federal Deficit Reduction Act increased state work participation requirements in the Temporary Assistance to Needy Families (TANF) program to 50%, and changed the caseload-reduction credit from FFY 1995 caseloads to FFY 2005 caseloads. Beginning in FFY 2007, the caseload-reduction credit will be based on changes between FFY 2005 and FFY 2006.

For New Jersey, failure to meet the work participation requirement could result in a \$20.2 million reduction in federal TANF and a potential increase in State expenditures of \$40.2 million.

Between FFY 2005 and FFY 2006, caseloads decreased by about 4.7%. (Note. The 4.7% figure is an estimate as the division may calculate caseload reduction differently and develop a different percentage.) As the State's participation rates during the July – October 2006 period was about 33%, the State may be about 12% above the target participation rate of around 45%. Thus, New Jersey may be subject to a reduction in federal funding and would be required to increase State funding.

**Question: Can the State meet the work participation requirements?**

**Answer:** New Jersey's preliminary Caseload Reduction Credit for FFY 2007 is 5.1%, meaning that our adjusted target is 44.9%. Through the first four months of FFY 2007, the preliminary rolling average work participation rate (WPR) is 37%, meaning that we will need to increase our monthly average WPR to better than 48% for the remainder of the federal fiscal year.

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DHS workgroup identified various strategies to meet the work participation requirements. Two significant recommendations, streamlining the sanctioning process and increasing the earned income disregard, will require the enactment of State legislation. The combination of restructuring the sanctioning process and raising the earned income disregard from the current 50% to 75% for up to six months will yield 11% towards the work participation rate. ***Failure to meet the 50% work participation rate by October 2007 may result in the State being penalized up to 5% of its TANF block grant.***

Staff at the Division of Family Development and the Department of Labor and Workforce Development has been working intensively to make program changes to both improve the Work First New Jersey Program and meet the participation rate requirements. A Steering Committee and several subcommittees composed of representatives from many agencies including the county welfare agencies, Department of Labor and Workforce Development, the Workforce Investment Boards, child care agencies, Legal Services, and other interested groups have been formed to strategize how New Jersey will meet the 50% participation rate.

36. b. The division recently adopted regulations to establish a pilot project that would increase the earned income disregard when determining benefits for recipients who are employed a minimum of 30 hours per week. The incentive will increase State costs by about \$3.3 million annually.

- **Question:** How many cases are affected by the regulatory change? How will the pilot project be monitored to determine whether there is an increase in the number of hours worked?

**Answer:** The Division estimates that 2,400 cases will be affected by the increased earned income disregard. Reports will be electronically generated to identify cases that are in the new disregard status because they are working 30 hours or more per week.

36. c. Work First New Jersey - Training Related Expenses (TRE) appropriations increase from about \$14.1 million to \$18.2 million (gross). However, available data indicates that the number of persons that will receive such assistance is unchanged at 5,850 monthly.

- **Question:** What accounts for the number of persons receiving TRE being unchanged at 5,850?

**Answer:** The number of persons receiving training related expenses was inadvertently not updated to reflect the transfer of the Post-TANF transportation program to this account in SFY 2008. The correct number of persons receiving TREs is estimated at 16,960.

36. d. The recommended budget indicates that the number of children receiving Child Care services monthly will decline from approximately 77,100 (FY 2007) to about 70,000

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(FY 2008). As child care is an essential component of the State meeting the federal work participation requirement, the reduction may impede the State's ability to meet that objective.

- **Question:** Will the reduction in the number of children receiving child care services negatively affect the State's ability to meet federal work participation requirements?

**Answer:** No, the decrease in number of children being served refers only to the higher income families served in the Abbott school districts. Due to their income exceeding 300% of the FPL, Abbott families will be responsible for paying the full cost of child care services. This number does not affect the TANF families and will have no impact upon the department's ability to meet the federal work participation requirements.

The drop in the number of children receiving child care services reflects the establishment of income eligibility requirements for Abbott Wraparound child care services in the 31 Abbott districts, as part of the Department's Child Care Reform Initiative. Families with annual incomes exceeding 300% of the FPL will pay out-of-pocket, fee for service expenses directly to the provider beginning September 1, 2007.

As a result of this change, we estimate that approximately 9,000 children would no longer qualify for free services based upon the 300% income threshold.

37. In FY 2008 1.1 million in federal funds are recommended for the Work First New Jersey Breaking the Cycle program, a \$6.1 million reduction from the \$7.2 million (gross) appropriated in FY 2007.

The \$7.2 million FY 2007 appropriation supports the following activities: Post-TANF Transportation, Homeless Initiatives, Hispanic Outreach and Faith Based Initiatives.

- **Question:** What project or projects will be eliminated?

**Answer:** Programs in the Breaking the Cycle account have been consolidated with more appropriate accounts. The Post-TANF Transportation Block Grant of \$4.1 million has been transferred to the Training-Related-Expenses account and \$2 million was transferred to the Support Services account for Homeless programs and the Hispanic Outreach Program. The remaining \$1.1 million is for Faith-Based Initiatives, a collaborative agreement with the Department of State (DOS) to provide multiple grants to qualified faith-based, non-profit organizations that enable these institutions to provide post-TANF clients with needed services to help them maintain self-sufficiency.

38. a. The FY 2008 recommended budget assumes \$20.0 million in savings "by reforming co-payments for after school and summer child care...." As of this writing, no information

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is available regarding this proposal, though the Legislature has rejected similar proposals that had been included in prior budget recommendations.

- **Question:** What specific reforms will be proposed?

**Answer:** DHS proposes to revise the current co-payment structure for families receiving both Abbott and non-Abbott child care services. The goals of this effort are to reduce the payment inequity between Abbott and Non-Abbott districts and relieve the financial burden on the cost of child care services for the lowest income families in New Jersey.

Currently, families living in Abbott communities receive free full day, full year preschool services for three and four year old children. This service is provided without regard to income. DHS is proposing to require families whose income is above 300% of the Federal Poverty Level (\$51,510 for a family of three) to pay for the full cost of Abbott wraparound services based on the prices charged by the child care provider. In these instances, the family would make payment directly to the child care provider. This revised co-payment and fee structure would maintain the eligibility for 13,400 families in Abbott districts for free care to those with incomes at or below 300% of the FPL.

Concurrent with the above changes, families living in the remainder of the state are eligible for subsidized child care through New Jersey Care for Kids (NJCK) if their income does not exceed 250% of the federal poverty level (\$42,925 for a family of three). We are also proposing that 10,000 families living with incomes at or below 100% of the FPL (\$17,170 per year) will now no longer be required to make a co-payment for child care services. In addition, co-payments for over 40,000 families in Non-Abbott districts with incomes between 100% and 250% of the FPL are being reduced by 10%.

38. b. The FY 2008 budget recommends \$379.5 million (gross) for Work First New Jersey Child Care to provide child care services to approximately 70,000 children monthly.

New Jersey is 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. To the extent that child care services are provided to ineligible children, diverting funds from children that are eligible.

**Question:** What percentage of the child care services being provided were ineligible for such services?

**Answer:** New Jersey volunteered to participate in the pilot study in order to learn what review methodology would be adopted by the federal government and to better understand the areas of policy and procedure needing improvement. The error rate pilot is intended to help identify, measure, and prevent errors in the future administration of child care funding.

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In addition to New Jersey, Florida, Kansas, Oregon, and Washington also agreed to participate in the second phase of an error rate testing pilot program, in an effort to assist the Administration for Children and Families (ACF) in complying with the Improper Payments Information Act of 2002 (IPIA). The second phase pilot differed from the first phase pilot in that a slightly revised error rate methodology was implemented.

Although the results of the pilot remain draft and are pending final review by the federal Administration of Children and Families, the preliminary data findings identified the following to include:

- The payment of hours that exceeded the documented need. (Halftime vs. fulltime, full-time for school aged children).
- The use of incorrect household size.
- The allowance of income without verification, ignoring income from a second job and failure to react to a reported income change.
- The incorrect application of the fee schedule and payment for days of non-attendance.
- Entering data incorrectly into the automated system (CARES).

39. State funding for the Substance Abuse Initiative increases by \$19.4 million in FY 2008. Part of increase represents more clients being served by the program, and some of the increase reflects a shortfall in financial support in terms of Medicaid revenues and the Division of Addiction Services.

**Question:** How much of the \$19.9 million increase reflects program growth? How much reflects a shortfall in Medicaid reimbursements and Division of Addiction Services' support?

**Answer:** The \$19.9 million is attributed to growth in substance abuse treatment services for non-TANF (General Assistance and DYFS) recipients. Total medical treatment costs are projected to increase over 20% per year through FY 2008 with 80% of these increases attributed to Non-TANF eligible recipients. DHS is claiming the maximum amount of federal financial participation for administrative and case management cost for Medicaid eligible recipients.

**DIVISION OF ADDICTION SERVICES**

40. An Office of Inspector General report (November 2006) recommended that the division conduct "risk audits" into certain contracts "to determine whether they were properly awarded and administered and whether funds were used in accordance with State and federal requirements."

- **Question:** How many "risk audits" were conducted and completed? How much, if any, funds will be recovered as a result of these audits?

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**Answer:** DAS has requested six audits for FY 07. Three have been started and two completed. We are currently in the recovery process for the two which identified funding as a finding. Additionally, DAS will work to increase the number of audits with the goal of getting providers on a four year cycle. DAS will also be coordinating its audits with Medicaid and Mental Health, consolidating audits for agencies that have contracts with these divisions for improved efficiency.

41. Both the Department of Children and Families and the Division of Family Development provide substance abuse services to children and families under their supervision. All providers also contract with the division for services.

- **Question:** What fiscal controls are in place to minimize the possibility of a provider agency billing and being reimbursed twice for the same client?

**Answer:** Currently DHS does not have an automated IT system that will allow us to identify clients served across departments. We have identified certain initiatives and have established a work group to cross match clients in these initiatives to safe guard against duplicated billing. We anticipate the collaborative audits discussed above to help identify these issues as well.

42. A consulting firm is attempting to determine whether and how much federal Medicaid administrative reimbursement can be obtained on behalf of non-hospital based substance abuse agencies.

- **Question:** What is the current status of the project? If undertaken, how much federal Medicaid administrative reimbursement may be realized?

**Answer:** The project has been well received by DAS providers. Nineteen providers are currently enrolled and we are gathering information in order to make the claim. If the claim proceeds smoothly, Maximus believes FFP will be obtained, of which 25% would be paid to participating providers as an incentive for the additional claiming work required of them.

43. Funding for the Essex County – County Jail Substance Abuse Programs would increase by \$5.0 million, from \$15.0 million to \$20.0 million.

The program, known as Delaney Hall, is operated by a private, for-profit provider and is not licensed by the division. The program provides substance abuse services to incarcerated persons as an alternative to being in the county jail. The Office of Legislative Services has limited information as to the number of clients being served, the average cost per client, program outcomes and recidivism.

- **Question:** Can the division, as the grant administrator, provide any information as the number of clients being served, the average cost per client,

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**program outcomes, etc.? Why is additional \$5.0 million required for the program?**

**Answer:** This current \$15 million state aid pass-through grant to Essex County for Delaney Hall supports 613 parolees at \$67 per day. The increase will support 808 parolees.

Program outcomes are managed by the Essex County Department of Corrections. The State Parole Board recently noted that as all participants are in parole status, it supervises all parolees within the facility and monitors contract compliance.

**DIVISION OF THE DEAF AND HARD OF HEARING**

44.a. The FY 2008 budget recommends \$290,000 for Services to Deaf Clients, the same as in prior fiscal years. In FY 2005 and FY 2006, only \$200,000 and \$143,000, respectively, was expended. Available FY 2007 expenditures are projected at around \$120,000.

- **Question:** As the division has been unable to spend its current appropriations, can FY 2008 recommended appropriation be reduced?

**Answer:** No, the funds are needed for projects that will serve individuals who are deaf and hard of hearing. These projects include publishing a resource manual—"Organizations Serving People with Hearing Loss in NJ", including CapTel (a captioned telephone device) in the existing Equipment Distribution Program and the possibility of creating a third assistive device demonstration center. The Division is also exploring the potential working with the Department of Health and Senior Services to provide funding for hearing aids and other necessities to children in need.

44.b. The FY 2008 budget recommends \$55,000 for the Communication Access Services, the same as in prior fiscal years. In both FY 2005 and FY 2006, only \$10,000 and \$28,000, respectively, was expended.

- **Question:** As the division has been unable to spend its current appropriations, can FY 2008 recommended appropriation be reduced?

**Answer:** To date in SFY 2007 83% or \$45,000 has been expended in Communication Access Account. It is anticipated that the remainder of these funds will be expended. A major division event, the 23<sup>rd</sup> Annual Deaf and Hard of Hearing Awareness Day occurs in June and most of the remainder will be expended on qualified sign language interpreters and realtime captioners.

**DIVISION OF MANAGEMENT AND BUDGET**

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45 The FY 2008 budget recommends \$470,000 for the Health Care Billing System, along with budget language that would allow additional funds to be appropriated to the program, if needed. The project currently has \$950,000 available and available information is that this amount is sufficient to complete the system.

- **Question:** Can the FY 2008 recommended appropriation be reduced or eliminated?

**Answer:** It is anticipated that the full amount of the appropriation will be needed to complete the development and implementation of this system during FY 2007 and FY 2008. The detailed system design is nearly complete. Programming is expected to begin shortly. The system will be in compliance with the federal HIPAA electronic billing and the new national provider identification requirements. This system will help us to enhance the generation of federal revenues and accountability by allowing us to edit billings more effectively to maximize the dollar value of claims and identify areas more easily where revenues may be falling short of expectations. With our current system we generate approximately \$9.3m in annual Medicare Part B revenue.