Discussion Points

Department of Human Services (General)

1. Executive Order No. 4 of 2018 directs all State entities that regularly interact with the public to undertake reasonable measures, to the extent permitted by law and budgetary constraints, to provide information to the public regarding the Affordable Care Act marketplace and ways to enroll.

- ***Question:*** **What has been the department's response to Executive Order No. 4 of 2018? What related initiatives has the department already implemented and what related initiatives does it intend to implement in FY 2018 and FY 2019? What, if any, related expenditures has the department incurred to date? Will there be any additional expenses the department expects to incur to comply with the executive order in FY 2018 or FY 2019?**

  DHS Response:

  As a Department that provides medical assistance to a significant number of New Jersey residents, we share the Governor's strong commitment to ensuring that New Jerseyans have access to affordable coverage. Outreach and enrollment is a priority for our Department. The Department is actively working across our Divisions to revise materials and identify distribution channels for enrollment messages and activities to meet the goals and expectations of Governor Murphy's Executive Order 4. The Department has already taken steps such as adding enrollment information to existing printed materials, including the Division of Disability Services' widely circulated Resource Guide, and developing new brochures about enrollment for the Marketplace and Medicaid to distribute through DHS networks. The nominal cost of these changes will be absorbed as part of the operating budget of DHS without the need for additional resources. The Department will be ready to submit its report to the Governor by the May 31 deadline.

  Moreover, DHS has also been working with Governor Murphy's Commission on Puerto Rico Relief, as well as other key stakeholders, to ensure those who have relocated to New Jersey as a result of the 2017 hurricane are provided access to much-needed assistance programs such as health insurance. Our Department has been participating in numerous informational meetings across New Jersey to help evacuees access services, including Medicaid.

2. In his March 13, 2018 Budget Message, the Governor advocated gradually raising the Statewide minimum wage from $8.60 per hour to $15 per hour. If enacted, this would affect many Department of Human Services (DHS) staff and third parties that operate many of DHS's services and programs.

- ***Question:*** **All other things being equal, by what amount would the department's operating expenses increase if a Statewide $15 minimum wage were in effect in FY 2019? Please differentiate between the salaries and wages expenditures for DHS employees and expenditures for services provided by third parties. How many DHS employees would receive higher wages with a $15 minimum wage? What would be the impact on DHS operating expenses in FY 2019 of, and the number of DHS employees affected by, raising the minimum wage to $11 per hour, $12 per hour, $13 per hour, and $14 per hour?**

Discussion Points (Cont'd)

DHS Response:

DHS operating expense would increase by approximately $1 million if a Statewide $15 minimum wage were in effect in FY 2019, as detailed below:

Wage	DHS staff*	DHS staff cost	Temporary contract staff	Temporary contract cost**	Total staff	Total Cost
$11.00/hour	1	$3,640	9	$41,579	10	$45,219
$12.00/hour	1	$5,460	32	$75,154	33	$80,614
$13.00/hour	40	$17,927	57	$184,410	97	$202,337
$14.00/hour	200	$126,435	74	$349,616	274	$476,051
$15.00/hour	202	$491,637	76	$546,679	278	$1,038,316

*Does not include impact of fringe benefits.
**Assumes 40 hour work week at 27% contract wage markup.

DHS funds grants, contracts and reimbursement rates for a number of third-party entities and agencies across program areas that could be impacted by a change in the minimum wage either directly or indirectly. These funding relationships include contracts with community-based providers that employ direct service professionals delivering developmental disability services, grant funded entities in the aging network that provide supports and services to older New Jerseyans in the community, personal care assistants who provide services under Medicaid managed care contracts, and child care providers who are funded through the child care subsidy program. The Department does not generally collect wage data for the individuals employed through these mechanisms, but changes in minimum wage could impact contract, grant and reimbursement costs for these services.

3. On October 1, 2017, the Division of Mental Health and Addiction Services (DMHAS) was officially transferred from the DHS to the Department of Health (DOH) in accordance with Reorganization Plan No. 001-2017. The jurisdictional transfer was intended to provide for the increased efficiency, coordination, and integration of the State's mental health and addiction prevention and treatment functions.

- ***Question:*** **What were the one-time expenditures to the DHS of effecting the jurisdictional transfer? How many employees, if any, were physically relocated as a result of the reorganization?**

DHS Response:

The Statewide operational cost to transfer the Division of Mental Health and Addiction Services (DMHAS) from the Department of Human Services (DHS) to the Department of Health was $1.7 million. To accommodate the transfer, 244 DMHAS employees where physically relocated. In addition, 265 Division of Developmental Disabilities employees were physically relocated to the Trenton DHS building into the former DMHAS space.

Discussion Points (Cont'd)

- ***Question:*** **Have there been any changes in full-time equivalent positions in the DHS as a result of the jurisdictional transfer beyond the one-to-one transfer of department employees to the DMHAS in DOH, for example, changes in full-time equivalent positions in units that provide support services to all divisions within the department? If so, what are the annualized savings of the personnel changes? What plans exist to coordinate programs and activities in areas over which DHS and DMHAS retain shared or overlapping oversight?**

  DHS Response:

  In addition to the one-to-one transfer of DMHAS employees to DOH, 71 DHS Central Office staff transferred in such support areas as licensing, auditing, personnel, and finance. No net savings are anticipated from this reallocation because services are currently shared between DHS and DOH in these areas as outlined in two Memorandum of Understandings between the Departments.

Division of Medical Assistance and Health Services (Medicaid/NJ FamilyCare)

4. Expenditures for mental health and substance use disorder services programs are split across two divisions in two departments, the Division of Medical Assistance and Health Services (DMAHS) in the DHS and the DMHAS in the DOH. In brief, payments eligible for federal Medicaid matching funds in the DHS are administered by the DMAHS/NJ FamilyCare, while "State-only" payments and federal block grants are administered by the DMHAS in the DOH. Recent efforts to move the system into fee-for-service and increase reimbursement rates are associated with a push to increase claims of federal Medicaid matching funds – which means spending shifts from the DMHAS to the DMAHS/NJ FamilyCare.

The Governor's FY 2019 Budget recommends retaining an annually recurring language provision that allows for the transfer of appropriations between the DMHAS and the DMAHS/NJ FamilyCare in order to permit flexibility in the handling of appropriations and ensure the timely payment of claims to providers of mental health and substance use disorder services. In particular, the Behavioral Health Rate Increase appropriations in the DMHAS, being mostly federal matching funds, may need to be transferred to Medicaid in order to be expended. The Governor recommends an unchanged FY 2019 appropriation of $136.0 million for Behavioral Health Rate Increase (page D-169).

- ***Question:*** **Please provide data on total spending for community-based mental health and substance use disorder treatment across the DMHAS and DMAHS/NJ FamilyCare for each year from FY 2016 (actual) through FY 2019 (recommended). Please disaggregate mental health from substance use disorder spending, and disaggregate State General Fund, federal Medicaid, federal block grant, and other State funds.**

Discussion Points (Cont'd)

DHS Response:

MENTAL HEALTH				
Amounts	FY16	FY17	FY18 proj	FY19 rec
Federal Medicaid Funding	$98,056,147	$158,857,308	$200,313,153	$211,209,700
Block Grant and Other Federal Funding	$25,160,656	$34,486,596	$31,494,000	$33,565,000
State Funding	$442,586,157	$468,141,098	$519,247,303	$506,375,665
Total Funding	$565,802,960	$661,485,003	$751,054,456	$751,150,365

SUBSTANCE USE DISORDER				
Amounts (000's)	FY16	FY17	FY18 proj	FY19 rec
Federal Medicaid Funding	$17,548,643	$24,571,792	$31,295,798	$33,419,397
Block Grant and Other Federal Funding	$75,727,799	$73,789,045	$78,317,594	$76,233,594
State Funding	$69,183,775	$77,716,529	$111,854,095	$184,792,906
Total Funding	$162,460,217	$176,077,366	$221,467,487	$294,445,897

*Amounts include expenditures at the Division of Medical Assistance and Health Services within the Department of Human Services as well as expenditures at the Division of Mental Health and Addiction Services within the Department of Health.

Affordable Care Act Medicaid Expansion

5. New Jersey began to implement the Medicaid expansion under the Affordable Care Act (ACA) in January 2014, which now provides health care coverage to over 540,000 New Jersey residents with household incomes under 138 percent of the federal poverty level, with nearly all of the cost paid with federal funds. Since implementation, the federal matching rate has dropped from 100 percent to the current 94 percent in 2018, and is scheduled to decrease to 93 percent in 2019, then to a minimum of 90 percent in January 2020.

The expansion has provided other positive budgetary effects for the State: Charity Care costs are down significantly from before the expansion, the State receives a higher "blended" federal matching rate for Graduate Medical Education, and many services previously funded entirely at State expense in the DMHAS are being shifted to Medicaid, where they receive federal matching funds. The State faces expansion-related costs in other areas, such as Medicaid administration (generally requiring a State or county share of 25 percent or 50 percent of costs), certain presumptive eligibility costs (matched at 50 percent) and the increased costs of coverage for the expansion population over the next several years.

- ***Question:*** **By component, what is the net fiscal impact to the State (inclusive of its counties) of the ACA Medicaid expansion in FY 2017 and FY 2018?**

Discussion Points (Cont'd)

DHS Response:

ACA Expansion Costs/(Savings)

DECISION TO EXPAND		*Figures in thousands	
Savings from new Federal Match on Previously Covered Populations		**SFY 17**	**SFY18**
New Federal Match on FamilyCare Parents Previously Covered under 1115 CHIP Wavier Authority	This represents approx 138,000 parents with incomes up to 133% of the FPL that became newly eligible for Medicaid under ACA eligibility rules. Savings are based on amounts reported for this group on the CMS 21 CHIP claim prior to 1/1/14.	(152,000)	(152,000)
General Assistance Population Previously Covered under 1115 Waiver Authority prior to 1/1/2014	This represents approximately 36,000 General Assistance recipients previously covered under 1115 wavier authority. On 1/1/14 they became newly eligible for Medicaid and the Federal government paid 100% of their costs for three years. Note that our 1115 wavier was approved on 4/15/2011. Prior to that time this group was covered with all State funds.	(150,100)	(150,100)
Payments for Newly Eligible Recipients	Starting January 1, 2017 the State is responsible for 5% of the costs for this population. The FMAP for this group will decline 1% per year until 2020 when it will be fixed at 90%.	87,880	171,071
Savings from new Federal Match on Previously Covered Populations Sub-total		**(214,220)**	**(131,029)**
Impact of Expanded Eligibility			
Reduction in Charity Care payments to hospitals	A decreased volume of Charity Care claims as due to a drop in the uninsured population brought about by the ACA has significantly reduce Charity Care Payments.	(174,000)	(199,000)
Reduction in FQHC payments	The implementation of the ACA will significantly reduce the State share of the FQHC payments because a significant portion of recipients receiving care at FQHC's are newly eligible for Medicaid due to the ACA.	(19,152)	(16,052)
Additional federal match for FQHC wrap payments		(11,566)	(12,697)
Shift from Mental Health Contracts to Medicaid	Due to additional Medicaid eligibility, the Division of Mental Health and Addiction Services (DMHAS), now under DOH, was able to budget reductions as more recpients previously served at DMHAS were now eligible for Medicaid which generated state savings at DMHAS.	(13,065)	(13,065)
Increase in the Federal match for	The State will be able to claim a higher Federal match on GME payments as result of the ACA.	(28,026)	(29,705)

Discussion Points (Cont'd)

Graduate Medical Education (GME) payments			
Increase in HMO 2% Assessment Revenue	The State will collect more revenue from this assessment as HMO enrollment increases due to the ACA.	(51,317)	(59,284)
Impact of Expanded Eligibility Sub-Total		**(297,126)**	**(329,803)**
TOTAL SAVINGS FROM DECISION TO EXPAND		**(511,346)**	**(460,832)**
OTHER ACA COSTS/SAVINGS			
New ACA costs/savings			
Woodwork	An estimated 104,000 recipients who were eligible for NJ FamilyCare prior to the ACA have enrolled.	93,781	93,781
Presumptive Eligibility	Presumptive Eligibility (PE) was mandated by the ACA. The State only receives a 50% match on services for PE recipients. If they are determined fully eligible the State may receive the enhanced ACA match rate. Not all PE recipients are determined eligible for Medicaid.	23,228	25,582
FamilyCare Parents Previously Covered under 1115 CHIP Wavier Authority transitioned to Federal Exchange	This represents approximately 8,200 parents with incomes between 134% and 200% of the FPL that became eligible to buy insurance on the Federal Exchange. Savings are based on amounts reported for this group on the CMS 21 CHIP claim prior to 1/1/2014.	(12,300)	(12,300)
Enhanced Match for CHIP	Section 2101 of the ACA increased the FMAP for State CHIP programs by 23%. New Jersey's FMAP for CHIP increased from 65% to 88% in the second quarter of SFY 2016.	(100,409)	(103,605)
New ACA costs/savings Sub-Total		**4,301**	**3,458**
ACA Fees			
Health Insurers Provider Fee	Section 1910 of the ACA imposes a fee on each covered entity engaged in the business of providing health insurance. This fee will be paid by all insurers including the Medicaid MCO's. MCO capitation rates will increase to cover this fee.	53,899	0
SHBP ACA Fee	The Transitional Reinsurance Fee charges $63 per each active and early retiree covered life in an insurance plan with a payment due to the U.S. Department of Health.	10,625	2,686
ACA Fees Sub-Total		**64,524**	**2,686**
TOTAL OTHER ACA COSTS/SAVINGS		**68,825**	**6,144**
TOTAL ACA COSTS/SAVINGS		**(442,522)**	**(454,688)**

Discussion Points (Cont'd)

*****Note: SFY17 numbers will differ from last year's chart since that fiscal year is now closed and actual costs/savings have been finalized.

- ***Question:*** **Please provide an extended year-by-year estimate of enrollment and State cost for FY 2020 through FY 2023 (similar to that provided in response to FY 2018 OLS Discussion Point #15).**

DHS Response:

(Implemented 1/1/2014)				
SYFs	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**
FMAP	93/90%	90%	90%	90%
State	$ 298,504,518	$ 351,181,785	$ 351,181,785	$ 351,181,785
Federal	$ 3,213,313,336	$ 3,160,636,068	$ 3,160,636,068	$ 3,160,636,068
Total	**$ 3,511,817,854**	**$ 3,511,817,853**	**$ 3,511,817,853**	**$ 3,511,817,853**
Average monthly enrollment	552,065	552,065	552,065	552,065

Eligibility Determination, Enrollment, and Utilization Data

6. In its January 1, 2018 report to Governor-elect Phil Murphy and Lieutenant Governor-elect Sheila Oliver, the Human and Children Services Transition Advisory Committee made several recommendations to the Executive regarding the streamlining of services across State agencies that serve individuals with disabilities, children, senior citizens, and low-income individuals and families. The committee also recommended the evaluation of the coordination among programs and technological systems that provide the State's social service network. The Healthcare Transition Advisory Committee made similar recommendations, stating that as of 2016, 36 percent of New Jersey's uninsured population, including approximately 23,000 children, is eligible for Medicaid. The report attributes the non-enrollment statistics to limited outreach and enrollment funding, a cumbersome enrollment process, and confusion over eligibility particularly in families with mixed immigration status.

According to the Governor's FY 2019 Budget, Grants-in-Aid funding for Medicaid Eligibility and Enrollment Services is anticipated to increase by $14.0 million from $72.1 million in FY 2018 to $86.1 million in FY 2019 (page D-187). Some $9.3 million of the increase would be from federal sources (from $50.1 million to $59.4 million) and the remaining $4.6 million from State sources (from $22.1 million to $26.7 million). Eligibility and Enrollment Services appropriations fund payments to the DMHAS' Health Benefits Coordinator (Conduent) and to county welfare agencies (CWAs) responsible for making NJ FamilyCare eligibility determinations and annual redeterminations.

- ***Question:*** **Please outline the department's current efforts, with information regarding expenditures and funding source, to upgrade and streamline the eligibility determination and enrollment process for public assistance and Medicaid programs.**

DHS Response:

Discussion Points (Cont'd)

The Department of Human Services (DHS) partners with counties across the State to support enrollment and eligibility. DHS also is focused on developing technological solutions to support eligibility and enrollment. In 2017, the Department launched the Web-based, smartphone-accessible NJHelps.org to help NJ residents check to see what benefits they may qualify for. Individuals can use this tool to assess their eligibility for food assistance (Supplemental Nutrition Assistance Program), cash assistance (General Assistance, Temporary Assistance for Needy Families), and health insurance (NJ FamilyCare/Medicaid). The screening tool then links individuals to NJ FamilyCare and SNAP/TANF/GA applications.

In 2017, DMAHS made it possible for residents to apply for the NJ FamilyCare Aged Blind and Disabled program electronically. The electronic application allows electronic upload of all documentation required to determine eligibility. Electronic access to these materials streamlines the process for applicants and county welfare agencies. The system also now allows for automated verification of Social Security number, date of birth, identity, death and asset verification for US banks.

The initiatives are funded through the CMS Medicaid Program Mechanized Claims Processing and Information Retrieval Systems, which provides enhanced 90% federal financial participation for eligibility and enrollment systems.

- ***Question:*** **Please outline the department's current efforts, with information regarding expenditures and funding source, to interface or integrate software with other State agencies that provide social services so as to better connect clients with the services for which they are eligible.**

DHS Response:

In 2018, the DHS Division of Medical Assistance and Health Services (DMAHS) will launch a myNJHelps.org client portal for registered users, allowing individuals to check on the status of their applications, upload copies of documents, receive electronic notifications as well as screen and apply for additional benefits. DMAHS also will automate verification of citizenship and self-attested income for NJ FamilyCare eligibility using NJ Department of Labor and Workforce Development data.

In addition, the DHS Division of Aging Services (DoAS), working with NJ FamilyCare, will use the new online Universal Application for the following aging programs: Specified Low-Income Medicare Beneficiary (SLMB), Pharmaceutical Assistance to the Aged and Disabled (PAAD) program, Senior Gold Prescription discount Program, Lifeline Utility Credit/Tenants Lifeline Assistance program, Hearing Aid Assistance to the Aged and Disabled (HAAAD) program, Screening for Extra Help with Medicare Part D, Screening for benefits provided by the Universal Service Fund (USF) and Low-Income Home Energy Assistance Program (LIHEAP). DoAS will also leverage the automated Asset Verification System (AVS) technology developed to verify assets for their applicants. The Division of Family Development shares the NJHelps.org screening tool which screens for Medicaid, SNAP, TANF, and General Assistance.

Discussion Points (Cont'd)

The initiatives are funded through the CMS Medicaid Program Mechanized Claims Processing and Information Retrieval Systems, which provides enhanced 90% federal financial participation for eligibility and enrolment systems.

- ***Question:*** **Please outline how the division anticipates utilizing the additional funding to improve program outreach and the enrollment process. How will the funds be distributed between Conduent and the CWAs? Does the department anticipate any of the additional funding to be used in coordinating interagency efforts?**

  DHS Response:

  The NJ FamilyCare Integrated Eligibility System (IES) is the integrated eligibility system DMAHS is building. The system supports the MAGI (Modified Adjusted Gross Income) Medicaid program and the Aged Blind and Disabled (ABD) Medicaid program. The system has two main portals. A client portal for NJ beneficiaries with: 1) online applications for MAGI Medicaid and Aged Blind and Disabled Medicaid programs, 2) automated address verification to improve success rate for mail sent to beneficiaries, and 3) smartphone friendly access for registered users to check status, upload documents, and receive electronic notifications. A worker portal used by the twenty-one county welfare agencies to: 1) determine eligibility for electronic applications for MAGI and ABD Medicaid programs, 2) automate asset verification for ABD program, and 3) connect to the federal data hub to automate the verification of identity, citizenship, date of birth, and Social Security number.

  For 2018, the major focus for the IES is to fully automate remaining eligibility and enrollment processes for our County Welfare Agencies (CWAs). This enhancement will automate entry of paper applications and redeterminations. This will allow CWAs to use the automated verification technology built into the worker portal for all applications whether they are electronic or are submitted using a paper application. Automating redeterminations will streamline the annual process that requires all NJ FamilyCare beneficiaries to confirm that they continue to meet NJ FamilyCare eligibility requirements.

  Additional FY2019 funding reflects the projected need for existing Eligibility and Enrollment Services. In FY 2018, the Department utilized budget language to transfer available Grant-In-Aid dollars to cover costs in excess of the appropriation.

7. According to the DHS Medicaid Communication No. 16-04[1], several insurance companies in the State are selling supplemental dental insurance policies to individuals receiving Medicaid Long Term Services and Supports in nursing homes and assisted living facilities. The Department of Banking and Insurance has granted the authority for these limited benefit dental policies.

When the supplemental dental insurance policy information is submitted to the Medicaid eligibility determining agency (EDA), such as Conduent or a CWA, directly from the insurance company, the EDA must verify with the Medicaid recipient, or the recipient's authorized representative, that this policy has been purchased. The purchase of these policies by a Medicaid

[1] http://www.state.nj.us/humanservices/dmahs/info/resources/medicaid/2016/16-04_Dental_Insurance_Policy_Guidance.pdf

Discussion Points (Cont'd)

recipient is considered a "change in circumstances" and must be followed by a complete Medicaid eligibility redetermination before the change can occur to the individual's Medicaid cost share.

When an EDA is completing a redetermination, it may realize that there may not be enough income to cover the cost of this new insurance premium. If there is not enough income to cover the cost of the supplemental policy, then the EDA will notify the Medicaid recipient, or the recipient's authorized representative, that the Medicaid recipient may not be able to purchase the policy due to insufficient income. Under federal regulations, an individual's income must first cover all personal, maintenance needs, and community spouse maintenance needs allowances before any additional health insurance premiums can be paid.

- ***Question:*** **How many Medicaid eligibility redeterminations were completed because of the purchase of supplemental dental insurance policies in FY 2016, FY 2017, and thus far in FY 2018; and what is the projected number of redeterminations for the remainder of FY 2018 and FY 2019? For each of FY 2016, FY 2017, and FY 2018 to date, please provide the number of redeterminations that resulted in a decision that the Medicaid recipient may not be able to purchase the policy due to insufficient income, and the number of decisions that authorized Medicaid recipients to purchase the policy.**

  DHS Response:

  Across FY 2016 and 2017, out of 126 supplemental dental policies submitted to the Eligibility Determining Agency (CWA), 30 were approved for consideration as acceptable for an eligibility review. There were no denials for the purchase of these policies based on income. Consistent with the DHS Medicaid Communication mentioned in the question, the submission of the policy resulted in a redetermination of Medicaid eligibility. Most Supplemental Dental policies did not make it through the redetermination process because they were rescinded by the Medicaid recipients or their Authorized Representative once they were made aware that the product was not free and that they were already receiving the same services through their Medicaid coverage.

- ***Question:*** **How do the supplemental dental insurance policies differ from the dental benefits provided under Medicaid?**

Discussion Points (Cont'd)

DHS Response:

SIDE BY SIDE COMPARISON OF DENTAL INSURANCE PLAN SERVICES				
PROCEDURE CODE	**DESCRIPTION OF SERVICE**	**PLATEAU COMMERCIAL POLICY 1 YEAR BENEFIT PERIOD**	**NJ FAMILYCARE DENTAL BENEFITS THROUGH MEDICAID**	**SERVICES ARE THE SAME IN BOTH PLANS?**
D0120	Periodic oral evaluation - established patient	As deemed appropriate by provider	Every 6 months and as deemed appropriate	Medicaid services provide more
D0140	Limited oral evaluation - problem focused	As deemed appropriate by provider	As deemed appropriate	Medicaid services provide more
D0150	Comprehensive oral evaluation - new or established patient	1 per year	Once per year and as deemed appropriate	Medicaid services provide more
D0210	Intraoral - complete series of radiographic images	1 every 3 years; additional as deemed appropriate by provider	1 every 3 years, additional as deemed appropriate by provider	Yes
D0220	Intraoral - periapical first radiographic image	As deemed appropriate by provider	As deemed appropriate by provider	Yes
D0230	Intraoral - periapical each additional radiographic image	As deemed appropriate by provider	As deemed appropriate by provider	Yes
D0270	Bitewing - single radiographic image	2 sets per benefit year (D0270, D0272, D0273, D0274) combined; additional as deemed appropriate by provider	4 sets per benefit year with demonstration of medical necessity with no frequency limits	Medicaid services provide more
D0272	Bitewings - two radiographic images			
D0273	Bitewings - three radiographic images			
D0274	Bitewings - four radiographic image			
D1110	Prophylaxis - Adult	4 per year combined;	4 per year combined; also allowed post	Yes
D4355	Full mouth			

Discussion Points (Cont'd)

	debridement	additional as deemed appropriate by provider	periodontal surgery and as deemed appropriate	
D4910	Periodontal maintenance			
D1206	Topical application of fluoride varnish	4 per year; additional as deemed appropriate by provider	For children only or as deemed appropriate	Plateau commercial policy provides this as a regular service / Medicaid is for children only and when medically necessary for everyone else
D1330	Oral hygiene instructions		Included with oral evaluation and daily preventative/hygiene services	Medicaid services provide more
D9410	House/extended care facility call (Dentist)	1 per year; additional as deemed appropriate by provider	Covered per facility visit by dentist; additional visits as appropriate	Yes
D9410	House/extended care facility call (Dental Hygienist)	4 per year; additional as deemed appropriate by provider	Covered per facility visit by dentist; additional visits as appropriate	Plateau commercial policy provides 4 visits per year / Medicaid provides 1 visit and more as deemed appropriate
D9630	Other drugs and/or medications as prescribed including daily application to the oral cavity	Daily; additional as deemed appropriate by provider	Daily; additional as deemed appropriate by provider	Yes
D9999	Unspecified adjunctive procedure, by report - oral cavity home care (OCHC)[Professional brushing, flossing	4 per year; additional as deemed appropriate by provider	To be provided by Long Term Care facility staff daily as part of patient/resident daily hygiene (required by the Dept. of Health)	Medicaid services provide more

Discussion Points (Cont'd)

	and swabbing gums]			

8. The responsibility to process applications for NJ FamilyCare is divided between County Welfare Agencies and the NJ FamilyCare Health Benefits Coordinator, Conduent (formerly Xerox). Conduent's contract, originally awarded in 2004, has been extended 17 times, currently through the end of February 2019. In 2015, the contract was rebid (Request for Proposal 16-X-24130, Health Benefits Coordinator (HBC) Medicaid Managed Care Programs). In 2017, the contract was initially awarded to Maximus, Inc.; however, Maximus' contract award was ultimately rescinded and a contract extension was provided to Conduent.

According to the department's responses to FY 2018 OLS Discussion Points, the funding methodology for Conduent is based upon a per member, per month rate of $3.98 for each NJ FamilyCare enrollment. Monthly billing is calculated by multiplying these rates with respective actual monthly enrollments as specified in the monthly Managed Care Report. The monthly billing also includes printing, postage, and translation costs.

- ***Question:*** **Please indicate the number of qualified bids the department received in response to Request for Proposal 16-X-24130. Why was Maximus' contract award rescinded? What errors were made in the bid evaluation and award process and what lessons has the department learned from the experience?**

  DHS Response:

  Four (4) qualified bids were received in response to this solicitation. Due to changing in the wording in one of the price lines, it was determined that this could lead to different interpretations of what was asked for. As a result, on December 8, 2016, a letter was provided to all four (4) bidders informing them that the Division of Purchase and Property had determined that it would reject all pricing submitted. There was no contract award; however, there was a Notice of Intent to Award (NOIA) dated June 16, 2017, which was rescinded by a letter dated December 20, 2017 to all four (4) responsive bidders. All rules in the bid evaluation and award process were properly followed.

- ***Question:*** **Is the department currently drafting another Request for Proposal for a Health Benefits Coordinator for the Medicaid Managed Care Programs? If so, what is the anticipated timeline for issuing the Request for Proposal and awarding a new contract?**

  DHS Response:

  The State anticipates rebidding and awarding this contract in FY 2019. The new RFP is almost complete and will be moving through the approval process shortly.

- ***Question:*** **Does the department intend to set different goals and expectations in any future contract than those provided under the current contract with Conduent? Please explain.**

Discussion Points (Cont'd)

DHS Response:

Since this information is not publicly available, DHS is unable to comment on any potential changes to the contract scope and new solicitation.

9. Maintaining continuity of care is often regarded as important in achieving positive health outcomes, and continuity of health care coverage is usually the primary method for ensuring continuity of care. However, Medicaid has long been characterized by a high degree of "churn," or clients quickly moving on and off the program, owing in part to changing finances making them temporarily ineligible, or failing to complete necessary applications to have eligibility redetermined before the initial period of eligibility expires.

According to the department's FY 2018 response to an OLS Discussion Point, in calendar year 2016, the monthly average new enrollment was 2.8 percent, while disenrollment was 2.6 percent. The monthly average new enrollment was 1.1 percent for aged, blind, and disabled (ABD) consumers, 2.6 percent for non-ABD children, and 3.9 percent for non-ABD adults. The monthly average disenrollment was 1.3 percent for ABD consumers, 2.2 percent for non-ABD children, and 3.6 percent for non-ABD adults.

- ***Question:*** **What was the rate of churn (the proportion of eligible individuals who newly enter and exit the program per year) in each NJ FamilyCare eligibility category for calendar year 2017?**

DHS Response:

Monthly average enrollment/disenrollment over calendar year 2017 has been 1.0%/1.3% for Aged Blind and Disabled, 2.5%/2.4% for Non-ABD Children and 3.5%/3.7% for Non-ABD Adults. Overall, calendar year 2017 monthly average enrollment has been 2.6% while disenrollment has been 2.7%.

10. In its January 1, 2018 report to Governor-elect Phil Murphy and Lieutenant Governor-elect Sheila Oliver, the Healthcare Transition Advisory Committee recommended that the State make Medicaid cost and utilization data publicly available to allow providers and payers to evaluate services in the context of the larger delivery system and in comparison to other programs. Some general data on costs and utilization of certain types of service are provided in Evaluation Data on page D-185 of the Governor's FY 2019 Budget.

At the January 24, 2018 Medical Assistance Advisory Council Meeting, DMAHS staff discussed the forthcoming NJ FamilyCare data analytics dashboards. The objective of the web-based dashboards is to enable users to access demographic and performance data regarding the Medicaid program. Assistance and guidance for the development of the dashboards was received under the Centers for Medicare and Medicaid Services (CMS) Data Analytics Medicaid Innovator Accelerator Program (IAP). The division anticipates the dashboards to be published on the division website in the summer of 2018.

- ***Question:*** **Please provide tables displaying data on spending and service utilization for the most recent year for which data are complete, summed for all managed care organizations**

Discussion Points (Cont'd)

and the fee-for-service program, for each major service and product category. (See FY 2018 Discussion Point #19 for a similar request).

DHS Response:

MANAGED CARE ENCOUNTERS SERVICED SFY17 PAID THROUGH 04/19/2018

Service ENC COS Code	Service ENC COS	Recipient Count	Claim Count	Payment Amount	Average Payment Amount per Claim
AUK	AUDIOLOGY	7,897	27,482	$725,741	$26.41
AUO	AUDIOLOGY - OUTPT HOSP, EXCEPT ER	13,820	43,631	$6,399,877	$146.68
DDD	DENTAL	356,755	2,866,866	$112,296,990	$39.17
EPD	EPSDT - DENTAL	488,654	4,751,201	$147,991,814	$31.15
EPO	EPSDT - OUTPT HOST, EXCEPT ER	2,690	4,203	$121,343	$28.87
EPS	EPSDT - MEDICAL	548,229	778,754	$40,109,990	$51.51
EPY	EPSDT - PRIVATE DUTY NURSING	1,604	350,280	$141,732,333	$404.63
ERE	EMERGENCY ROOM - OUTPT HOSP	596,378	1,346,514	$392,057,024	$291.16
FPU	FAMILY PLANNING	49,435	173,101	$16,006,783	$92.47
HAJ	HEARING AIDS	9,336	29,256	$15,765,241	$538.87
HHH	HOME HEALTH	24,033	348,200	$60,515,393	$173.79
HHO	HOME HEALTH - OUTPT HOSP, EXCEPT ER	21,064	136,604	$3,393,413	$24.84
HOH	HOSPICE SERVICES	3,580	147,640	$34,499,853	$233.68
IAI	INPT HOSP - ACUTE	130,229	183,626	$1,241,051,972	$6,758.59
LSL	LABORATORY SERVICES	962,217	10,598,082	$77,363,905	$7.30
LSO	LABORATORY SERVICES - OUTPT HOSP, EXCEPT ER	409,674	3,885,794	$33,906,750	$8.73
MBH	MANAGED LONG	2,274	18,777	$1,301,636	$69.32

Discussion Points (Cont'd)

	TERM BEHAVIORAL HEALTH, NO INPT				
MDC	MEDICAL DAY CARE	21,491	3,310,863	$271,174,551	$81.90
MEB	MEDICAL EQUIPMENT - PHARMACY	43,605	104,693	$1,182,188	$11.29
MEO	MEDICAL EQUIPMENT - OUTPT HOSP, EXCEPT ER	27	134	$36,268	$270.65
MEQ	DURABLE MEDICAL EQUIPMENT	91,662	364,908	$34,178,879	$93.66
MHE	MENTAL HEALTH - OUTPT HOSP, ER	30,205	48,423	$15,429,955	$318.65
MHI	MENTAL HEALTH - INPT HOSP	2,270	2,889	$7,631,495	$2,641.57
MHM	MENTAL HEALTH	9,070	30,365	$1,383,860	$45.57
MHO	MENTAL HEALTH - OUTPT HOSP, EXCEPT ER	52,961	456,638	$26,124,839	$57.21
MLT	MANAGED LONG TERM SERVICES & SUPPORT	18,267	1,247,317	$142,668,908	$114.38
MSB	MEDICAL SUPPLIES - PHARMACY	79,251	186,814	$5,184,743	$27.75
MSH	MEDICAL SUPPLIES - HOME HEALTH	192	668	$261	$0.39
MSO	MEDICAL SUPPLIES - OUTPT HOSP, EXCEPT ER	192,478	409,427	$30,497,492	$74.49
MSR	MEDICAL SUPPLIES	130,901	815,035	$43,612,093	$53.51
NFC	NURSING FACILITY - CUSTODIAL	20,881	151,472	$769,749,857	$5,081.80
NFI	NURSING FACILITY - OTHER	13,348	27,609	$62,616,313	$2,267.97
OOO	OUTPT HOSP - OTHER, EXCEPT ER	423,185	4,078,073	$536,995,303	$131.68
OT3	OTHER THERAPIES - PHYSICIAN	282,018	654,723	$9,945,841	$15.19

Discussion Points (Cont'd)

OTC	OTHER THERAPIES	53,905	1,271,092	$20,885,863	$16.43
OTF	PODIATRIST SERVICES	96,074	416,703	$13,433,201	$32.24
PCA	PERSONAL CARE ASSISTANCE	38,278	8,085,713	$421,910,051	$52.18
POP	PROSTHETICS & ORTHOTICS	85,932	224,197	$31,800,067	$141.84
PPP	PERSONAL PREFERENCE PROGRAM	10,632	628,069	$155,018,825	$246.82
RAO	RADIOLOGY - OUTPT HOSP, EXCEPT ER	479,167	1,355,581	$176,786,696	$130.41
RAX	RADIOLOGY	622,526	2,365,429	$83,914,374	$35.48
RXA	PHARMACY - REIMBURSABLES	2,855	13,688	$61,981,806	$4,528.19
RXB	PHARMACY - EXCLUDING REIMBURSABLES	1,330,597	21,845,149	$1,418,495,623	$64.93
RXO	PHARMACY - OUTPT HOSP, EXCEPT ER	469,280	1,898,823	$120,640,629	$63.53
SAE	SUBSTANCE ABUSE - OUTPT HOSP, ER	13,932	33,564	$10,806,878	$321.98
SAI	SUBSTANCE ABUSE - INPT HOSP	2,657	3,345	$11,541,800	$3,450.46
SAN	SUBSTANCE ABUSE	2,344	5,218	$1,444,380	$276.81
SAO	SUBSTANCE ABUSE - OUTPT HOSP, EXCEPT ER	14,800	177,031	$4,700,082	$26.55
SM3	STANDARD MEDICAL PHYSICIAN	1,475,546	14,068,338	$723,784,102	$51.45
SM4	NURSE SPECIALTY	257,635	733,797	$25,973,474	$35.40
SM5	PHYSICIAN ASSISTANT	92,715	193,641	$6,960,744	$35.95
TRO	TRANSPORTATION - OUTPT HOSP, EXCEPT ER	45,283	137,960	$23,584,814	$170.95
TRT	TRANSPORTATION	195,598	5,925,840	$138,700,441	$23.41
UNZ	UNKNOWN	198,392	518,960	$66,177,775	$127.52

Discussion Points (Cont'd)

VC3	VISION PHYSICIAN	137,380	639,493	$29,957,928	$46.85
VCV	OPTOMETRIST SERVICES	336,267	592,458	$9,999,011	$16.88
VCW	OPTICAL APPLIANCES	317,719	831,223	$3,969,277	$4.78
				$7,846,120,741	

* data run 4/19/18

MANAGED CARE SUB CAPITATION ENCOUNTERS SERVICED SFY17 PAID THROUGH 04/19/2018

Sub Capitation Provider Code	Sub Capitation Provider Description	Recipient Count	Claim Count	Payment Amount	Average Paymnt Amount per Claim
100	100 - MEDICAL - PRIMARY CARE	639,274	5,359,992	$89,036,616	$16.61
300	300 - DENTAL - PRIMARY CARE	358,137	3,031,444	$33,057,488	$10.90
500	500 - VISION	1,458,560	14,114,186	$26,744,511	$1.89
800	800 - CARE MANAGEMENT	88,748	735,911	$64,249	$0.09
900	900 - LABORATORY	1,093,326	10,565,819	$11,041,626	$1.05
910	910 - THERAPIES (PT, ST, OT)	272,269	2,404,156	$2,833,244	$1.18
930	930 - HEARING	88,861	736,467	$389,292	$0.53
				$163,167,027	

* data run 4/19/18

FFS SERVICED SFY17 PAID THROUGH 04/19/2018 (excluding caps)

Type Code	Service Type Description	Recipient Count	Claim Count	Payment Amount	Average Paymnt Amount per Claim
01	INPATIENT	60,594	82,874	$590,347,290	$7,123.43
02	LTC	25,031	206,350	$1,445,682,495	$7,005.97
03	OUTPATIENT	148,966	1,914,011	$205,987,037	$107.62
04	PHYSICIAN	170,395	996,870	$61,507,712	$61.70
05	CHIROPRACTOR	35	178	$1,109	$6.23
06	HOME-HEALTH	759	4,405	$664,918	$150.95
07	TRANSPORTATION	8,690	25,371	$2,306,122	$90.90
08	VISION	3,367	13,979	$178,508	$12.77

Discussion Points (Cont'd)

09	SUPPLIES-DME	1,690	8,335	$1,442,821	$173.10
10	PODIATRY	1,350	4,744	$168,980	$35.62
11	DENTAL	25,967	151,977	$5,664,872	$37.27
12	PHARMACY	65,500	637,922	$44,561,427	$69.85
13	EPSDT	4,011	17,879	$622,961	$34.84
14	MCARE-PARTA	22,393	73,471	$15,461,791	$210.45
15	MCARE_PARTB	41,568	579,463	$1,952,418	$3.37
16	LABORATORY	65,918	972,635	$45,679,532	$46.96
17	P-AND-O	1,154	3,943	$554,129	$140.53
18	INDEPENDENT-CLINIC	314,299	10,325,273	$2,178,584,378	$211.00
19	PSYCHOLOGIST	5,551	30,669	$2,790,602	$90.99
21	OPTOMETRISTS	3,193	5,669	$157,056	$27.70
22	MID LEVEL PRACTITIONER	20,108	63,172	$3,263,710	$51.66
23	HEARING-AID	671	2,028	$879,227	$433.54
				$4,608,459,097	

* data run 4/19/18

- ***Question:*** **Please provide a status update on the NJ FamilyCare data analytics dashboards with the anticipated publication date for the website. Thus far, what federal and State funds have been used for this initiative? What federal or State funds are anticipated to be spent on the initiative in FY 2019?**

  DHS Response:

  An initial rollout of interactive dashboards related to eligibility will be made publically available by late spring 2018. By the end of summer 2018, the Division anticipates rolling out additional dashboards related to Consumer Assessment of Healthcare Providers and Systems Performance Measures (CAHPS®), Healthcare Effectiveness Data and Information Set (HEDIS) performance measures, long term care eligibility, information related to our Medicaid expansion population, and selected MCO information.

  Training for the visualization tool and consulting hours have been provided by CMS's Medicaid Innovation Accelerator Program (IAP). Total funding to develop and maintain the dashboards detailed at the January MAAC meeting is approximately $5,000 annually ($2,500 state/$2,500 federal). Existing employees from the Office of Business Intelligence and Office of Information Systems have been leveraged to develop both the dashboards and the new analytics website. Annual costs reflect the cost to purchase desktop licenses for the data visualization tool.

<u>Long Term Care</u>

Discussion Points (Cont'd)

11. The Managed Long Term Services and Supports (MLTSS) program, first implemented in July 2014, shifts most NJ FamilyCare long-term care, including nursing home services, into a managed care system. Medicaid recipients who become eligible for long-term care services must enroll in an NJ FamilyCare managed care plan, and the plan is responsible for managing the person's care and reimbursing the entities that provide care. When the MLTSS program was first implemented in FY 2015, a "default rate" was established for nursing facilities that have not negotiated a reimbursement rate with a resident's managed care organization (MCO). This was known as the Any Willing Provider (AWP) policy, and it was intended to allow more time for transition and minimize sudden shifts in reimbursement. (Individuals who were residing in nursing homes prior to the start of MLTSS are generally not required to enroll in MLTSS, and the facilities continue to be paid on a fee-for-service basis by the State.)

In February 2018, the department issued a letter[2] to nursing facility (NF) providers announcing "an enhanced NF quality improvement initiative, called Any Willing Qualified Provider (AWQP). This plan updates and upgrades NF provider requirements and uses specific quality indicators to determine the level of NF engagement with the MCOs in the MLTSS contracting process." According to department documents, the progressive accountability component will begin in January 2019 when the NFs will receive their AWQP designation depending on if they meet or exceed the Statewide average benchmark, as established by CMS, on at least four of the seven quality performance standards. Generally, AWQP establishes the groundwork for a NF and an MCO to negotiate payment rates based upon quality outcomes. However, recommended language governing nursing home reimbursements (page D-192) continues to include a provision regarding a default rate.

- ***Question:*** **What expenditures by funding source – including costs associated with additional personnel - has the department made to implement the AWQP initiative in FY 2018? What are the anticipated expenditures for FY 2019?**

  DHS Response:

  The Division of Aging Services has used internal staff resources to support this initiative and no additional costs have been incurred.

- ***Question:*** **What is the number of nursing facilities that use the default rate with at least one MCO? What is their percentage of all nursing facilities?**

  DHS Response:

  The Division does not require the MCOs to report on the number of nursing facilities that have a negotiated a reimbursement schedule; however, all nursing facilities contracted with an MCO are being paid at or above the default rate.

- ***Question:*** **When does the department anticipate that the default rate will be eliminated due to the implementation of the AWQP initiative, thus requiring nursing facilities and MCOs to negotiate rates? What plans does the department have to ensure that access to providers remains adequate?**

[2] http://www.state.nj.us/humanservices/dmahs/home/Letter_to_Medicaid_Nursing_Homes_February_2018.pdf

Discussion Points (Cont'd)

DHS Response:

The FY 2019 budget assumes a default rate as required in the Budget language. DHS will work closely with the Legislature and provider industry to ensure a smooth transition to the AWQP model. As this is being done in phases, the default rate will remain in place for FY 2019. DHS in collaboration with the MCOs will monitor network access as the progressive accountability actions are implemented.

12. A language provision included in the annual appropriations acts since FY 2014 and recommended to be continued in FY 2019 (page D-193) requires the DHS to gather financial data on nursing homes and periodically assess the financial status of the industry. The function has historically been performed by the Health Care Facilities Financing Authority. In response to an FY 2018 OLS Discussion Point, the department provided the following table of information:

Ratio/Metric	Background Question	9/15 Statewide Median	9/16 Statewide Median	EWS Screen	Desired Trend
Days cash on hand	Does the facility have adequate cash reserves?	15.6	13.9	14.0	↑
Days in current liabilities	How quickly is the facility paying creditors?	50.0	54.5	90.0	↓
Operating margin	Does revenue cover expenses?	3.3%	1.5%	0.0%	↑
Earnings before depreciation	Does operating revenue cover cash expenses?	$426,000	$334,000	$0	↑
Occupancy %	How many beds, on average are occupied at the facility?	88.8%	87.4%	84%	↑
Resident service revenue per resident day	How much is the facility paid for resident care?	$290	$292	N/A	
Operating expense per resident day	How much does it cost a facility to care for residents?	$289	$288	N/A	

- ***Question:*** **Please provide an update to the above table with the most recent available data.**

DHS Response:

Ratio/Metric	Background Question	9/16 Statewide Median	9/17 Statewide Median	EWS Screen	Desired Trend
Days cash on hand	Does the facility have adequate cash reserves?	13.9	12.7	14.0	↑

Discussion Points (Cont'd)

Days in current liabilities	How quickly is the facility paying creditors?	54.5	57.5	90.0	↓
Operating margin	Does revenue cover expenses?	1.5%	1.3%	0.0%	↑
Earnings before depreciation	Does operating revenue cover cash expenses?	$334,000	$257,000	$0	↑
Occupancy %	How many beds, on average are occupied at the facility?	87.4%	83.0%	84%	↑
Resident service revenue per resident day	How much is the facility paid for resident care?	$292	$290	N/A	
Operating expense per resident day	How much does it cost a facility to care for residents?	$288	$295	N/A	

13. According to FY 2018 Assembly Budget Hearing follow-up questions, the DHS was in process of procuring a vendor to ensure that nursing facility bills for dually eligible beneficiaries of Medicaid and Medicare are being paid by the proper program. This action was in response to reports that New Jersey Medicaid was paying for claims that should have been paid by Medicare. As explained by the department, when a client is transferred from a hospital to a nursing facility, an assessment needs to be completed for Medicare. Since the clients are also Medicaid-eligible and the assessments can be time-consuming, facilities often incorrectly bill Medicaid.

- ***Question:*** **Please provide an update on the vendor procurement process, identifying the selected vendor, all associated expenses, and any estimated savings the vendor has produced for the New Jersey Medicaid program.**

  DHS Response:

  The current Medicaid Third Party Liability (TPL) Services contract vendor, Health Management Systems (HMS), has been given approval to proceed with this project. Project meetings with the vendor have taken place, and they are in the final stages of finalizing the steps needed to proceed. The recoveries estimated by the vendor are a total of $8-10 million in annual recoveries, $4-5 million state share. The cost of the project lies on the vendor. They will be paid a percentage of the money collected which is currently 9.26% of recovered dollars.

- ***Question:*** **Would enrollment in the Dual-Eligible Special Needs Plan (D-SNP)[3] under Medicare provide the appropriate care coordination to prevent incorrect Medicaid payments? How would the oversight of a contracted State dual-eligible billing administrator differ from that provided through the D-SNP?**

  DHS Response:

[3] A D-SNP is a special kind of Medicare managed care plan that coordinates all covered Medicare and Medicaid managed care benefits in one health plan.

Discussion Points (Cont'd)

FIDE-SNP is only a small percentage of our total ABD dual population therefore a contracted state dual eligible bill administrator would look at claims for the entire dual population not just FIDE-SNP**.**

- ***Question:*** **How many dually-eligible individuals live in the State and how many are enrolled in the D-SNP?**

DHS Response:

In March 2018, there were 190,641 dually-eligible individuals enrolled in NJ FamilyCare. Of these, 34,337 were in a FIDE-SNP plan.

Other NJ FamilyCare

14. P.L.2017, c.239 requires that the hourly rate for personal care services within the Medicaid program be no less than the established fee-for-service rate, even if those services are delivered through a managed care delivery system, beginning July 1, 2018. It also requires that all rate increases be used solely to augment wages for workers who directly provide personal care services. The majority of Medicaid personal care services are reimbursed through a managed care delivery system and not through fee-for-service.

The Governor recommends budget language that would establish the fee-for-service rate at $16.00 per hour (page D-189) and appropriating an additional $16.9 million for personal care assistance reimbursement rates across several DHS accounts. The increase would be necessary because Medicaid MCO rates vary, but are generally between $12.00 and $16.00 per hour. The FY 2018 Appropriations Act set the fee-for-service rate at $19.00.

- ***Question:*** **What would be the State cost to increase the fee-for-service and managed care hourly rate for personal care services to $17, $18, and $19 under P.L.2017, c.239?**

DHS Response:

The estimated increase in state costs for each $1 incremental increase paid to the PCA providers is $16.9 million.

- ***Question:*** **Please justify the proposed decrease in the fee-for-service rate for personal care services from $19.00 per hour to $16.00 per hour. How many personal care service workers are at risk of receiving a reduction in wages because of the lower proposed reimbursement rate? What would be the cost of increasing the fee-for-service rate to $19.00 per hour while reimbursing personal care services provided through a managed care delivery system at the lower rate of $16.00 per hour?**

DHS Response:

Establishing a $16.00 per hour for fee-for-service rate for personal care services allows for consistency in what is paid to these providers regardless of the payor and also provides for

Discussion Points (Cont'd)

an overall increase in funds to the industry as the majority of PCA services are provided in managed care. DMAHS does not have access to what wages providers pay to direct care workers. The estimated difference in State costs in FFS between paying $16.00 and $19.00 per hour is $46,000.

15. The Medicaid Disproportionate Share Hospital (DSH) program allows the State to receive federal matching funds for certain payments to hospitals for costs that are not otherwise eligible for federal Medicaid matching funds (e.g. Charity Care, and most payments to psychiatric hospitals). Federal Medicaid DSH allotments are scheduled to be reduced by $4.0 billion in federal FY 2020 and $8.0 billion per year from federal FY 2021 through federal FY 2025. The United States Secretary of Health and Human Services will be required to determine the distribution of these reductions across states, so it is not yet clear how the scheduled reduction of DSH funds might affect New Jersey. The President's federal FY 2019 Budget further proposes reducing DSH allotments by $8.0 billion per year from federal FY 2026 through 2028.

State budget documents have historically represented most DSH funds as general revenue without indicating how DSH funds are spent. In response to FY 2018 OLS Discussion Point #23, the department indicated that it estimated that the State would make $846.3 million in Medicaid DSH-eligible payments in FY 2017, of which the estimated federal share was $423.1 million, equal to the standard 50 percent federal Medicaid matching fund rate for New Jersey. For federal FY 2017, New Jersey's preliminary federal DSH allotment is $706.6 million.[4]

- ***Question:*** **Please provide the distribution of federal Medicaid DSH funding, showing the estimated allocation in FY 2018 and FY 2019 by program and budget line item. For each program, please indicate the amount of the federal cost share and the source of the State share corresponding to the federal funds (See FY 2018 OLS Discussion Point #23).**

  DHS Response:

[4] Federal Register Vol. 82, No. 212

Discussion Points (Cont'd)

Projected DHS Revenues (millions)				Federal Source Detail			
FY 2018	**State Source**	**Total**	**Federal**	**Title XIX**	**Medicaid Uncompensated, Acute**	**Medicaid Uncompensated, Mental Health**	**Medicaid Uncompensated Care, Psychiatric**
Charity Care	HCSF	252.00	126.00	53.00	73.00		
Hospital Relief Offset Mental Health	HSCF, GF	24.70	12.40	12.40			
State and County Psychiatric Hospital Uncompensated Care Costs	GF, C	360.80	180.40				180.40
Mental Health Contract Payments to General Acute Hospitals	GF	52.90	26.50			26.50	
Public General Acute Care Hospitals	GF, C	113.10	56.60		56.60		
Other Agency Payments to Hospitals	GF, D	30.30	15.20		15.20		
Medicaid State Only	GF, D	8.10	4.10		4.10		
Ambulatory Care Assessment-ImpermissibleAdjustment	n/a	(56.60)	(28.30)		(28.30)		
Total		**785.30**	**392.90**	**65.40**	**120.60**	**26.50**	**180.40**

State Fund Source

C = County general revenue

D = State dedicated funds

GF = State General Fund

HCSF = Health Care Subsidy Fund

Projected DHS Revenues (millions)				Federal Source Detail			
FY 2019	**State Source**	**Total**	**Federal**	**Title XIX**	**Medicaid Uncompensated, Acute**	**Medicaid Uncompensated, Mental Health**	**Medicaid Uncompensated Care, Psychiatric**
Charity Care	HCSF	252.00	126.00	53.00	73.00		
Hospital Relief Offset Mental Health	HSCF, GF	24.70	12.40	12.40			
State and County Psychiatric Hospital Uncompensated Care Costs	GF, C	346.70	173.40				173.40
Mental Health Contract Payments to General Acute Hospitals	GF	44.30	22.20			22.20	
Public General Acute Care Hospitals	GF, C	119.10	59.60		59.60		
Other Agency Payments to Hospitals	GF, D	30.30	15.20		15.20		
Medicaid State Only	GF, D	7.20	3.60		3.60		
Ambulatory Care Assessment-Impermissible Adjustment	n/a	(56.50)	(28.30)		(28.30)		
Total		**767.80**	**384.10**	**65.40**	**123.10**	**22.20**	**173.40**

Discussion Points (Cont'd)

- ***Question:*** **In FY 2017, what amount of the federal allotted DSH funds did the department not utilize? What are the department's plans to maximize federal DSH funds in FY 2018 and FY 2019?**

  In Federal Fiscal Year 2017, the State did not utilize approximately $300 million in allotted DSH funds. For FY 2018, all hospital payments eligible for DSH reimbursement, per federal rules, are currently receiving federal matching funds.

16. Services provided at a Federally Qualified Health Center (FQHC) to an individual enrolled in an NJ FamilyCare managed care organization (MCO) are reimbursed by the MCO at a negotiated rate. However, if a reimbursement is less than 100 percent of the FQHC's "reasonable and related costs," then federal law requires the Medicaid program to make a supplemental payment to cover the difference between the MCO's payment and the cost to the FQHC. This supplemental payment is commonly referred to as a "wrap-around" payment.

- ***Question:*** **For FY 2017, FY 2018, and FY 2019, please provide the actual or estimated total cost to Medicaid for all wrap-around payments to FQHCs. What percentage of total Medicaid reimbursements to FQHCs do these payments represent?**

  DHS Response:

Medicaid FQHCs Expenditures:

$s in millions

	SFY 2017	SFY 2018 Est*	SFY 2019 (Projected)**
HMO	$51.2	$59.5	$62.5
Supplemental (Wrap Around)	$56.4	$62.5	$65.7
FFS	$24.8	$26.8	$28.1
Total Medicaid	**$132.4**	**$148.8**	**$156.3**
% Supplemental (Wrap Around) to Medicaid reimbursement	**42.6%**	**42.0%**	**42.0%**

* based on 9 months of actual data and projected
** based on SFY2018 data projected with a 5% increase
*** Increase in Medicaid FQHCs expenditures (approximately 12.3%) from SFY 2017 to SFY 2018 due to increase in payments for FFS claims and HMO claims

17. The Transportation Broker Services contract established a sole provider (broker) responsible for arranging non-emergent medical transportation (NEMT) services for Medicaid recipients in all counties through its provider network. The division is responsible for monitoring the contract and for oversight of the fiscal agent that processes encounter claims submitted by the broker. According

Discussion Points (Cont'd)

to a report published in March 2018 by the Office of the State Auditor[5], expenditures under the contract were $171.7 million, $177.9 million, and $180.9 million in fiscal years 2015, 2016, and 2017, respectively, and provided services to 135,000 of the 1.67 million Medicaid recipients. Expenditures are partially reimbursed by the federal government. Since 2009, DHS has contracted with LogistiCare to manage Medicaid NEMT.

The State Auditor's report recommended that the division's procedures for administering the contract be improved. Specifically, the review found the division's procedures for assessing liquidated damages, providing mileage reimbursements to individuals who transport Medicaid recipients, and processing the monthly capitation fees need to be strengthened to reduce costs.

In response to the report, the division noted several actions taken to improve oversight of the NEMT contract, such as, adding two staff members to the current five who monitor the NEMT program, and requiring the broker to track drivers and limit mileage payment for multi-load situations.

- ***Question:*** **How much has been spent, by funding source, on NEMT services thus far in FY 2018? What is the anticipated cost total for FY 2018 and FY 2019?**

  DHS Response:

  As of the end of March 2018, the State has spent $129.8 million on NEMT services in FY 2018. The State share is $42 million and the Federal share is $87.8 million. The anticipated cost for FY 2018 is $173.1 million of which the State share is $56.1 million and the Federal share is $117 million. The anticipated cost for FY 2019 is $173.3 million. Due to the federal statutory change in FMAP for the expansion population, the projected State share is $57.2 million and the projected Federal share is $116.1 million.

- ***Question:*** **How many Medicaid recipients used NEMT services thus far in FY 2018? How many are anticipated to do so in FY 2019?**

  DHS Response:

  129,962 unique riders have used NEMT since July 1, 2017 and the Division anticipates 157,000 unique riders for FY 2019.

- ***Question:*** **Please itemize the cost for additional staff and any other initiative associated with improving the management of the NEMT contract in FY 2018. What are the anticipated itemized costs in FY 2019?**

  DHS Response:

  Currently, four full-time staff are dedicated to oversight of the NEMT contract. The Division anticipates the addition of a fifth staff member effective May 1, 2018 at a salary cost of approximately $80,000 total. The Assistant Director of Managed Behavioral Health and Customer Service dedicates 15% of time to NEMT Contract Management. The combined time of Regional Staff Nurse support for field observations is approximately the same

[5] http://www.njleg.state.nj.us/legislativepub/auditor/547017.pdf

Discussion Points (Cont'd)

amount of time as one full time employee. As part of the enhanced oversight in the revised contract the Division anticipates the addition of two staff for FY 2019. The itemized cost for these additional staff will depend on their initial salaries, with minimal state impact due to a federal match.

Division of Aging Services (DoAS)

18. The Governor's FY 2019 Budget recommends funding two Community Based Senior Programs accounts at a combined $45.4 million (page D-196). Many of the programs aggregated in these accounts are described in evaluation data on pages D-194 and D-195, but spending on each program is not.

- ***Question:*** **Please provide a breakdown of funding in the Community Based Senior Programs accounts by program for FY 2017, FY 2018, and FY 2019. Please indicate federal matching funds for any program for which they are earned as a result of State spending. Is any redistribution of funds proposed for FY 2019?**

Discussion Points (Cont'd)

DHS Response:

Community Based Senior Programs
Fiscal Years 2017 - 2018 - 2019 Allocations

Program		FY 2017 Allocation	FY 2018 Allocation	FY 2019 Allocation
State GIA Funding - Community Based Senior Programs: Adult Protective Services (APS)		$1,036,000	$1,036,000	$1,036,000
Social Service Block Grant (SSBG)		$12,761,000	$12,761,000	$12,761,000
Alzheimer's-COPSA		$751,800	$751,800	$751,800
Alzheimer's (AADSP)		$156,200	$156,200	$156,200
Alzheimer's (AADSP)		$500,000	$500,000	$500,000
JACC/GO		$10,027,000	$7,527,000	$7,527,000
Adult Protective Services (APS)		$1,000,000	$1,000,000	$1,000,000
Eldercare Funds		$2,309,000	$2,309,000	$2,309,000
Congregate Housing Services Program (CHSP)	$784,000			
Adult Protective Services (APS)	$900,000			
Supplemental Home Delivered Meals (SHDM)	$625,000			
SSBG Like Grant Funds		$400,000	$400,000	$400,000
211 Call Center-Atlantic		$142,000	$142,000	$142,000
Administrative Transfer		$3,850,000	$3,850,000	$3,850,000
Administrative Transfer		$191,000	$191,000	$191,000
Casino Revenue Funding - Community Based Senior Programs:				
Adult Protective Services (APS)		$1,842,000	$1,842,000	$1,842,000
Safe Housing and Transportation (SHTP)		$1,726,000	$1,726,000	$1,726,000
Congregate Housing Services Program (CHSP)		$2,077,000	$2,077,000	$2,077,000
State Weekend Home Delivered Meals (SWHDM)		$1,020,000	$1,020,000	$1,020,000
Alzheimer's (AADSP)		$2,674,000	$2,674,000	$2,674,000
Alzheimer's-Training		$50,000	$50,000	$50,000
Statewide Respite (SRCP)		$5,359,000	$5,359,000	$5,359,000
Subtotals State Funds		$47,872,000	$45,372,000	$45,372,000
Federal CNOM Funding (JACC/GO)		$0	$2,500,000	$2,500,000
		$47,872,000	$47,872,000	$47,872,000

Discussion Points (Cont'd)

Division of Developmental Disabilities (DDD)

Developmental Centers

19. The division administers five residential developmental centers for individuals with developmental disabilities. The developmental centers are supported by a combination of State and federal funds. Specifically, the Governor's FY 2019 Budget recommends $87.3 million in State funding ($17.3 million less than the FY 2018 adjusted appropriation) and $197.6 million in federal funds ($1.0 million less than the FY 2018 adjusted appropriation).

According to Evaluation Data on pages D-203 and D-204, in FY 2019, 1,274 individuals will reside in the five developmental centers, a decline of 88 individuals from the FY 2018 revised data, and there are 4,009 funded positions allocated to this program, a decline of 28 positions from the number of positions filled in January 2018. Additionally, 13 individuals are expected to transition from the developmental centers to the community in FY 2019 (page D-207).

- ***Question:*** **How many individuals were admitted to the five developmental centers in 2017, and thus far in 2018? How many were discharged in each period?**

- ***Question:*** **How many individuals currently residing in one of the five developmental centers are community-placement eligible?**

  DHS Response:

  In FY 2017, twenty-one individuals moved to the community and there were no admissions. In FY 2018, as of April 18, fourteen individuals have moved to community and there have been no admissions. As of April 1, there were 48 individuals in-agreement for community placement, meaning that the individual, the Interdisciplinary Team and the Guardian were in agreement. The Division is actively working on placement options.

Community-Based Residential Programs

20. P.L.2017, c.238, known as "Stephen Komninos' Law," is scheduled to take effect on May 1, 2018. The law enhances notification requirements for instances when a resident with developmental disabilities of a community-based residential program (group homes and supervised apartments) has incurred an injury. The law also increases DHS administrative responsibilities regarding site visits and incident investigations. Furthermore, the law requires the drug testing of all direct care staff members who may come into direct contact with individuals with developmental disabilities prior to employment and randomly during the course of their employment, with DHS paying for all associated expenses.

Overall, the law requires substantial changes to the State's system of DDD service provider oversight. At the time the law was enacted, it was not clear to what extent the department would adapt its current consumer-oriented system of oversight to the provider-oriented system prescribed by the law.

- ***Question:*** **How many different entities providing community-based residential programs to individuals with developmental disabilities does the department license?**

Discussion Points (Cont'd)

- ***Question:*** **What steps has the department taken to implement P.L.2017, c.238?**

- ***Question:*** **What financial resources are allocated for implementation in FY 2019? Of these, how much are new costs, as opposed to costs that would have been incurred under the previously existing system of oversight? Please itemize these costs, including specifically expenditures for staff and drug tests for direct care staff.**

- ***Question:*** **In what ways does the department expect that elements of its previous oversight system will be eliminated in implementing P.L.2017, c.238?**

  DHS Response:

  There are 133 licensed community residential providers and 384 licensed community care homes providing services to individuals with developmental disabilities. The Department has taken significant steps to implement Komninos' Law, including a comprehensive communications plan for stakeholders, a mandatory training module for all direct support professionals, and staffing to manage required oversight and reporting functions. Implementation of Komninos' Law will enhance existing oversight.

  The legislation did not allocate financial resources for implementation. The Department will realign existing staff with new functions and request a supplemental in FY 2019 if additional resources are required for other costs. Gross costs are estimated at approximately $10 million, which will be offset by an anticipated 45% federal match through the Department's cost allocation plan:

Item	Estimated cost
Staffing	$7,911,000
IT equipment for field staff (tablets, cell phones, data)	$151,000
Vehicles for field staff	$560,000
IT system development and enhancements	$250,000
Assessment tool development and validation	$159,000
Drug testing contract	$1,000,000
Total	**$10,031,000**
55% State share	$5,517,000

21. On October 17, 2017, the State Auditor published a report regarding licensed residential programs serving individuals with developmental disabilities.[6] In the report it was recommended that the department: 1) improve its monitoring of background checks of employees of residential program providers; 2) require community care residence providers to obtain federal background checks in addition to the State background checks already required for employees and to obtain federal and State background checks for alternates; and 3) improve the coordination between the Office of Licensing and the Division of Developmental Disabilities to confirm and identify support living programs that do not require licensing.

The report also observed that statutory changes requiring either providers or employees to pay for criminal background checks, as done in other states, could defray certain cost for the

[6] http://www.njleg.state.nj.us/legislativepub/Auditor/544816.pdf

Discussion Points (Cont'd)

department. Furthermore, the report observed that the department could recoup certain expenses associated with inspecting and licensing residential programs if it charged a licensing fee to providers of residential programs serving individuals with developmental disabilities, as it did for mental health residential programs when such programs were within its jurisdiction.

- ***Question:*** **How has the department changed or anticipates changing procedures to implement the State Auditor's recommendations? What are the costs of these changes?**

- ***Question:*** **Would the department support statutory changes that would require providers or employees to pay for criminal background checks? Would this expense be more appropriate for providers or employees?**

- ***Question:*** **If residential programs serving individuals with developmental disabilities were charged an identical licensing fee as mental health residential programs, how much revenue would the department collect, based on FY 2018 numbers? Does the department support imposing such a licensing fee?**

  DHS Response:

  Some of the Department's procedural changes to implement P.L.2017, c.328, which will also address the State Auditor's recommendations, including the assumption of responsibility for completing employee fitness determinations for community residential program providers, increased Licensing oversight, and requiring community care residence providers (CCRPs) to obtain federal background checks.

  The cost of additional background checks for the 384 CCRPs and their adult household members is estimated at $74,592 ($64.75 per print, assuming 3 checks per household). The cost of background checks for approximately 1,150 CCRP alternates is estimated at $74,463. The Department requires six additional full-time employees at a cost $450,000 to manage the administrative responsibilities associated with these changes.

  There is a specific formula for determining Mental Health residential program licensing fees. However, assuming an average cost of $575 per site, the fee on 1,835 DDD sites would produce about $1 million. The Department cannot comment on policy options without reviewing the full legislative proposal and its impact.

<u>Fee-for-Service Conversion</u>

22. On July 1, 2015, the division began shifting its method of reimbursement to a fee-for-service reimbursement system for community providers, replacing a system primarily based on cost-reimbursement contracts. The new reimbursement system is intended to promote fairness and equity in rates paid to providers, portability of benefits for consumers, affordability for the State, and simplicity and practicality for all involved parties. It is also a part of the larger shift to ensure that all services provided by the division are eligible for a federal Medicaid funding match and are approved through the Comprehensive Medicaid Waiver.

Discussion Points (Cont'd)

All providers must now be enrolled as Medicaid providers to receive reimbursement from the State. All individuals (with some exceptions) who receive services from the division are required to be Medicaid-eligible.

In response to an FY 2018 OLS Discussion Point, the department estimated that approximately 60 percent of providers were already Medicaid-eligible fee-for-service billers and anticipated that 100 percent of providers would be enrolled by July 1, 2017.

- ***Question:*** **What percentage of current providers are Medicaid-eligible? If less than 100 percent, when does the department anticipate that all providers will be enrolled in Medicaid? What are the major challenges to enrollment for providers?**

- ***Question:*** **What is the deadline for providers to be enrolled or risk losing clients? Will clients be allowed to continue to receive services from providers that do not become Medicaid-eligible?**

- ***Question:*** **What percentage of current recipients of DDD services is enrolled in Medicaid? When does the department anticipate that 100 percent of recipients of DDD services will be enrolled in Medicaid? What are the major challenges to enrollment for recipients of DDD services?**

- ***Question:*** **What number of persons with developmental disabilities has the division declined to serve due to lack of Medicaid eligibility? What criteria are used to decide whether or not to serve a person who is not eligible for Medicaid?**

  DHS Response:

  Of the 208 legacy contracted providers, 148 (71%) are qualified for at least one Medicaid service. The Division anticipates that all providers will be enrolled by the end of FY 2018. There have not been major systemic challenges in the provider enrollment process. Aside from short-lived backlogs around critical dates, most issues are provider or service specific, such as incomplete applications or confusion about which services or provider types to select. The Provider Portal page on the Division's website provides guidance on the application process and the Provider Enrollment Unit is available to answer questions and guide providers as needed. Provider delays may result in individuals choosing to receive services elsewhere because service recipients will not be able to access the expanded fee-for-service budgets and range of services until their providers enroll. Contracts are being maintained in FY 2019 to ensure service continuity. The Division continues to emphasize the importance of provider enrollment, particularly the impact on individuals, and continues to meet one-on-one with providers to address issues.

  There are a limited number of individuals receiving services that do not currently have Medicaid (this is related to financial eligibility and is separate from HCBS waiver enrollment). Challenges to enrollment include:
  - Earned/unearned income exceeds the Medicaid allowance, usually due to Social Security Disability benefits or a survivor's pension benefit.
  - Special Needs Trusts that do not meet Medicaid standards for disregard.

Discussion Points (Cont'd)

- Non-response to the annual Medicaid-eligibility redetermination.
- Delays when income or asset levels require private payment or other arrangements before Medicaid benefits can be accessed.

When individuals exceed the standard Medicaid income level, they can become eligible under the 300% Federal Benefit Rate (FBR) waiver standard by submitting a Medicaid Only application directly to the Waiver Unit. If there are no income or asset issues, the individual will receive services while the application is being reviewed by Medicaid. If determined eligible, Medicaid eligibility date is retroactive to the application date, which allows all State dollars expended to receive a federal Match.

The Division has not declined services to individuals for lack of Medicaid eligibility. The shift to fee-for-service began with Medicaid-eligible individuals and the Division has established a Medicaid Eligibility Helpdesk and a Medicaid Troubleshooting Form to assist individuals who are having any issues obtaining Medicaid.

23. P.L.2017, c.85 establishes procedures for monitoring the transition by community-based providers from cost-reimbursement contracts to a fee-for-service reimbursement system. The law calls for independent stakeholder oversight boards, one for the developmental disability system and one for the substance abuse and mental health system. The law also requires the issuance of a request for proposals (RFP) to perform an independent evaluation of the transition in each system. As of April 4, 2018, no members have been appointed to the Independent Developmental Disability Fee-for-Service Transition Oversight Board or the Independent Mental Health and Addiction Fee-for-Service Transition Oversight Board, and no RFP has been issued.

- ***Question:*** **What is the status of the implementation of P.L.2017, c.85? By what date does the department anticipate the issuance of the RFP and the organizational meeting of the Independent Developmental Disability Fee-for-Service Transition Oversight Board?**

DHS Response:

The Department intends to fulfill the requirements of the law as promptly as possible. The Department has submitted an RFP scope to the Division of Purchase and Property for the evaluation component of the law.

<u>Home and Community-Based Services</u>

24. After the finalization of the 2014 federal Home and Community-Based Services (HCBS) Rule and the publication of New Jersey's Statewide Transition Plan (which articulates the State's plan to comply with the rule), some New Jersey providers expressed concerns that their settings may be determined to be ineligible to participate in Medicaid, generally due to their having "characteristics of an institution," as defined in the federal rule. After meeting with stakeholders in the summer of 2016, the department submitted a revised plan to the federal government that would increase flexibility to individuals and providers in meeting the HCBS rule. The State has yet to receive approval for the plan.

Discussion Points (Cont'd)

A CMS Bulletin issued on May 9, 2017[7] informed state agencies of the extension of the transition period from March 17, 2019 until March 17, 2022 for states to demonstrate compliance with the HCBS Rule for settings that were operating before March 17, 2014 due to "the difficult and complex nature of this task." Furthermore, the DHS, under the extension of the Comprehensive Medicaid Waiver[8], is required to continue and improve existing demonstration programs that increase options for those who need long term care by enhancing access to home and community based services.

- ***Question:*** **Please provide a status update on the approval of the HCBS Statewide Transition Plan.**

- ***Question:*** **Under the plan, how many facilities currently serving DDD customers are not Medicaid-eligible? Please share these data according to the reason for ineligibility. How many facilities still need to be evaluated?**

- ***Question:*** **Please specify the amount of funding, differentiated by funding source, set aside in FY 2018 and FY 2019 to assist providers in achieving compliance with the federal HCBS rule. What are the department's specific plans to utilize the funding to further that objective?**

  DHS Response:

  The Statewide Transition Plan has not yet been approved by CMS. Once final and approved, the Division will complete a formal review to determine how many settings may be impacted, but the Division has identified fourteen providers operating fifty settings that may not be considered community integrated. Federal match has already ceased on at least one of these programs. There is no compliance funding available.

Community Care Waiver

25. Effective November 1, 2017, the Community Care Waiver (CCW) was incorporated into New Jersey's larger and more wide-ranging Comprehensive Medicaid Waiver (CMW), and was re-named the Community Care Program (CCP). The department has emphasized that this is an administrative adjustment only and does not eliminate any services. The CCP, as did the CCW, allows the division to provide eligible individuals with home and community based services as opposed to providing support in an institutional setting. However, new services are now available to CCP participants who have transitioned into fee-for-service: community inclusion services, interpreter services, natural supports training, and supports brokerage.

Federal and State funding for CCP in FY 2019 is anticipated to be $1.11 billion, as follows: $793.7 million for Individual Supports; $116.0 million for Individual and Family Supports; and $203.9 million for Employment and Day Services. In addition, the Governor recommends including a new language provision in the FY 2019 Appropriations Act that would allow for supplemental mid-year

[7] https://www.medicaid.gov/federal-policy-guidance/downloads/cib050917.pdf

[8] http://www.nj.gov/humanservices/dmahs/home/Waiver_Renewal_Approval_Letter.pdf

Discussion Points (Cont'd)

appropriations of unspecified amounts for DDD Grant-in-Aid programs, including the CCP, without any additional legislative approval (page D-209).

Evaluation Data on page D-206 indicate that in FY 2019 a projected 7,810 individuals would live in group homes or supervised apartments and 512 in community care residential facilities, for a total of 8,322 individuals being supported outside of their own home through CCP. Additionally, 17,130 individuals would receive DDD services while residing in their own home, but the Evaluation Data do not identify how many of them would be enrolled in the CCP. In response to the FY 2018 OLS Discussion Points, the department indicated that the maximum number of allowable CCW participants was 11,878 in FY 2017 and 12,328 in FY 2018.

- ***Question:*** **What is the maximum number of allowable Community Care Program participants in FY 2018 and FY 2019?**

- ***Question:*** **What prevents the department from enrolling the maximum number of participants in the Community Care Program?**

- ***Question:*** **How many individuals who are enrolled in the Community Care Program live in their own homes, as opposed to a division-funded residential placement?**

- ***Question:*** **How many providers of residential services are serving Community Care Program enrollees? Have any of these providers indicated they would no longer be providing services in FY 2019?**

  DHS Response:

  The maximum number of allowable Community Care Program (CCP) participants is 12,778 in FY 2018 and 13,228 in FY 2019. Although the waiver has a maximum enrollment for budget neutrality calculations, the Division is able to request an increase as needed. Enrollment has not been to the maximum level because new enrollment is often offset to a degree by transitions out of the program including changes such as admissions to skilled nursing facilities. Some individuals on the Community Services Waiting List are not eligible for CCP because they are children and the CCP is for those over 21 years old. Others are not eligible because they do not meet the institutional level of care standard for the CCP program, although they may be able to enroll in the Supports Program for other services. In addition, some individuals who are eligible do not have immediate needs at the time and can delay the selection of services as they consider options.

  Approximately 2,300 individuals on the CCP live in settings such as their own home, supported living/self-determination settings (e.g., apartment with limited hours of support), and unsupervised apartments. However, under the Department's fee-for-service (FFS) model, all individuals outside of family homes have a lease or tenant agreement and effectively live in their own homes with full tenant rights under the law. Individuals living in different types of physical settings may receive similar services and there is no distinction based on residential or 'own home' categorizations.

26. According to the department's response to FY 2018 OLS Discussion Points, there were 2,799 adults and 213 children on the priority Community Services Waiting List (CSWL), a waiting list for

Discussion Points (Cont'd)

determination of eligibility for enrollment in the CCP. All adults on the list were able to receive day and employment services through the division and may be enrolled in the Supports Program while remaining on the list for future residential services under the CCP. Of the 2,799 adults on the list, 7 percent were enrolled in the Supports Program. The division anticipated removing 250 individuals from the list in FY 2018.

FY 2019 Evaluation Data indicate that 2,500 individuals are anticipated to be "Priority Placements" in FY 2019 (page D-206). The Priority Placement classification indicates that the State has deemed these individuals to be at significant risk of homelessness or facing imminent peril if an emergency were to happen. The Governor's FY 2019 Budget anticipates $33.7 million in gross annual program costs for the priority placement population.

- ***Question:*** **How many individuals are currently on the CSWL in the general and priority category?**

- ***Question:*** **What percentage of the adults on the waiting list is enrolled in the Supports Program?**

  DHS Response

  On the CSWL, there are 2,701 individuals in the priority category and 2,142 in the general category. Forty-six percent of the adults on the wait list are enrolled in the Supports Program.

Client Housing

27. In collaboration with the New Jersey Housing and Mortgage Finance Agency, the department has developed the Supportive Housing Connection (SHC), a new voucher-based rental assistance program for individuals with developmental disabilities who live in DDD community-based residential programs. The SHC is intended as a bridge program to be used until an individual can access a local, state, or federal housing assistance program. The SHC responds to a requirement under the federal CMS Home and Community-Based Services (HCBS) Final Rule to separate the cost of housing provided to Medicaid-eligible individuals with developmental disabilities from the cost of other services. The cost disaggregation partially follows from the unavailability of federal Medicaid matching funds for the cost of housing services.

In January 2017, the division issued the new Housing Assistance Policy, effective February 6, 2017.[9] Under the new policy, individuals participating in the SHC program contribute 30 percent of their gross annual income toward the rent, directly paid to the landlord. The remainder of the rental cost, up to Fair Market Rent as established annually by the federal Department of Housing and Urban Development, is paid by the SHC directly to the landlord. Under the previous system that is being phased out, DDD clients living in community-based residential programs pay cost recoveries directly to the division equal to 75 percent of their income for all services provided by the DDD, including housing services.

The Governor recommends $52.7 million for Client Housing in FY 2019 (page D-208). The appropriation is comprised of $37.7 million from the General Fund and $15.0 million from client copayments received by the DDD under the vanishing community-based residential programs

[9] http://www.state.nj.us/humanservices/ddd/documents/housing_assistance_policy.pdf

Discussion Points (Cont'd)

financing system (page C-12). In addition, the Governor recommends including a new language provision in the FY 2019 Appropriations Act that would allow for supplemental mid-year appropriations of unspecified amounts for DDD Grant-in-Aid programs, including Client Housing, without any additional legislative approval (page D-209). Evaluation Data indicate that the department anticipates 7,851 SHC vouchers in FY 2019 (page D-207). According to a FY 2018 OLS Discussion Point response, the division anticipated shifting nearly 9,000 contracted residence beds to SHC housing vouchers in FY 2018.

- ***Question:*** **What is the census of available beds in residences which are currently operated by contract-based reimbursement providers?**

- **Question: What is the division's anticipated timeline for all contract-based reimbursement for housing to be shifted to vouchers? Has the migration been slowed by any SHC funding limitations?**

- ***Question:*** **How many of the individuals on the CSWL received an SHC voucher thus far in FY 2018? How many are anticipated in FY 2019?**

  DHS Response:

  As of April 1, 2018, 5,561 individuals continue to receive waiver services in group homes and supervised apartments through cost-reimbursement contracts. All housing costs will have shifted to rental vouchers by July 1, 2018, and service costs will continue to convert during FY 2019. There have been no delays or funding limitations. In FY 2018 to date, 158 Individuals on the CSWL have received a housing voucher and all CSWL individuals enrolling on the CCP or SP in FY 2019 are eligible for a voucher. The Division anticipates enrolling all eligible individuals in one of the waiver programs by the end of FY 2019.

Supports Program

28. The Supports Program is intended to provide community supports for adults with developmental disabilities who are living in unlicensed settings, such as with family members or in their own homes. DDD is transitioning all individuals who receive services from the division and are not enrolled in the Community Care Program into the Supports Program. This will allow the State to receive a 50 percent federal match for the program's expenditures, but also subjects DDD to certain federal rules that do not apply to services funded entirely by the State.

Evaluation Data on page D-206 of the Governor's FY 2019 Budget indicate Supports Program enrollment as 120 individuals in FY 2016, 874 individuals in FY 2017, an estimated 4,586 individuals in FY 2018, and an anticipated 8,625 individuals in FY 2019. The Administration anticipates the average annual cost per individual to be $19,678 in FY 2019. Total FY 2019 appropriations are recommended at $71.1 million for Individual and Family Support Services and $131.5 million for Employment and Day Services for individuals in the Supports Program (page D-208). In addition, the Governor recommends including a new language provision in the FY 2019 Appropriations Act that would allow for supplemental mid-year appropriations of unspecified amounts for DDD Grant-in-Aid programs, including the Supports Program, without any additional legislative approval (page D-209).

Discussion Points (Cont'd)

According to responses to an FY 2018 OLS Discussion Point, the division anticipates full enrollment in the Supports Program in FY 2018, with all individuals aging out of the Department of Children and Families and into DDD being offered Supports Program enrollment.

- ***Question:*** **How many individuals receive services by the division, but are not enrolled in the Supports Program or the CCP?**

- ***Question:*** **How many individuals currently receiving services from the division are not enrolled in Medicaid, and not eligible for the Supports Program or the CCP? How is the division working with these individuals to enroll them in Medicaid?**

  DHS Response:

  Approximately 10,000 individuals currently receive services from the Division but are not enrolled in the Community Care Program or Supports Program. The Division anticipates enrolling all eligible individuals in one of the waiver programs by the end of FY 2019. There are a limited number of individuals receiving services that do not currently have Medicaid (this is related to financial eligibility and is separate from HCBS waiver enrollment). The Division is reviewing the individual cases to determine what the barrier, if any, is to obtaining Medicaid.

Out-of-State Placements

29. In certain instances individuals who meet the eligibility requirements for DDD services are served by out-of-State facilities. Some individuals who are aging into DDD services have been supported in facilities that are located out-of-State. Other individuals who start receiving DDD services may find that an out-of-State facility best meets their individual needs.

Individuals who reside in out-of-State facilities classified as Intermediate Care Facilities for Individuals with Intellectual Disabilities are excluded through budget language from mandatory enrollment in Medicaid (page D-189). According to the department's response to an FY 2018 OLS Discussion Point, only two of the 31 out-of-state providers meet the Community Care Program standards, but the division is working with all providers on Medicaid eligibility. Furthermore, 103 of the 343 individuals placed in out-of-state facilities are eligible for Medicaid, with a projected federal funding of $3.6 million.

Evaluation Data in the Governor's FY 2019 Budget indicate that 340 individuals are anticipated to be in out-of-State placement (page D-207) at an annual cost of $135,327 per individual and $46.0 million in gross expenditures in FY 2019.

- ***Question:*** **How many individuals are currently receiving DDD-funded care in out-of-State placements? How many are currently enrolled in Medicaid?**

- ***Question:*** **How many out-of-State facilities are hosting DDD customers? How many of these facilities are Medicaid-eligible for New Jersey? Have any out-of-State facilities become newly Medicaid-eligible for New Jersey in FY 2018? Does the division anticipate any additional out-of-State facilities becoming Medicaid-eligible in FY 2019?**

Discussion Points (Cont'd)

- ***Question:*** **How many individuals who had been moved to an in-State placement from out-of-State have subsequently moved back to out-of-State?**

- ***Question:*** **Of the $46.0 million in projected FY 2019 costs for out-of-State placements, what portions are paid with State funds, federal funds, and individuals' contributions to care?**

  DHS Response:

  There are 344 individuals receiving DDD-funded care from 34 out-of-state providers. Of those individuals, 299 are Medicaid eligible, with 98 being actively claimed on. Two providers are eligible for home and community based services (HCBS) reimbursement through the CCP but the other settings do not meet the HCBS standards (e.g., facility-based or campus settings). Post the 2015 enactment of legislation on this topic, two individuals who moved to New Jersey to an in-placement from out-of-state subsequently moved back. Of the $46 million, approximately $39.5 million is State, $3.5 million is federal match on the two facilities, and $3 million is client contributions.

Division of Family Development (DFD)

Child Care

30. Beginning in 2016, as required by federal law and as part of the State's Child Care Development Block Grant (CCDBG) plan, all staff employed at subsidized child care facilities must undergo criminal history background checks. Prior to 2016, State law required such checks of staff employed at licensed child care centers only; however, federal law expanded the requirement to include staff employed at license-exempt providers, such as participating schools, summer camps, and family day care providers that receive CCDBG subsidies. In response, the State enacted P.L.2017, c.89 which requires the DHS to cover the costs of background checks for all registered family day care providers.

The FY 2017 Appropriations Act included $3.7 million intended to cover the costs of additional background checks needed to comply with these requirements. According to the department's response to an FY 2018 OLS Discussion Point, the department spent $1.1 million to fingerprint 22,479 child care center staff in FY 2017 (July 1, 2016 through April 2017), and did not anticipate any additional funding for FY 2018.

- ***Question:*** **What is the current cost per individual to conduct criminal history record background checks for child care providers?**

- ***Question:*** **How many criminal history background checks has DHS paid for thus far, and at what cost, in FY 2018? How many, and at what cost, does the department anticipate in FY 2019? Does the Governor's FY 2019 Budget include additional funding to cover these costs?**

Discussion Points (Cont'd)

DHS Response:

The current cost to conduct criminal background checks for individuals who work for child care providers is $62 per person. As of 4/18/2018 there have been 25,576 background checks completed for child care staff at a cost of $1,585,712.

Although the Department generally anticipates a similar level of activity in FY 2019, additional centers could obtain licenses, current centers could change staff needs, and other business decisions could be made by the programs that accept child care subsidies.

31. The federal CCDBG rules also require that payment rates for child care services be sufficient to ensure access for eligible families to child care services comparable to those provided to families not eligible to receive subsidies. The federal law requires a Market Rate Study (MRS) every three years, and New Jersey issued an MRS for calendar year 2016.

Effective January 7, 2018, DHS issued new FY 2018 maximum child care payment rates.[10] These rates include incentive rates ranging from four percent up to 24 percent for child care centers that are rated at a three or above in Grow NJ Kids, New Jersey's Quality Rating Improvement System. According to the department, an additional $15.0 million was appropriated in the FY 2018 Budget for the Child Care Subsidy Program for these rate increases.

Child care advocates are concerned that the subsidy rates for infants do not provide the resources necessary to maintain the required staff ratios, safety standards, and employee certifications. As a result, child care centers are moving away from infant care to higher-reimbursed age groups, leaving a provider gap for low-income families. In its January 1, 2018 report to Governor-elect Phil Murphy and Lieutenant Governor-elect Sheila Oliver, the Human and Children Services Transition Advisory Committee report indicates that the infant reimbursement rates would require at least a $42.0 million increase in funding to provide sufficient services in the State.

The Governor's FY 2019 Budget includes $362.8 million gross funding for Work First New Jersey Child Care, an increase of $8.0 million (2.2 percent) from the FY 2018 adjusted appropriation. Nearly all of the increase is reflected in federal funds.

- ***Question:*** **Has the federal government given any indication whether it will require additional data on market rates to determine whether the State is compliant with the "equal access" requirements beyond FY 2018? Is the DHS planning any further MRS?**

- ***Question:*** **How much does the department anticipate spending, by funding source, in FY 2018 and FY 2019 for the increased child care payment rates? Please separate this amount by rate increase and new incentive rate.**

[10] http://www.childcarenj.gov/getattachment/Resources/Reports/SFY-2018-Maximum-Child-Care-Payment-Rates.pdf.aspx?lang=en-US

Discussion Points (Cont'd)

- ***Question:*** **Does the DHS believe that the FY 2018 rates are sufficient to ensure equal access to quality child care services, particularly for the infant population?**

- ***Question:*** **In the three most recent fiscal years and thus far in FY 2018, how many child care providers receiving subsidies provided services for infants? Does the department see any correlation between the infant subsidy rate and the number of child care providers offering infant services?**

  DHS Response:

  States are required to conduct a market rate study (MRS) every three years. DHS Division of Family Development (DFD) is in the process of conducting a MRS. This MRS is due on July 1st, 2018. DFD implemented an across the board rate increase in January 2018 with a further quality-based rate increase slated for implementation in the late Spring. DFD estimates these rate increases will total $15 million in FY 2018 and in $15 million in FY 2019, supported with TANF funding.

  At this time, the Department does not have a waiting list for child care centers and is able to place children in care as soon as it is requested. The Department recognizes the importance of supporting services for infant care and structured the $15 million rate increase (both the across the board rate increase and the incentive rate increase) to provide higher rates for infant care.

  Thus far in FY 2018 approximately 4,985 Providers accept child care subsidies for infants. In FY 2017, 4,277 providers accepted child care subsidies for infants; and FY 2016, the total was 4,072 providers.

Work First New Jersey (WFNJ) and Emergency Assistance (EA)

32. As of January 1, 2016, the department is funding, on a limited basis, Intensive Case Management (ICM) programs for individuals who were enrolled in previous Emergency Assistance (EA) extension pilots. The ICM service is being provided as a contract modification on providers' Social Services for the Homeless program contracts. The ICM funding pays for staff to provide case management and limited rental subsidies. According to the department's response to a FY 2018 OLS Discussion Point, the total cost to provide ICM services was anticipated to be $4.0 million in FY 2017. As of March 2017, ICM programs had served 697 clients of which 341 were still receiving services.

- ***Question:*** **How many individuals were served through the ICM program in FY 2017 and thus far in FY 2018?**

- ***Question:*** **What were the outcomes for these individuals (Please provide a table similar to the one shown in response to FY 2018 OLS Discussion Point #48)?**

Discussion Points (Cont'd)

- ***Question:*** **What was the total spent on the ICM program, by county, in FY 2017, and thus far in FY 2018? What is the projected total in FY 2019?**

  DHS Response:

  From January 2016 through January 2018, the program has served 967 individuals.

OUTCOME	CY17	CY18 THRU JANUARY	TOTAL CASES
Entered an affordable housing programs (Section 8, local housing programs, State Rental Assistance Program, housing authority)	102	115	217
Income increase/Found work	70	61	131
**DFD funded State Rental Assistance Program vouchers	80	22	102
Found something affordable (more affordable apartment, room, boarding home)	37	42	79
Shared Arrangement/Family	100	98	195
Assisted living	11	6	17
Family supplementing income so client can remain in the Apartment	26	13	39
Landlord decreased rent	15	2	17
Voluntary quit from the program / lost contact / terminated for non-compliance	41	16	57
Moved out of state/country	17	1	18
Discharged after completing 6 months in the program	38	17	55
Referred back to board of social services (inappropriate referral/pending SSI)	22	9	31
Client passed away	7	0	7
Transferred to another ICM provider/county for continued services	2	0	2
TOTAL OUTCOMES	**568**	**399**	**967**

Discussion Points (Cont'd)

For period ending June 30th, 2017 DHS/DFD has spent $3.8 million on the ICM program. DHS/DFD estimates that it will spend $6.8 million in FY 2018 and FY 2019 on the ICM program. See Chart below for allocation by county.

COUNTY	SFY 2018 ICM ALLOCATION AMOUNT
ATLANTIC	$419,910
BERGEN	$934,170
BURLINGTON	$771,170
CAMDEN	$134,445
CAPE MAY	$289,410
CUMBERLAND	$152,856
ESSEX	$360,060
GLOUCESTER	$104,500
HUDSON	$131,530
HUNTERDON	$185,690
MERCER	$245,500
MIDDLESEX	$160,500
MONMOUTH	$84,500
MORRIS	$272,000
OCEAN	$875,910
PASSAIC	$1,024,880
SALEM	$33,000
SOMERSET	$324,530
SUSSEX	$192,530
UNION	$115,000
WARREN	$5,000
TOTAL	**$6,817,091**

33. According to a FY 2018 OLS Discussion Point response, the department anticipated launching a pilot program by the end of calendar year 2017 intended to provide up to 36 months of temporary housing assistance to individuals who have exhausted their allowable EA benefits, but have a pending application for Supplemental Security Income or Social Security Disability Insurance. The anticipated FY 2018 cost of the program was $15.65 million, with services to be provided to an estimated 1,260 individuals.

- ***Question:*** **Please provide a status update on the pilot program. How many individuals has the department served thus far, and at what cost to the State?**

Discussion Points (Cont'd)

- ***Question:*** **How many individuals does the department anticipate serving in FY 2019, and at what cost to the State?**

- ***Question:*** **What are the eligibility requirements for the program and what procedures are in place to assist participants in securing unsubsidized housing following the 36 months?**

- ***Question:*** **How is the pilot program different from the ICM program?**

  DHS Response:

  The pilot program, known as Provisional Housing - Awaiting SSI/SSD Eligibility (PHASE), officially launched on December 17, 2017. As of March 2018, 438 cases have been managed through the program, covering 19 counties. The average housing cost is $908 per month, per case. Although the program required start-up time and outreach and education in FY 2018, the Division anticipates further uptake in FY 2019.

  Eligibility for PHASE is based on the following: a) the exhaustion of all EA and applicable extensions; b) documentation of a valid medical deferral; c) a pending SSI application, and d) proof of legal representation for the SSI claim. The County Welfare Agency /Municipal Welfare Agency (CWA/MWA) is responsible for providing intensive case management in an effort to assist PHASE participants in securing affordable housing throughout the life of their participation in the program. Additionally, clients that are approved for SSI can receive an additional 3 months of assistance to locate housing.

  The PHASE pilot provides an EA time limit extension of up to 36 months to disabled WFNJ-TANF/GA clients who are pending an approval of their SSI/SSDI application or awaiting a decision on their appeal. The program responds to the lengthy amount of time that it takes to secure federal SSI approval and benefits, which can be a difficult period for individuals to manage.

  The ICM program is a current special initiative that serves SSI-EA clients who have exhausted 12 months of EA and both hardship extensions. Despite the client's SSI income, housing may still be unaffordable. The ICM program provides up to six months of additional rental assistance through a contracted vendor, who provides intensive case management by locating and facilitating placement in permanent affordable housing, such as shared living arrangements or subsidized housing and other services to the family.

Discussion Points (Cont'd)

34. Work First New Jersey (WFNJ)/Temporary Assistance for Needy Families (TANF) EA funding can be used to fund overnight stays in homeless shelters throughout the State (N.J.A.C.10:90-6.3). Advocates from homeless shelters have expressed concerns that the reduction in EA funding has reduced the revenue to the homeless shelters to a level which may affect their ability to operate. In response to an FY 2018 OLS Discussion Point, the department stated that homeless shelters received $11.7 million in EA funding in FY 2016. The Governor's FY 2019 Budget allocates $37.2 million in WFNJ/TANF EA, an increase of $1.6 million from the FY 2018 adjusted amount.

- ***Question:*** **How much EA funding was received by homeless shelters in FY 2017? How much is anticipated for FY 2018 and FY 2019?**

- ***Question:*** **Has the department considered an alternate funding source to ensure that homeless shelters can remain open and provide services adequate to meet needs, especially during economic downturns?**

  DHS Response:

  In FY 2017, DFD expended $9.7 million to place TANF recipients in shelters. Additionally, DFD expended $14.7 million in General Assistance funds for hotels/motels/shelters for GA clients.

  Emergency Assistance funding does not only support temporary housing and shelter, but is also used to prevent homelessness by paying back rent, mortgage and utilities, moving expenses, security deposits, and house furnishings and storage fees for eligible individuals. Emergency Assistance is not directly allocated to shelters; rather, in counties where homeless shelters are part of the Emergency Assistance program, shelter providers receive a per diem rate for individuals placed at the emergency shelter.

35. Pending legislation (A-1864/S-490) would eliminate the family cap on WFNJ/TANF benefits. Currently, the family cap, pursuant to N.J.S.A.44:10-61, prohibits a household from gaining additional cash assistance WFNJ/TANF benefits as a result of the birth of a child, unless the child is born fewer than 10 months after applying for benefits or the birth of the child is a result of rape or incest. Certain limited exceptions to the family cap are provided pursuant to N.J.A.C.10:90-2.18 for families with a working parent and for children born to minors.

Federal funds from the TANF program may be used to pay for part of the additional benefits provided under these bills. However, federal TANF funding is provided in the form of a block grant, so any federal funds used to support enhanced cash assistance benefits would be unavailable for other WFNJ/TANF-related spending, such as child care or emergency assistance.

- ***Question:*** **How many TANF households were affected by the family cap in each of the last five completed fiscal years?**

- ***Question:*** **What would be the estimated cost to the State to repeal the TANF family cap?**

Discussion Points (Cont'd)

DHS Response:

In FY 2018, from July 1, 2017 through January 31, 2018, 1,235 cases are affected, with a total number of 1,587 capped children. The estimated annual cost of including these children in the TANF benefit calculation under the current funding formula is $1.2 million.

Supplemental Nutrition Assistance Program (SNAP)

36. Prior to July 2014, the State had engaged in a practice called "heat & eat," whereby it had been making annual energy assistance payments of $1 of Low Income Home Energy Assistance Program (LIHEAP) funds to Supplemental Nutrition Assistance Program (SNAP, formerly known as food stamps) recipient households that were not enrolled in LIHEAP. This nominal payment qualified these households for a heating and cooling standard utility allowance under SNAP, which had the effect of increasing their monthly SNAP benefit which is provided completely by federal funds. Under the federal "Agricultural Act of 2014," the nominal fee that qualified SNAP recipients for the heating and cooling standard utility allowance was raised to an amount exceeding $20, at which point the State discontinued the "heat & eat" program.

Pending legislation (A-3010/S-839), which as of April 16, 2018 has passed both houses of the Legislature, would provide that every household that is eligible to receive benefits under SNAP must receive a minimum annual energy assistance payment of $21 in order to qualify the household for a heating and cooling standard utility allowance under SNAP. Under the bill, the annual $21 payment is to first be charged to the unexpended balance of federal funds available for LIHEAP, to the extent permitted by federal law and regulation. However, the President's federal FY 2019 Budget proposes the elimination of LIHEAP.

According to page 14 of the FY 2019 Budget in Brief, "The Governor's proposed budget includes funding to leverage available federal resources to provide over 140,000 New Jersey households with $86 million more in food assistance from the Supplemental Nutrition Assistance Program (SNAP)." Although not stated directly, the context and the numbers cited seem to suggest that this may refer to re-implementing "heat & eat."

According to Evaluation Data on page D-214, SNAP benefits are anticipated to increase by $75 million in FY 2019, with the average monthly benefit per person increasing by approximately $9.00.

- ***Question:*** **Does the Governor's FY 2019 Budget anticipate restoring the "heat & eat" program or a similar program to help households qualify for the heating and cooling standard utility allowance under SNAP? If so, are any additional State funds recommended for this purpose in FY 2019?**

- ***Question:*** **How many SNAP households would qualify for a heating and cooling standard utility allowance if the "heat & eat" program were reinstated pursuant to pending legislation? What is the total anticipated annual SNAP benefit increase for the State under the "heat & eat" program? What would be the average increase in monthly benefits per household?**

- ***Question:*** **In the absence of federal LIHEAP funds, what alternate energy assistance resources would the department use to reinstate the "heat & eat" program? What would**

Discussion Points (Cont'd)

be the cost to provide every household in the State that is eligible to receive benefits under SNAP with an annual energy assistance payment of $21?

DHS Response:

The restoration of Heat & Eat utilizes federal LIHEAP funding; therefore, the Governor's FY 2019 budget does not include any recommendation for state funds. The Department estimates that 140,355 SNAP households may be eligible for the higher utility allowance which could increase SNAP by an average of $50.24 for a total federal cost increase of $84.6 million in increased benefits for NJ recipients. The Department of Community Affairs is responsible for energy assistance; therefore, DHS doesn't anticipate using any resources to support this provision.

Supplemental Security Income (SSI)

37. The Governor recommends an appropriation of $19.5 million for the State Supplemental Security Income Administrative Fee in FY 2019 (page D-216). A footnote on page D-217 indicates that administration of the program will switch from the federal Social Security Administration to the State of Pennsylvania during FY 2019. A similar footnote in the FY 2017 and the FY 2018 Governor's Budgets had indicated the transition would occur during each respective fiscal year. This shift would not alter the value of SSI benefits provided to recipients. The Executive has estimated before that the shift would save about $6.0 million in annual administrative expenditures.

- ***Question:*** **What has caused the delay in transitioning SSI supplemental payments from administration by the federal government to Pennsylvania?**

- ***Question:*** **How does the FY 2019 Budget recommendation calculate the assumed savings related to the planned change of administration?**

  DHS Response:

  In working through the implementation processes, Pennsylvania and New Jersey identified issues that needed to be addressed which delayed the transition. New Jersey will now contract with the vendor on eligibility determinations since only NJ can authorize eligibility for NJ residents. Currently, PA and NJ-DHS representatives are meeting to finalize any remaining issues with the agreement.

  The FY 2017 Budget Recommendation included savings of $5.5 million, which is half of the projected annualized savings of $11 million. The FY 2018 and FY 2019 Budget recommendation do not show any additional savings but continue the reduced funding amount reflected in FY 2017.