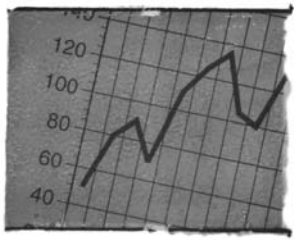

ANALYSIS OF THE NEW JERSEY BUDGET

DEPARTMENT OF HUMAN SERVICES

FISCAL YEAR 2011 - 2012

PREPARED BY OFFICE OF LEGISLATIVE SERVICES
NEW JERSEY LEGISLATURE • APRIL 2011

NEW JERSEY STATE LEGISLATURE

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DEPARTMENT OF HUMAN SERVICES

Budget Pages..... C- 6; C-13; C-21; C-25; C-27; D-163 to D-214; G-3 to G-4.

Fiscal Summary ($000)

	Expended FY 2010	Adjusted Appropriation FY 2011	Recommended FY 2012	Percent Change 2011-12
State Budgeted	$4,875,069	$4,847,281	$5,303,300	9.4%
Federal Funds	5,304,717	5,674,796	5,073,678	(10.6%)
Other	724,108	819,125	775,222	(5.4%)
Grand Total	$10,903,894	$11,341,202	$11,152,200	(1.7%)

Personnel Summary - Positions By Funding Source

	Actual FY 2010	Revised FY 2011	Funded FY 2012	Percent Change 2011-12
State	10,369	9,790	9,390	(4.1%)
Federal	4,778	4,981	5,060	1.6%
Other	46	48	49	2.1%
Total Positions	15,193	14,819	14,499	(2.2%)

FY 2010 (as of December) and revised FY 2011 (as of January) personnel data reflect actual payroll counts. FY 2012 data reflect the number of positions funded.

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

Highlights

The Administration will submit a Comprehensive Medicaid Waiver to the federal government. The FY 2012 recommended budget assumes savings of $225.0 million from this waiver. There is no waiver application available for review as of this writing.

The divisions directly or indirectly affected by the waiver are: Mental Health and Addiction Services; Medical Assistance and Health Services; Disability Services; and Developmental Disabilities. The waiver may also affect county welfare agencies and boards of social services which administer the Medicaid program and may also provide services that are reimbursed by Medicaid.

The submission of a Comprehensive Medicaid Waiver does not mean that the federal government will approve the waiver application, nor does it establish a time frame as to when the federal government will act upon the plan. In all likelihood, the application that is submitted will not be the document that may be approved. Discussions between the federal government and the State will likely result in significant changes to any document that is submitted.

Division of Mental Health and Addiction Services

- **Psychiatric Hospitals**. Recommended appropriations of $363.5 million incorporate $9.0 million in savings by closing a psychiatric hospital, either Hagedorn or Trenton by the end of FY 2012 based on the discussions of the New Jersey State Mental Health Facilities Evaluation Task Force.

  In FY 2012, the State hospitals are expected to provide services to about 1,630 patients. The overall number of funded positions will be reduced by 10.7%, to approximately 4,060 staff.

- **Direct State Services** (other than Psychiatric Hospitals) appropriations of $13.2 million are unchanged from FY 2011 levels.

- **Grants-in-Aid.** Total appropriations increase by $3.9 million, to $380.9 million as follows:

  Community Services for mental health increase by $5.6 million, to $342.1 million. An additional $10 million is recommended to develop 145 residential placements for patients currently at State hospitals and clients in the community. Funding of $2.0 million is provided to phase-in the involuntary outpatient commitment law, although no further details are provided. Offsetting these increases are approximately $6.5 million in various reductions and additional federal reimbursements.

  Addiction Services grant funding is reduced by $1.7 million, to $38.8 million. However, proposed budget language on D-176 would make up to $2.1 million in funds from the "Alcohol Treatment Programs Fund" for "general addiction programs" which may be used to offset the grant funding reduction.

Highlights (Cont'd)

- **State Aid** appropriations to reimburse county psychiatric hospitals are reduced by $13.1 million, to $131.7 million, based on "trends" associated with lower costs at county hospitals.

- **Federal Funds** decrease by $1.5 million, to $68.4 million. The reduction will not affect addiction or mental health services. Rather, the reduction involves federal funds awarded to the division for addiction services planning activities.

- **Other Funds** of $12.4 million are unchanged from FY 2011 levels. Most of these monies support addiction services programs.

Division of Medical Assistance and Health Services

- **Direct State Services** appropriations increase $4.4 million, to $32.6 million. The additional funds are for various data processing related activities handled by division and contracted personnel. Specifics regarding the increase are not available.

- **Grants-in-Aid.** Total appropriations increase by $346.7 million, from $2.442 billion to $2.789 billion. This assumes federal approval of a Comprehensive Medicaid Waiver valued at $225.0 million.

  Medicaid appropriations increase by $92.4 million, to $2.667 billion. (This amount excludes NJ FamilyCare, General Assistance Medical Services, other non-medical services expenditures, enhanced federal matching funds and Comprehensive Medicaid Waiver funds.)

  The $2.667 billion factors in increases based on existing expenditure and utilization trends and assumes $101.3 million in savings from various initiatives, of which the largest are: transitioning services and clients to managed care ($41.4 million) and fraud and settlement recoveries ($39.0 million).

  However, once the loss of enhanced federal matching funds and the projected impact of the Comprehensive Medicaid Waiver monies are considered, total Medicaid appropriations will increase by $364.0 million, to $2.44 billion.

  The recommended budget proposes to change the methodology by which Graduate Medical Education and Hospital Relief Offset Payments are distributed (budget language on pp. D-183 and D-184). The methodology by which pharmacies are reimbursed for prescription drugs would also change (budget language on pp. D-187 to D-188.)

  It is noted that approximately $1.1 billion is recommended for the Managed Care Initiative. After the FY 2012 recommended budget was released, the division's independent actuaries which propose the managed care reimbursement rates were asked to examine the proposed rates in light of the proposed expansion of managed care with respect to the additional persons that would be served and the additional services that would now be provided through managed care. It is possible that this review may result in additional funds being requested for the Managed Care Initiative later in the budget process.

Highlights (Cont'd)

Eligibility Determination Services and Health Benefits Coordination Services. These programs assist recipients in the eligibility process and in selecting an appropriate managed care program. The recommended budget requires most recipients to enroll in managed care and expands the array of services provided through managed care. Therefore, program costs are expected to increase by $7.7 million, to $22.7 million.

General Assistance (GA) Medical Services. State appropriations decrease by $50.8 million, to $74.7 million. The recommended budget assumes that the federal government will approve the State's request to incorporate the GA population in the Medicaid program. Efforts to obtain federal approval in FY 2010 and FY 2011 were not successful.

NJ FamilyCare – Affordable and Accessible Health Coverage Benefits. State appropriations increase by $25.8 million, to $249.6 million. Total program costs for both children and adults are expected to increase by $93.5 million, to over $1.08 billion.

Savings of $4.0 million are anticipated by eliminating coverage for certain adults in the program who are supported entirely with State funds. This may affect between 10,000 and 15,000 adults.

- **Federal Funds.** The overall amount of federal funds anticipated decreases by $434.2 million, to over $3.2 billion.

  In the Health Services Administration and Management program the amount of federal funds is expected to increase $29.2 million, to $117.4 million. The increase is attributable to data processing related activities as these type of costs may qualify for an increased federal administrative matching rate.

  The amount of federal funds for General Medical Services decrease by $463.4 million, to $3.1 billion, due to the loss of enhanced federal Medicaid matching funds plus $101.3 million in savings initiatives to reduce overall Medicaid costs previously discussed.

- **Other Funds** available to the division decrease $30.5 million, to $657.9 million. Available information indicates that the reduction is due to a shift in the allocation of Charity Care payments to hospitals between federal fund and Other Funds. As the overall amount of Charity Care funds being distributed will increase, this reduction will not affect the Charity Care program.

Division of Disability Services

- **Grants-in-Aid** appropriations (gross) increase by $10.0 million to $194.9 million and offset the loss of enhanced federal Medicaid reimbursement. The increase primarily affects the Payments for Medical Assistance Recipients – Personal Care program.

  The recommended budget incorporates Personal Care services within the array of services that managed care entities will provide in FY 2012 in an attempt to better control costs and utilization of services. Despite this, Personal Care appropriations (gross) are expected to increase from $304.7 million to $316.8 million.

Highlights (Cont'd)

- The $10.1 million reduction in **Federal Funds** to $188.7 million is due to the loss of enhanced federal Medicaid matching funds.

Division of Developmental Disabilities

The Direct State Services and Grants-in-Aid appropriations include approximately $220.7 million in State funds to offset the loss of enhanced federal Medicaid reimbursement and to replace other federal funds.

The net effect is that the State appropriation for the Division of Developmental Disabilities, including the developmental centers and community programs, will increase by $212.9 million in FY 2012, from $530.6 million to $743.5 million

- **Developmental Centers**. Recommended appropriations of $483.0 million (gross) are reduced by $15.7 million and incorporate $6.7 million in savings due to closing the Vineland Developmental Center over the next few years, census reduction at the developmental centers of 119 residents and various other personnel and administrative reductions.

  In FY 2012, over 2,500 residents will receive services at developmental centers, compared to nearly 2,650 in FY 2011.

- **Direct State Services** (Administration and Support Services and Community Programs) appropriations of $51.7 million (gross) represent an increase of about $1.0 million over FY 2011 levels. The total number of funded positions is reduced by 70, to 700.

- **Grants-in-Aid.** Gross appropriations increase $52.0 million to $991.1 million. The budget recommendation provides:

  Either $6.6 million or $8.1 million to begin the process of developing community placements for Vineland residents. (Two different amounts are cited in various budget documents.)

  An additional $13.0 million to annualize FY 2011 costs and to provide for various placements and services to clients on the waiting list or who are aging out of the school system.

  Savings of $2.3 million are anticipated by obtaining federal reimbursement for certain out-of-State placements.

- **Federal Funds** decrease by $176.2 million, to $730.7 million, due to the loss of enhanced federal Medicaid reimbursements and other federal funds. Most federal funds represent ICF/MR ($345.6 million) and Community Care Waiver ($353.4 million) revenues.

  Overall, $220 million in additional State funds are provided to offset the loss of enhanced federal Medicaid reimbursement ($124.4 million) and to replace other federal funds ($96.3 million).

Highlights (Cont'd)

- **Casino Revenue and Other Funds** anticipated are largely unchanged from FY 2011 levels: Casino Revenue Funds - $32.5 million and Other Funds - $52.1 million.

Commission for the Blind and Visually Impaired

- **Direct State Services** appropriations are reduced by $1.5 million, to $11.0 million. The reduction is in the Services for the Blind and Visually Impaired program ($8.7 million) and will reduce the number of funded positions by eight, to over 220. The department has indicated that 20 teaching positions are being eliminated.

  Despite the overall reduction in the number of positions supported by the program, available data do not indicate any reduction in the number of clients who will receive services.

- **Grants-in-Aid** ($3.3 million), **Federal Funds** ($13.4 million) and **Other Funds** ($0.6 million) are unchanged from FY 2011 levels.

Division of Family Development

- **Direct State Services** appropriations are reduced by over $2.0 million, to $149.0 million (gross). General Fund appropriations are unchanged at $40.2 million, while the amount of Federal Funds is reduced to $108.7 million.

  Though funding is reduced for the Work First New Jersey Technology Investment program, sufficient State and federal funds are available to continue the development and implementation of a new welfare computer system.

- **Grants-in-Aid.** Total appropriations decrease $49.0 million, to $460.8 million (gross), as General Fund and Other Fund appropriations are reduced by $32.4 million and $14.0 million, respectively.

  The largest grant reductions are in the Work First New Jersey Child Care program where appropriations are reduced by $43.1 million (gross) and Substance Abuse Initiatives program which is reduced by $2.5 million (gross). Savings of about $42.7 million are anticipated in the area of Child Care from administrative changes, caseload trends and additional co-payment revenues.

- **State Aid.** Total appropriations decrease $42.3 million, to $849.6 million.

  General Fund appropriations are reduced by $74.3 million, primarily due to a reductions in appropriations for the General Assistance program ($29.6 million), the Work First New Jersey - Client Benefits program ($48.7 million), and the Payments for Supplemental Security Income program ($3.4 million). Offsetting these reductions, appropriations for Food Stamp Administration - State increase $7.0 million.

  While the decrease in General Fund appropriations for Client Benefits is based on the amount of Federal Funds allocated in support of the program, the General Assistance reductions are based on changes to the overall program, including a $15.00 per month reduction in monthly benefits eligible clients receive. Under the proposal,

Highlights (Cont'd)

"employable" recipients would receive $125 per month and "unemployable" recipients would receive $195 per month.[1]

- **Federal Funds** increase by $27.4 million, to $827.1 million, and primarily represent funds from the following federal programs: Temporary Assistance to Needy Families, Child Care Block Grant and the Supplemental Nutrition Assistance Program (Food Stamps).

- **Other Funds** are unchanged at $5.1 million and support Child Care, the General Assistance and Work First New Jersey – Client Benefits programs.

Division of the Deaf and Hard of Hearing

- **Direct State Services** appropriations are unchanged at $1.0 million.

Division of Management and Budget

- **Direct State Services** appropriations decrease $21.3 million, to $32.7 million, as an FY 2011 supplemental appropriation for $22.0 million is not reflected.

- **Grants-in-Aid** appropriations are unchanged at $8.8 million.

- **Federal Funds** and **Other Funds** are largely unchanged at $27.8 million and $8.9 million, respectively.

Background Papers:

[1] Recipients would also be eligible for the Supplemental Nutrition Assistance Program (Food Stamps) and may see an increase in their Food Stamps benefits. It is not known whether the dollar increase in Food Stamps benefits will offset the $15 per month reduction in GA benefits.

Fiscal and Personnel Summary

AGENCY FUNDING BY SOURCE OF FUNDS ($000)

	Expended FY 2010	Adj. Approp. FY 2011	Recom. FY 2012	Percent Change 2010-12	Percent Change 2011-12
General Fund					
Direct State Services	$610,511	$567,250	$633,580	3.8%	11.7%
Grants-In-Aid	3,638,461	3,543,092	4,020,224	10.5%	13.5%
State Aid	490,299	606,482	519,039	5.9%	(14.4%)
Capital Construction	5,342	0		0.0%	0.0%
Debt Service	0	0	0	0.0%	0.0%
Sub-Total	**$4,744,613**	**$4,716,824**	**$5,172,843**	**9.0%**	**9.7%**
Property Tax Relief Fund					
Direct State Services	$0	$0	$0	0.0%	0.0%
Grants-In-Aid	0	0	0	0.0%	0.0%
State Aid	0	0	0	0.0%	0.0%
Sub-Total	**$0**	**$0**	**$0**	**0.0%**	**0.0%**
Casino Revenue Fund	$130,456	$130,457	$130,457	0.0%	0.0%
Casino Control Fund	$0	$0	$0	0.0%	0.0%
State Total	**$4,875,069**	**$4,847,281**	**$5,303,300**	**8.8%**	**9.4%**
Federal Funds	$5,304,717	$5,674,796	$5,073,678	(4.4%)	(10.6%)
Other Funds	$724,108	$819,125	$775,222	7.1%	(5.4%)
Grand Total	**$10,903,894**	**$11,341,202**	**$11,152,200**	**2.3%**	**(1.7%)**

PERSONNEL SUMMARY - POSITIONS BY FUNDING SOURCE

	Actual FY 2010	Revised FY 2011	Funded FY 2012	Percent Change 2010-12	Percent Change 2011-12
State	10,369	9,790	9,390	(9.4%)	(4.1%)
Federal	4,778	4,981	5,060	5.9%	1.6%
All Other	46	48	49	6.5%	2.1%
Total Positions	**15,193**	**14,819**	**14,499**	**(4.6%)**	**(2.2%)**

Actual payroll counts are reported for fiscal years 2010 as of December and revised fiscal year 2011 as of January. The Budget Estimate for fiscal year 2011 reflects the number of positions funded.

AFFIRMATIVE ACTION DATA

Total Minority Percent	59.5	59.5	59.5	----	----

Significant Changes/New Programs ($000)

Budget Item	Adj. Approp. FY 2011	Recomm. FY 2012	Dollar Change	Percent Change	Budget Page

The Administration will submit a Comprehensive Medicaid Waiver to the federal government. The FY 2012 recommended budget assumes savings of $225.0 million from this waiver. There is no waiver application available for review as of this writing.

The divisions directly or indirectly affected by the waiver are: Mental Health and Addiction Services: Medical Assistance and Health Services; Disability Services; and the Division of Developmental Disabilities. The waiver may also affect county welfare agencies and boards of social services which administer the Medicaid program and may also provide services that are reimbursed by Medicaid.

The submission of a Comprehensive Medicaid Waiver does not mean that the federal government will approve the waiver application or establish a time frame as to when the federal government will act upon the plan. In all likelihood, the application that is submitted will not be the document that may be approved. Discussions between the federal government and the State will likely result in significant changes to any document that is submitted.

Division of Mental Health and Addiction Services

Psychiatric Hospitals	**$374,005**	**$372,521**	**($1,484)**	**(.4%)**	**D-169**
Less Enhanced Federal Medicaid Matching Percentage	**(2,852)**		**n.a.**	**n.a.**	**D-169**
Institutional Closure Savings		**(9,000)**	**n.a.**	**n.a.**	**D-169**
Psychiatric Hospitals NET	**$371,153**	**$363,521**	**($7,632)**	**(2.1%)**	**D-169**

The FY 2011 recommended appropriation of $363.5 million incorporates $9.0 million in savings through the closing of a psychiatric hospital, either Hagedorn or Trenton.

Based on current census data, closing Hagedorn would affect 245 patients, while over 400 patients would be affected by the closing of Trenton.

Additional savings are anticipated by eliminating interpreter services at Ancora ($0.3 million) and eliminating the sick leave injury program ($1.8 million). Offsetting these reductions, an additional $2.9 million (net) in State funds are required to replace lost federal Medicaid funds.

The number of clients expected to receive services at State hospitals is expected to decline by over 100, to about 1,630. The number of staff at State hospitals is expected to decline by about 500, to 4,040.

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

Budget Item	Adj. Approp. FY 2011	Recomm. FY 2012	Dollar Change	Percent Change	Budget Page
Olmstead Support Services	**$55,919**	**$65,631**	**$ 9,712**	**17.4%**	**D-174**
Community Care	**$262,638**	**$258,563**	**($4,075)**	**(1.6%)**	**D-174**

The above appropriations incorporate various funding increases:

- An additional $10.0 million to develop 145 residential placements: State psychiatric hospital patients - 95 placements and community clients - 50 placements.
- $2.0 million to phase-in the implementation of the involuntary outpatient commitment law.

Savings of up to $6.5 million are anticipated as follows:

- New federal funds for community mental health services - $4.3 million.
- Mental health/addiction services contract reductions - $1.1 million.
- Partial care staffing reductions - $0.8 million.
- Short term care facilities reductions - $0.3 million.

The number of clients who receive community mental health services will increase from 302,100 to 304,300. Major community mental health expenditures include:

- Emergency/Screening Services - $52.9 million.
- Outpatient Services - $59.2 million.
- Partial Care - $16.3 million.
- Residential - $52.2 million.
- Supported Housing - $66.7 million.
- Integrated Case Management - $20.7 million.
- Program for Assertive Community Treatment - $17.7 million.

Community Based Substance Abuse Treatment and Prevention – State Share	**$26,198**	**$24,501**	**($1,697)**	**(6.5%)**	**D-174**

The recommended appropriation incorporates the following increases/decreases:

- An additional $0.6 million is provided to replace the loss of Alcohol Education, Rehabilitation and Enforcement Funds.
- Contract settlements are expected to save $2.1 million.
- Mental health/addiction services contract reductions will save $1.1 million.

The $24.5 million recommended appropriation may be supplemented by an additional $2.1 million from the "Alcohol Treatment Program Fund" for "general addictions programs."

Program Data indicates that in FY 2012, the number of persons who receive various substance abuse services will increase by 9,600 to 207,900.

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

Budget Item	Adj. Approp. FY 2011	Recomm. FY 2012	Dollar Change	Percent Change	Budget Page
Support of Patients in County Psychiatric Hospitals	**$144,808**	**$131,659**	**($13,149)**	**(9.1%)**	**D-175**

The $13.1 million reduction is based on "trends" due to lower costs at county psychiatric hospitals. However, Program Data indicates that the number of patients who receive services at county psychiatric hospitals has increased from about 650 (FY 2009) to nearly 680 (FY 2012).

Division of Medical Assistance and Health Services

Direct State Services	**$28,204**	**$32,616**	**$ 4,412**	**15.6%**	**D-180**

Additional funds are provided for data processing related activities in the areas of Services Other Than Personal ($0.2 million), Payment to Fiscal Agents ($7.0 million) and Additions, Improvements and Equipment ($0.2 million). The division is currently in the process of preparing a Request for Proposal concerning the provision of fiscal intermediary services.

Offsetting these increases, Personal Services expenditures are reduced by $3.0 million, even though the number of State funded positions will increase by 12, to 160.

Payments for Medical Assistance Recipients	**$2,574,216**	**$2,666,636**	**$92,420**	**3.6%**	**D-180 to D-181**
Less Enhanced Federal Matching Percentage	**(496,564)**		**n.a.**	**n.a.**	**D-180**
Comprehensive Medicaid Waiver		**(225,000)**	**n.a.**	**n.a.**	**D-180**
Net Payments for Medical Assistance Recipients	**$2,077,652**	**$2,441,636**	**$363,984**	**17.5%**	

Payments for Medical Assistance Recipients **EXCLUDES** the following programs: NJ FamilyCare, General Assistance Medical Services, Health Benefits Coordination and Eligibility Determination Services.

The initial Medicaid appropriation of $2.67 billion is based on existing Medicaid expenditure and utilization trends, offsets federal funds that did not materialize and reduced federal Medicaid reimbursement.

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

Budget Item	Adj. Approp. FY 2011	Recomm. FY 2012	Dollar Change	Percent Change	Budget Page

Offsetting this increase, $101.3 million in savings are applied, before savings of $225.0 million from the Comprehensive Medicaid Waiver:

- Transition services and clients to managed care - $41.4 million.
- Fraud and settlement recoveries - $39.0 million.
- Eliminate Medicaid coverage for certain Medicare Part D costs - $13.0 million.
- Enroll certain Medicaid recipients in Medicare special needs plans - $5.9 million.
- Eliminate annual hospital inflation factor - $2.0 million.

In addition, the methodology by which pharmacies are reimbursed for prescription drugs would change pursuant to budget language, D-187 to D-188. This change is intended to be "budget neutral."

Overall, assuming the State obtains federal approval of a Comprehensive Medicaid Waiver during FY 2012, State Medicaid costs would increase by nearly $364.0 million, to $2.44 billion. Most of the increase is related to the loss of enhanced federal Medicaid reimbursement.

Managed Care Initiative	**$1,070,047**	**$1,080,540**	**$10,493**	**1.0%**	**D-181**

This expenditure item is reflected in the Payments for Medical Assistance Recipients category discussed above. As was noted, approximately $41.4 million in savings are anticipated by increasing the number of persons who receive services through managed care rather than fee-for-service and by expanding the types of services provided through managed care.

The division's independent actuarial firm, which develop the managed care reimbursement rates, is reexamining the rates that had been developed in light of the budget proposals. It is possible that this review may result in additional funds being requested for the Managed Care Initiative later in the budget process.

Hospital Relief Offset Payments	**$62,645**	**$62,645**	**0**	**—**	**D-181**
Graduate Medical Education	**$30,000**	**$45,000**	**$15,000**	**50.0%**	**D-181**

These two expenditure items are reflected in the Payments for Medical Assistance Recipients category previously discussed. They are listed here because in FY 2012 the formulas by which these monies are distributed to hospitals is changed. The new distribution formulas are on pp. D-183 and D-184. Background Papers provide information as to the amounts individual hospitals will receive under the new formulas.

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

Budget Item	Adj. Approp. FY 2011	Recomm. FY 2012	Dollar Change	Percent Change	Budget Page
Eligibility Determination Services	**$5,716**	**$13,048**	**$ 7,332**	**128.3%**	**D-181**
Health Benefits Coordination Services	**$9,340**	**$9,689**	**$ 349**	**3.7%**	**D-181**

Program costs are expected to increase as most persons who are not enrolled in a managed care program will be required to enroll in a managed care program. This primarily affects the aged, blind and disabled population, along with children under the supervision of the Department of Children and Families. Also, as certain medical services that are not part of existing managed care plans will be incorporated into managed care, these programs will assist clients to find the most appropriate managed care plan.

General Assistance Medical Services	**$125,530**	**$74,711**	**($50,819)**	**(40.5%)**	**D-181**

The reduction in program costs assumes federal approval of a State Plan Amendment to incorporate General Assistance recipients into the Medicaid program.

The FY 2010 and FY 2011 appropriations acts had assumed federal approval to include this population group in Medicaid, but such approvals have not been received.

NJ FamilyCare-Affordable and Accessible Health Coverage Benefits	**$223,763**	**$249,588**	**$25,825**	**11.5%**	**D-181**

Total program costs are expected to increase from approximately $987.5 million to $1.08 billion: Children - $346.0 million; and Adults - $734.9 million.

The number of adults participating in the program is expected to increase from over 204,200 to 219,900 in FY 2012, despite the elimination of coverage for certain adults paid with 100% State funds. The elimination of coverage is expected to save $4.0 million. Available information is that between 10,000 – 15,000 adults may be terminated from NJ FamilyCare.

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

Budget Item	Adj. Approp. FY 2011	Recomm. FY 2012	Dollar Change	Percent Change	Budget Page
Division of Disability Services					
Payments for Medical Assistance Recipients – Personal Care TOTAL	**$148,428**	**$158,380**	**$ 9,952**	**6.7%**	
General Fund	**$70,723**	**$80,675**	**$ 9,952**	**14.1%**	**D-190**
Casino Revenue Fund	**$77,705**	**$77,705**	**0**	**—**	**D-190**

Overall program costs increase by $10.0 million despite efforts to control costs by requiring prior authorization of service and by reducing the hourly rate paid to services providers from $16.15 to $15.50.

In FY 2012, Personal Care services will be provided through managed care entities in an effort to control utilization and costs.

At present, between 25,000 – 27,000 persons receive services monthly.

Division of Developmental Disabilities

Approximately $220.7 million in State funds are included in Direct State Services and Grants-in-Aid accounts to offset the loss of enhanced federal Medicaid reimbursement ($124.4 million) and to replace other federal funds ($96.3 million).

Developmental Centers TOTAL	**$498,680**	**$482,987**	**($15,693)**	**(3.1%)**	**D-193**
General Fund	**35,766**	**128,187**	**$92,421**	**258.4%**	**D-193**
Federal	**462,914**	**$354,800**	**($108,114)**	**(23.4%)**	**D-193**

The recommended budget begins the process of closing the East Campus of the Vineland Developmental Center (VDC), affecting over 330 residents. Savings of $2.2 million are anticipated in FY 2012 due to the closing of the West Campus of VDC. Additional savings of $4.5 million will be achieved through reductions in overtime, the elimination of the sick leave injury program and less equipment spending.

For FY 2012, the developmental center census would decrease by about 120 residents, from approximately 2,650 (FY 2011) to 2,530 (FY 2012). Despite a reduction in the overall census at the developmental centers, the number of funded positions is expected to increase by 120, to 7,800.

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

Budget Item	Adj. Approp. FY 2011	Recomm. FY 2012	Dollar Change	Percent Change	Budget Page
Direct State Services: Administration and Support Services					
TOTAL	**$12,278**	**$12,538**	**$ 260**	**2.1%**	**D-195**
General Fund	**$4,338**	**$4,338**	**0**	**—**	**D-195**
Federal	**$7,940**	**$8,200**	**$ 260**	**3.3%**	**D-195**

Despite a $0.3 million increase in funding for Personal Services, the number of funded positions is expected to decrease by 20, to about 190.

Direct State Services: Community Programs					
TOTAL	**$38,387**	**$39,115**	**$ 728**	**1.9%**	**D-198**
General Fund	**$5,400**	**$5,400**			**D-198**
Federal	**$32,987**	**$33,715**	**$ 728**	**2.2%**	**D-198**

Funding levels for Purchased Residential Care ($4.4 million) and Adult Activities ($2.6 million) programs are unchanged. Recommended appropriations for the Social Supervision and Consultation program increase by over $0.6 million, to $32.0 million.

Despite the overall increase in funding, the number of funded positions decreases by 50, to over 520, even though there has been an overall increase in the number of persons with developmental disabilities who receive community services. Existing staff would also have to develop residential placements and related support services for some of the Vineland Developmental Center clients who may be placed into community programs.

Grants-in-Aid TOTAL	**$939,078**	**$991,069**	**$51,991**	**5.5%**	**D-199**
General Fund	**$452,031**	**$572,468**	**$120,437**	**26.6%**	**D-198 to D-199**
Federal	**$403,077**	**$334,028**	**($69,049)**	**(17.1%)**	**D-199**
Casino Revenue Fund	**$32,516**	**32,516**	**0**	**—**	**D-198 to D-199**
Other Funds	**$51,454**	**$52,057**	**$ 603**	**1.2%**	**D-199**

The overall Grants-in-Aid appropriation includes either $6.6 million or $8.1 million in Bridge Funding related to the Vineland Developmental Center Closure. (Available budget documents cite two different dollar amounts.)

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

Budget Item	Adj. Approp. FY 2011	Recomm. FY 2012	Dollar Change	Percent Change	Budget Page

Unlike past initiatives to close State institutions, there is no distinct line item that identifies funding related to Vineland's closure. Rather, the monies may be included in various Grants-in-Aid accounts such as Group Homes and Olmstead Residential Services.

Grants-in-Aid: Supervised Apartments TOTAL	**$87,475**	**$87,235***	**($ 240)**	**(.3%)**	**D-199**
General Fund	**$40,590**	**$52,743**	**$12,153**	**29.9%**	
Federal	**$46,885**	**$34,492**	**($12,393)**	**(26.4%)**	

* The total amount of funds available for Supervised Apartments, including monies from other programs, is $99.8 million.

Approximately 1,330 supervised apartments will be supported by the appropriation, at an average annual cost of nearly $75,300.

Grants-in-Aid: Supported Living TOTAL	**$25,056**	**$24,816***	**($ 240)**	**(1.0%)**	**D-199**
General Fund	**$11,570**	**$14,894**	**$ 3,324**	**28.7%**	
Federal	**$13,486**	**$9,922**	**($3,564)**	**(26.4%)**	

* The total amount of funds available for Supported Living, including monies from other programs, is $33.2 million.

Approximately 900 supported living slots will be available, at an average annual cost of over $37,100.

Grants-in-Aid: Community Services Waiting List Placements TOTAL	**$14,369**	**$16,824**	**$ 2,455**	**17.1%**	**D-199**
General Fund	**$10,055**	**$11,116**	**$ 1,061**	**10.6%**	
Federal	**$4,314**	**$5,708**	**$ 1,394**	**32.3%**	

The recommended appropriation will provide services to an additional 130 clients who are on the waiting list, and provides full year funding for placements initiated during FY 2011.

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

Budget Item	Adj. Approp. FY 2011	Recomm. FY 2012	Dollar Change	Percent Change	Budget Page
Grants-in-Aid: Private Institutional Care TOTAL	**$57,174**	**$52,674**	**($4,500)**	**(7.9%)**	**D-199**
General Fund	**$55,863**	**$51,363**	**($4,500)**	**(8.1%)**	**D-199**
Casino Revenue Fund	**$1,311**	**$1,311**	**0**	**—**	**D-199**

This appropriation represents costs associated with placements in out-of-State facilities and does not include costs associated with placements in private facilities within New Jersey.

The reduction in costs are due to the anticipated realization of federal reimbursement for a portion of out-of-State placement costs ($2.3 million), coupled with a reduction in the number of out-of-State placements. Program Data reflects a reduction of 20 placements, but does not differentiate between out-of-State or in-State placements. It is assumed that the reduction is in out-of-State placements as that has been the division's goal.

Grants-in-Aid: Group Homes TOTAL	**$407,435**	**$436,388***	**$28,953**	**7.1%**	**D-199**
General Fund	**$102,415**	**$193,698**	**$91,283**	**89.1%**	
Other Funds	**$51,454**	**$52,057**	**$ 603**	**1.2%**	
Casino Revenue Fund	**$20,354**	**$20,354**	**0**	**—**	**D-199**
Federal	**$233,212**	**$170,279**	**($62,933)**	**(27.0%)**	

* The total amount of funds available for Group Homes, including monies from other programs, is $508.6 million.

Approximately 5,300 group home slots will be supported by the appropriation, at an average annual cost of nearly $95,700.

Grants-in-Aid: Olmstead Residential Services TOTAL	**$60,978**	**$64,997**	**$ 4,019**	**6.6%**	**D-199**
General Fund	**$33,666**	**$43,523**	**$ 9,857**	**29.3%**	
Federal	**$27,312**	**$21,474**	**($5,838)**	**(21.4%)**	

In FY 2012, 113 developmental centers residents will be placed into community programs.

Information is not available as to how much of the $65.0 million appropriation is related to the closure of the Vineland Developmental Center, or how many of the 113 residents to be placed into community programs are from Vineland.

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

Budget Item	Adj. Approp. FY 2011	Recomm. FY 2012	Dollar Change	Percent Change	Budget Page

Monies from this account are subsequently transferred to other accounts, such as Group Homes, Supervised Apartments, and Adult Activities.

Grants-in-Aid: Emergency Placements TOTAL	**$7,973**	**$25,883**	**$17,910**	**224.6%**	**D-199**
General Fund	**$4,408**	**$9,608**	**$ 5,200**	**118.0%**	
Federal	**$3,565**	**$16,275**	**$12,710**	**356.5%**	

Information is not available as to the number of persons assisted by this program, the average cost per placements, or the reason why funding increases by nearly 225%, to $25.9 million (gross).

Grants-in-Aid: Day Program Age Outs	**$2,252**	**$5,886**	**$ 3,634**	**161.4%**	**D-200**

Information specific to this program such as how many clients will receive services is not available. Data are incorporated within the overall Adult Activities program.

In FY 2012, the number of contracted Adult Activity slots will increase by 400, to over 9,200, at an average cost of $20,700. Thus, the additional $3.6 million above would be adequate to support an additional 175 "age out" clients.

Commission for the Blind and Visually Impaired

Direct State Services: Services for the Blind and Visually Impaired	**$10,277**	**$8,747**	**($1,530)**	**(14.9%)**	**D-202**

Available information is that the Personal Services account, within the Services for the Blind and Visually Impaired program, is reduced by $1.5 million. The department has indicated that 20 teaching positions will be eliminated, though the number of funded positions is expected to decline by 11 from current levels, to nearly 280 positions.

Program Data indicate that the funding reduction will not affect services: There is no reduction in the number of clients who receive vocational rehabilitation, community, prevention and home instruction services in FY 2012.

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

Budget Item	Adj. Approp. FY 2011	Recomm. FY 2012	Dollar Change	Percent Change	Budget Page
Division of Family Development					
Direct State Services Total	**$150,939**	**$148,963**	**($1,976)**	**(1.3%)**	**D-206**
General Fund	**$40,212**	**$40,239**	**$ 27**	**.1%**	**D-206**
Federal	**$110,727**	**$108,724**	**($2,003)**	**(1.8%)**	**D-206**

The overall reduction is in the Work First New Jersey – Technology Investment account. The $78.0 million recommended for Technology Investment should be adequate, as together with available unexpended balances sufficient funds are available to continue development and implementation of a new welfare computer system known as CASS.

Grants-in-Aid: DFD Homeless Prevention Initiative TOTAL	**$3,974**	**$609**	**($3,365)**	**(84.7%)**	**D-207**
General Fund	**$752**	**0**	**($ 752)**	**(100.0%)**	
Federal	**$3,222**	**$609**	**($2,613)**	**(81.1%)**	

No information is provided concerning the reduction, but it may be related to the budget recommendation that "supplemental living support payments" to persons receiving Work First New Jersey benefits, be discontinued. Thus, Work First New Jersey recipients may not be able to receive assistance from the Homeless Prevention Initiative.

Grants-in-Aid: Work First New Jersey-Child Care TOTAL	**$353,844**	**$310,738**	**($43,106)**	**(12.2%)**	**D-207**
General Fund	**$121,817**	**$92,711**	**($29,106)**	**(23.9%)**	
Federal	**$187,027**	**$187,027**	**$0**	**--**	
Other Funds	**$45,000**	**$31,000**	**($14,000)**	**(31.1%)**	**D-207**

Overall funding is reduced by $43.1 million: General Fund - $29.1 million and Other Funds from the Workforce Development Partnership Fund -$14.0 million.

Available information is that the number of children that will receive child care services will decrease from about 55,700 to 53,600 per month. Most of the reduction is in the Abbott Child Care Services component of Child Care.

The recommended budget assumes $42.7 million in savings as follows:

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

Budget Item	Adj. Approp. FY 2011	Recomm. FY 2012	Dollar Change	Percent Change	Budget Page

- Caseload trends - $15.8 million.
- Replace vouchers with electronic benefit cards -$11.2 million.
- Requiring a parent to work a minimum of 25 hours of work per week to receive "wraparound" child care services - $6.0 million.
- Income eligibility equalization - $5.0 million.
- Convert contract slots to fee-for-service - $2.6 million.
- Equalize wrap-around child care co-payments - $2.1 million.

Information is not available as to how many families would be affected by the work requirement, the income eligibility equalization or the equalization of wrap-around child care payments.

Grants-in-Aid: Substance Abuse Initiative TOTAL	**$33,132**	**$30,632**	**($2,500)**	**(7.5%)**	**D-207**
General Fund	**$21,003**	**$21,003**	**0**	**—**	
Federal	**$12,129**	**$9,629**	**($2,500)**	**(20.6%)**	

The reduction in total appropriations is based on "caseload trends." Available data do not reflect any material reduction in the number of persons who are referred to and assessed by the program, and who are then referred to treatment services.

State Aid: County Administration Funding FEDERAL FUNDS	**$282,028**	**$271,193**	**($10,835)**	**(3.8%)**	**D-208**

This represents the amount of Federal Funds available to counties for administrative costs related to various federal programs administered by the counties. Information is not available as to why overall funding is reduced even though the number of persons who apply for and who are determined eligible for benefits has increased.

State Aid: Work First New Jersey – Client Benefits TOTAL	**$130,641**	**$121,616***	**($9,025)**	**(6.9%)**	**D-208**
General Fund	**$90,528**	**$41,818**	**($48,710)**	**(53.8%)**	
Federal	**$36,213**	**$75,898**	**$39,685**	**109.6%**	
Other Funds	**$3,900**	**$3,900**	**0**	**—**	

* The manner in which federal Temporary Assistance to Needy Family (TANF) funds are expended by the State for programs authorized by TANF is discretionary so long as the State meets its Maintenance of Effort obligation of over $300 million in State expenditures.

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

Budget Item	Adj. Approp. FY 2011	Recomm. FY 2012	Dollar Change	Percent Change	Budget Page

The recommended appropriation will assist approximately 107,000 recipients monthly, an increase from the monthly average of 104,300 persons (FY 2011). During January 2011, over 115,000 persons received assistance.

Pursuant to proposed budget language, the appropriation cannot be used to provide "supplemental living support payments." It is not clear whether this would prohibit payments for rental assistance and hotel/motel costs.

State Aid: General Assistance GRAND TOTAL	**$203,242**	**$173,607**	**($29,635)**	**(14.6%)**	
General Assistance Emergency Assistance Program	**$97,200**	**$81,740**	**($15,460)**	**(15.9%)**	**D-208**
General Fund	**$96,000**	**$80,540**	**($15,460)**	**(15.9%)**	
Other Funds	**$1,200**	**$1,200**	**0**	**—**	
Payments for Cost of General Assistance	**$106,042**	**$91,867**	**($14,175)**	**(13.4%)**	**D-208**

The General Assistance (GA) program is to be restructured and would save either $30.8 million or $31.6 million. (Available budget documents cite two different figures.) An additional $1.4 million would be saved based on "caseload trends."

New GA applicants would be required to "undergo job search and . . . substance abuse treatment during an initial evaluation period." Recipients would receive monthly case assistance and 18 months of emergency assistance.

Benefits would be reduced by $15.00 per month: "employable" GA recipients would receive $125 per month, rather than $140 per month; and "unemployable" GA recipients would receive $195 per month, rather than $210 per month. Further, "unemployable" recipients would have to provide medical evidence that they are unable to work for at least six continuous months. (It is not clear whether this requirement applies to persons who have applied for and are awaiting a decision on federal Social Security Disability benefits or SSI benefits.)

Also, none of the GA appropriation can be expended on "supplemental living support payments." Again, it is not known whether this would prohibit payments for rental assistance and hotel/motel costs.

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

Budget Item	Adj. Approp. FY 2011	Recomm. FY 2012	Dollar Change	Percent Change	Budget Page

Overall, in FY 2012, a monthly average of 60,500 GA recipients are expected to receive benefits, a 5,300 increase from the monthly average of 55,200 that receive benefits in FY 2011. In February 2011, over 55,900 persons were enrolled in the program.

State Aid: Work First New Jersey – Emergency Assistance FEDERAL	**$98,647***	**$101,828***	**$ 3,181**	**3.2%**	**D-208**

* The manner in which federal Temporary Assistance to Needy Family (TANF) funds are expended by the State for programs authorized by TANF is discretionary so long as the State meets its Maintenance of Effort obligation of over $300 million in State expenditures. The State has decided to use federal TANF funds exclusively to provide Emergency Assistance benefits.

The recommended appropriation would provide assistance to 20,700 persons monthly during FY 2012, a small increase from FY 2011 levels of 20,100.

Although the number of persons who receive Emergency Assistance on a monthly basis may vary significantly, in January 2011, 21,000 persons received assistance.

State Aid: Payments for Supplemental Security Income	**$89,545**	**$86,089**	**($3,456)**	**(3.9%)**	**D-208**

Appropriations are reduced by about $3.5 million, to $86.1 million, based on "trends." Program Data indicates that the number of persons who receive State supplemental payments and emergency assistance will increase in FY 2012.

The number of persons who receive monthly supplemental payments is expected to increase from 172,000 to over 178,700, while the number of persons who receive emergency assistance will increase to over 2,300 per month. In January 2011, nearly 171,800 persons received supplemental payments and 2,100 persons received emergency assistance.

State Aid: Food Stamp Administration - State	**$17,225**	**$24,225**	**$ 7,000**	**40.6%**

The actual administration of the federal Supplemental Nutrition Assistance Program (Food Stamps) is handled by the counties. Between December 2008 – December 2010, the number of persons who receive benefits increased 51%, from approximately 474,800 to 715,700. The increase in the number of persons applying for and receiving Food Stamps has increased county administrative expenditures.

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

Budget Item	Adj. Approp. FY 2011	Recomm. FY 2012	Dollar Change	Percent Change	Budget Page
Division of Management and Budget					
Direct State Services	**$53,968**	**$32,670**	**($21,298)**	**(39.5%)**	**D-212**

Recommended appropriations decrease by $21.3 million, as a (pending) FY 2011 $22.0 million supplemental appropriation for Personal Services ($7.6 million), Materials and Supplies ($0.8 million), and Maintenance and Fixed Charges ($13.6 million) is not continued.

Available Information is that the $22.0 million supplemental appropriation is required to address a "shortfall." While no explanation is provide as to the reasons for this "shortfall" it is noted that the level of Federal Funds projected for Administration and Support Services in FY 2011 was revised from $52.8 million to $27.6 million.

Significant Language Changes

The Governor's FY2012 recommended budget eliminates many language provisions that are procedural in nature, since they are unnecessary or duplicative of authority provided in General Provisions to the Director of the Division of Budget and Accounting.

Rather than list all these language provisions and explain why these language provisions are no longer necessary, the focus of this section will be on language provisions that have policy implications or which have significant fiscal implications.

Mental Health Services

2011 Appropriations Handbook	**2012 Recommended Budget**
p. B-99.	
An amount not to exceed $1,408,000 may be transferred from the Payments for Medical Assistance Recipients - Nursing Homes account in the Department of Health and Senior Services to the Division of Mental Health and Addiction Services for the continuation of services at the Senator Garrett W. Hagedorn Gero-Psychiatric Hospital, subject to the approval of the Director of the Division of Budget and Accounting.	No comparable language provision.

Explanation

The language was included in the FY 2011 appropriations act to provide additional funds to the Hagedorn Hospital after it was decided not to close Hagedorn during FY 2011. The language is not needed in FY 2012.

Division of Mental Health and Addiction Services

2011 Appropriations Handbook	**2012 Recommended Budget**
p. B-94.	p. D-176.
Notwithstanding the provisions of any law or regulation to the contrary, in addition to the amount hereinabove appropriated for Community Based Substance Abuse **continued on the next page)**	Notwithstanding the provisions of any law or regulation to the contrary, monies in the "Alcohol Treatment Programs Fund" established pursuant to section 2 of P.L.2001, **continued on the next page)**

Significant Language Changes (Cont'd)

2011 Appropriations Handbook	2012 Recommended Budget
Treatment and Prevention - State Share, an amount not to exceed $575,000 is appropriated from the unexpended balances of fees paid into the Alcohol Education, Rehabilitation and Enforcement Fund to support the Intoxicated Driving Program Unit, subject to the approval of the Director of the Division of Budget and Accounting.	c.48 (C.26:2B-9.2), not to exceed$2,147,000, (may be used for general addiction programs in the Division of Mental Health and Addiction Services.

Explanation

In FY 2010, up to $575,000 in unexpended balances from the Alcohol Education and Enforcement Fund was available to support the Intoxicated Driving Program. The FY 2011 language is being replaced by language that would permit the use of over $2.1 million in Alcohol Treatment Programs funds for various addiction programs, including the Intoxicated Driving Program. Sufficient unexpended balances should remain from FY 2011 to support this cost shift.

2011 Appropriations Handbook	2012 Recommended Budget
p. B-94. An amount not to exceed $2,057,000 may be transferred from the Olmstead Support Services account in the Division of Mental Health Services, to the Health Care Subsidy Fund Payments account in the Department of Health and Senior Services, to increase the Mental Health Subsidy Fund portion of this account in order to maintain the fiscal 2008 per bed allocation for Short-Term Care Facility (STCF) beds, for new STCF beds which opened between January 1, 2008 and June 30, 2011 subject to the approval of the Director of the Division of Budget and Accounting.	p. D-176 Similar language, except that the June 30, 2011 date has been changed to reference new beds that open by June 30, 2012 and the amount to be transferred has been increased to $2,490,000.

Explanation

The $2,490,000 is the estimated amount that will be transferred to the Department of Health and Senior Services for financial assistance for Short-Term Care Facilities in FY 2012.

Significant Language Changes (Cont'd)

2011 Appropriations Handbook	2012 Recommended Budget
p. B-95.	
The unexpended balance in the Community Care Account at the end of the preceding fiscal year in an amount not to exceed $3,000,000 is appropriated for a capital project to St. Clare's Health System, subject to the approval of the Director of the Division of Budget and Accounting for a project consisting of capital improvements to remediate life safety problems at Saint Clare's Hospital-Boonton, subject to the entering of a capital agreement between the Department of Human Services and St. Clare's Health System which shall provide, among other things, that the provision of the State monies is contingent upon St. Clare's Health System providing an amount of its own funds sufficient to complete the project subject to approval by the Department of Human Services.	No comparable language provision.

Explanation

This language provided financial assistance to St. Clare's Health System for certain one-time capital improvements. The language is not required in FY 2012.

Division of Medical Assistance and Health Services

The following language provision has been reformatted for readability purposes.

2011 Appropriations Handbook	2012 Recommended Budget
p. B-102.	p. D-183.
Notwithstanding the provisions of any law or regulation to the contrary, those hospitals that are eligible to receive a Hospital Relief Subsidy Fund (HRSF) payment as hereinabove appropriated in the Payments for Medical Assistance Recipients - Inpatient **continued on the next page)**	Notwithstanding the provisions of any law or regulation to the contrary, the amount hereinabove appropriated to Hospital Relief Offset payments is conditioned upon the following: those hospitals that are eligible to receive a Hospital Relief Subsidy Fund **continued on the next page)**

Significant Language Changes (Cont'd)

2011 Appropriations Handbook	2012 Recommended Budget
Hospital program may receive enhanced payments from the Medicaid program for providing services to Medicaid and NJ FamilyCare beneficiaries. The total payments shall not exceed the amount appropriated and shall be allocated among hospitals proportionately based on the amount of HRSF payments (excluding any adjustments to the HRSF for other Medicaid payment increases). Interim payments shall be made from the Hospital Relief Offset Payment account, based on an estimate of the total enhanced amount payable to a qualifying hospital, and subject to cost settlement. The enhanced payment, determined at cost settlement, shall be an amount approved by the Director of the Division of Budget and Accounting per Medicaid patient day, adjusted by a volume variance factor (the ratio of expected Medicaid inpatient days to actual Medicaid inpatient days for the rate year) and an HRSF factor (the ratio of the hospital's HRSF payments to total HRSF payments) and subject to a pro rata adjustment so that the total enhanced per diem amounts are equivalent to the total State and federal funds appropriated not to exceed an amount to be approved by the Director of the Division of Budget and Accounting. The total of these payments shall be reduced by an amount equal to any increase in Medicaid and NJ FamilyCare fee-for-service payments to New Jersey hospitals enacted herein or subsequent to this legislation.	(HRSF) payment may receive enhanced payments for providing services to Medicaid and NJ and NJ FamilyCare beneficiaries. The HRSF payment shall be an amount approved by the Director of the Division of Budget and Accounting, determined for Acute Care hospitals and is to be distributed using a new formula effective July 1, 2011. The new formula shall be based on hospital Medicaid utilization compared to industry-wide utilization for behavioral health, substance abuse, pregnancy, childbirth, and newborn services. Methodology for determining this payment is based on a HRSF factor for all acute care general hospitals, expressed as a percentage and is defined as the sum of Medicaid primary discharges for Medicaid and NJ FamilyCare program (Title XIX and Title XXI respectively from the Social Security Act) fee-for-service and encounter (HMO) claims for all DRGs Major Diagnostic Categories (MDCs) 14, 15, 19, and 20 (as specified in the All Patient Diagnosis Related Groups Patient Classification System Definitions Manual in published by 3M Health Information Systems), excluding discharges from Medicaid Excluded units, divided by the industry-wide sum of these discharges. The aforementioned discharge count will be obtained for each hospital using the most recent calendar year of data available for which the Division has 24 months of paid claims data as of February 1 the year prior to the subsidy payment year. The HRSF factor for each hospital is then multiplied by the total appropriated HRSF amount, to arrive at the hospital's individual allocation. The division will use a phase-in process to transition to the new methodology over a three year period (State Fiscal Year 2012 – 2014). During the transition period, the allocation will be determined using a sum of the previous three State Fiscal Year (SFY) **continued on the next page)**

Significant Language Changes (Cont'd)

2011 Appropriations Handbook	2012 Recommended Budget
	allocation amounts plus the allocation amounts calculated for the new year, using the new formula. The hospital four year sum is divided by the sum of the four year allocation for all hospitals to arrive at a percent to total. This percent is multiplied by the total HRSF amount. The new one year methodology will be implemented beginning SFY 2015. These total enhanced allocated amounts shall be equal to the total State and federal funds appropriated and are not to exceed an amount to be approved by the Director of the Division of Budget and Accounting.

Explanation

The formula by which Hospital Relief Offset Payments are distributed is being revised. A Background Paper provides information as to the amount each hospital will receive in FY 2012 under the new formula, compared to the amount received in FY 2011 under the old formula.

The following language provision has been reformatted for readability purposes.

2011 Appropriations Handbook	2012 Recommended Budget
p. B-102.	pp. D-183, D-184.
Notwithstanding the provisions of any law or regulation to the contrary, for those hospitals that qualify for a Hospital Relief Subsidy Fund payment the State Medicaid program may reimburse those hospitals Graduate Medical Education outpatient payments up to the amount the hospital would have received under Medicare principles of reimbursement for Medicaid and NJ FamilyCare fee-for-service beneficiaries. Payments shall be made from and are hereinabove appropriated in the Payments for Medical **continued on the next page)**	The amount hereinabove appropriated to Graduate Medical Education is conditioned upon the following: Effective July 1, 2011, the new GME allocation shall be calculated based on the sum of Medicaid Primary (Title XIX of the Social Security Act) and Enhanced FamilyCare Part A Inpatient fee-for-service payments (Net of Administrative Payments and Medicaid Excluded unit payments) and data from the hospital's most recent available submitted cost report as of February 1 the **continued on the next page)**

Significant Language Changes (Cont'd)

2011 Appropriations Handbook	2012 Recommended Budget
Assistance Recipients - Inpatient Hospital account, and shall be based on the qualifying hospitals first finalized 1996 cost reports. The amount that the qualifying hospital would otherwise be eligible to receive from the Hospital Relief Subsidy Fund shall be reduced by the amount of this Graduate Medical Education outpatient payment. The total amount of these payments shall not exceed an amount approved by the Director of the Division of Budget and Accounting in combined State and federal funds. In no case shall these payments and all other enhanced payments related to those services primarily used by Medicaid and NJ FamilyCare beneficiaries that the hospital receives exceed the amount the hospital would otherwise have been eligible to receive from the Hospital Relief Subsidy Fund in the State fiscal year. Notwithstanding the provisions of any law or regulation to the contrary, commencing at the beginning of the current fiscal year, of the amounts hereinabove appropriated to Payments for Medical Assistance Recipients - Inpatient Hospital, distribution of the Graduate Medical Education (GME) Medicaid payment to eligible acute care teaching hospitals shall not include federal funds without federal approval. GME shall be distributed using the same methodology as was used in State fiscal year 2008.	year prior to the subsidy payment year for acute care general hospitals. The aforementioned hospital payments will be obtained using the hospital's most recent fiscal year of data for which the Division has 24 months of paid claims data prior to February 1 of the year prior to the rate year. An Indirect Medical Education (IME) Factor is calculated for each Medicaid identified acute care general hospital using a ratio of net available beds (less nursery beds) to submitted IME Resident Resident Full Time Equivalencies (FTEs) and the Medicare IME formula. This IME factor is applied to the above mentioned Medicaid and FamilyCare Part A payments to obtain a hospital specific IME payment. Each Medicaid identified acute care general hospital's IME payment amount is then divided by the sum of all Medicaid identified acute care general hospitals to arrive at a percent to total. This percentage is multiplied by the total appropriated GME amount to determine the hospital's individual allocation. The Division will use a phase-in process to transition to the new methodology over a three-year period (SFY 2012-2014). During the transition period, the allocation amount will be determined using a sum of the previous three state fiscal year (SFY) allocation amounts plus the allocation amount calculated for the new year using the new formula. This hospital four year sum is divided by the sum of the four year allocation for all hospitals to arrive at a percent to total. This percent is multiplied by the total appropriated GME amount. The new one year methodology will be implemented beginning SFY 2015. The total amount of these payments shall not exceed an amount approved by the Director of the Division of Budget and Accounting in combined State and federal funds.

Significant Language Changes (Cont'd)

Explanation

The formula by which GME funds are distributed is being revised. Under the revised formula, additional hospitals will be eligible to receive GME funds. A Background Paper provides information as to the amount each hospital will receive in FY 2012 under the new formula, compared to the amount received in FY 2011 under the old formula.

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p. B-103.

Notwithstanding the provisions of any law or regulation to the contrary, the NJ FamilyCare program benefit service packages, premium contributions, copayment levels, enrollment levels, and any other program features or operations may be modified as the Commissioner of Human Services deems necessary based upon a plan approved by the Director of the Division of Budget and Accounting to ensure that monies expended for the NJ FamilyCare program do not exceed the amount hereinabove appropriated.

Notwithstanding the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), to the contrary, the Commissioner of Human Services shall adopt immediately upon filing with the Office of Administrative Law such regulations as the Commissioner deems necessary to ensure that monies expended for the NJ FamilyCare program do not exceed the amount hereinabove appropriated. Such regulation may change or adjust the financial and non-financial eligibility requirements for some or all of the applicants or beneficiaries in the program, the benefits provided, cost-sharing amounts, or may suspend in whole or in part the processing of applications for any or all categories of individuals covered by the program.

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p. D-187

Notwithstanding the provision of any law or regulation to the contracy, the amount hereinabove appropriated to NJ FamilyCare – Affordable and Accessible Health Coverage Benefits are subject to the following conditions:

(a) as of August 1, 2011, or at such later data as shall be determined by the Commissioner as needed to administratively effectuate these requirements, all existing enrollments as of such date shall be terminated for all single adults or couples without dependent children and there shall be no new enrollments for such persons after such date for those: (i) whose family gross income does not exceed 100% of the poverty level; and (ii) who were enrolled in the NJ FamilyCare program on January 9, 2006, who are currently enrolled in NJ FamilyCare, and are ineligible for Medicaid.

(b) as of August 1, 2011, or at such later data as shall be determined by the Commissioner as needed to administratively effectuate these requirements, enrollment of parents who were enrolled in the New Jersey Health ACCESS program on October 31, 2001, and are currently enrolled in

the NJ FamilyCare program, shall be

(continued on the next page)

Significant Language Changes (Cont'd)

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	terminated and there shall be no future enrollment of such persons in the NJ FamilyCare program. (c) as of August 1,2011, or at such later date as shall be determined by the Commissioner as needed to administratively effectuate these requirements, enrollment of single adults or couples without dependent children who were enrolled in the New Jersey Health ACCESS program on October 31, 2001, and who are currently enrolled in the NJ FamilyCare program shall be terminated and there shall be no future enrollments of such persons in the NJ FamilyCare program. as of July 1, 2011, all parents or caretakers whose application to enroll in the NJ FamilyCare program were received on or after March 1, 2010: (i) whose gross family income does not exceed 200% of the poverty level; (ii) who have no health insurance, as determined by the Commissioner of Human Services; and (iii) who are ineligible for Medicaid shall not be eligible for enrollment in the NJ FamilyCare program and there shall be no future enrollments of such persons in the NJ FamilyCare program.as of July 1, 2011, any adult alien lawfully admitted for permanent residence, but who has lived in the United States for less than five full years after such lawful admittance and whose enrollment in the NJ FamilyCare program was terminated on or before July 1, 2010 shall not be eligible to be enrolled in the NJ FamilyCare program, provided, however, that this termination of enrollment and benefits shall not apply to such persons who are either (i) pregnant or (ii) under the age of 19.

Significant Language Changes (Cont'd)

Explanation

The new language provision replaces FY 2011 language provisions and would terminate NJFamilyCare coverage for various groups of adults whose costs are supported entirely with State funds. This will save $4.0 million.

The groups of adults affected by this language includes: (1) single and married adults without dependent children with income under 100% of the federal poverty level (FPL); (2) grandfathered-in recipients of NJ ACESS, a program that was ended in 2001; (3) parents and caretakers whose income is below 200% FPL who are not eligible for Medicaid and whose application for NJ FamilyCare was receive on or after March 1, 2010; and (4) lawfully admitted adult aliens who were terminated from NJ FamilyCare on or before July 1, 2010. Available information is that this may affect between 10,000 and 15,000 persons.

2011 Appropriations Handbook	**2012 Recommended Budget**
p. B-103.	p. D-184
Of the amount hereinabove appropriated for the NJ FamilyCare program, there shall be transferred to various accounts, including Direct State Services and State Aid accounts, such amounts, not to exceed $9,000,000, as are necessary to pay for the administrative costs of the program, subject to the approval of the Director of the Division of Budget and Accounting.	Similar language except the amount is now $6,000,000.

Explanation

The amount available for transfer from the NJ FamilyCare account for administrative costs of the program is reduced from $9.0 million to $6.0 million. No information has been provided as to whether the $3.0 million reduction will affect the overall administration of the program.

Significant Language Changes (Cont'd)

2011 Appropriations Handbook	2012 Recommended Budget
p. B-103.	
Premiums received from families enrolled in the NJ FamilyCare program established pursuant to P.L.2005, c.156 (C.30:4J-8 etal.) are appropriated for NJ FamilyCare payments.	No comparable language provision.

Explanation

Available information is that the FY 2011 language provision was omitted in error from the FY 2012 recommended budget. The Administration will attempt to correct the error during the budget process.

The following language provision has been reformatted for readability purposes.

2011 Appropriations Handbook	2012 Recommended Budget
p. B-104.	pp. D-187, D-188.
Notwithstanding the provisions of any law or regulation to the contrary, and subject to the notice provisions of 42 CFR 447.205 where applicable, no funds appropriated for prescription drugs in the Payments for Medical Assistance Recipients - Prescription Drugs or General Assistance Medical Services (account shall be expended except under the following conditions: (a) reimbursement for the cost of all legend and non-legend drugs shall be calculated based on lesser of the Average Wholesale Price less a volume discount not to exceed 17.5% as shall be determined by the Commissioner and the Director of the Division of Budget and Accounting; the federal Maximum Allowable Cost; the State Maximum Allowable Cost; or a pharmacy's usual and customary charge; (b) the current prescription drug dispensing fee structure set as a variable rate of $3.73 to $3.99 shall remain in effect through the **(continued on the next page)**	Notwithstanding the provisions of any other law or regulation to the contrary, and subject to the notice provisions of 42 CFR 447.205 where applicable, the amounts hereinabove appropriated for fee-for-service prescription drugs in the Payments for Medical Assistance Recipients – Prescription Drug or General Assistance Medical Services account are subject to the following conditions: (1) through August 31, 2011 (a) reimbursement for the cost of all legend and non-legend drugs shall be calculated based on the lowest of: (i) the Average Wholesale Price less a volume discount not to exceed 17.5% as shall be determined by the Commissioner and the Director of the Division of Budget and Accounting; or (ii) the federal upper limit (FUL); or (iii) the state upper limit (SUL); or **(continued on the next page)**

Significant Language Changes (Cont'd)

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current fiscal year, including the current increments for impact allowances as determined by revised qualifying requirements and allowances for 24-hour emergency services; and (c) in the absence of a drug cost comparison program, multisource generic and single source brand name drugs shall be dispensed without prior authorization but multisource brand name drugs shall require prior authorization issued by the Division of Medical Assistance and Health Services or its authorizing agent; however, a 10-day supply of the multisource brand name drug shall be dispensed pending receipt of prior authorization. Certain multisource brand name drugs with a narrow therapeutic index, other drugs recommended by the Drug Utilization Review Board or brand name drugs with lower cost per unit than the generic, may be excluded from prior authorization by the Division of Medical Assistance and Health Services.

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(iv) a pharmacy's usual and customary charge; and
(b) the current prescription drug dispensing fee structure set as a variable rate of $3.73 to $3.99 shall remain in effect through August 31, 2011;
(2) on or after September 1, 2011
(a) drug cost for all legend and non-legend single source, brand name multi-source, and multi-source drugs shall be calculated based upon, in the discretion of the Commissioner:
(i) cost acquisition data submitted by providers, suppliers, and/or wholesalers of pharmaceutical services for single source, brand-name multi-source and multi-source drugs; or
(ii) the wholesale acquisition cost (WAC) less a one percent volume discount for single-source and multi-source brand name drugs; or
(iii) the lesser of the SUL or FUL for multi-source drugs;
(3) on or after September 1, 2011, drug reimbursement shall be calculated, in the discretion of the Commissioner, based on either
(i) the lesser of the acquisition data from providers, suppliers and/or wholesalers for single source, brand-name multi-source, and multi-source drugs plus a professional fee or a provider's usual and customary charge; or
(ii) the lesser of WAC less one percent plus a dispensing fee of $3.73 to $3.99 for single-source and multi-source brand name drugs or a provider's usual and customary charge; or
(iii) the lesser of SUL or FUL plus $3.73 to $3.99 for multi-source drugs or a provider's (usual or customary charge.
In the absence of acquisition data on or after September 1, 2011, reimbursement shall be based on the lesser of 3.ii or 3.iii above.
To effectuate the purposes of this paragraph which is intended to be budget neutral, the Department of Human Services shall mandate ongoing submission of current drug acquisition data by providers, suppliers,

(continued on the next page)

Significant Language Changes (Cont'd)

2011 Appropriations Handbook	2012 Recommended Budget
	and/or wholesalers of pharmaceutical services for reimbursement of dispensing or administering single source, brand-name multi-source, and multi-source drugs, and no funds hereinabove appropriated shall be paid to any entity that fails to submit required data.

Explanation

The proposed language amends the methodology by which pharmacies are reimbursed for fee-for-service drugs in the Medicaid program. (This change would also affect drugs dispensed in the PAAD and Senior Gold programs.)

While the change in how pharmacies are reimbursed for fee-for-service prescription drugs is intended to be "budget neutral," the Office of Legislative Services cannot verify this claim.

It is noted that the budget language imposes considerable reporting requirements on "providers, suppliers, and/or wholesalers of pharmaceutical services" as a condition of obtaining reimbursement. Assuming that this information is provided, it is not known what additional costs the State will incur to process the information. Further, the extent to which affected entities will be willing to share this type of business data is not known, even if not submitting the data will result in a loss of reimbursement. While similar information may be submitted to the federal government, the information is considered proprietary and the federal government does not share this information with states.

It is noted that there may be very few recipients who are left in the fee-for-service program as most recipients would be required to enroll in a managed care program.

2011 Appropriations Handbook	2012 Recommended Budget
p. B-104.	
Of the amount hereinabove appropriated for Payments for Medical Assistance Recipients - Prescription Drugs, such sums as are necessary are available for payment of Medicare Part D copayments and for certain pharmaceuticals not included in Medicare Part D prescription plan formularies for those individuals who are dually eligible for **(continued on the next page)**	No comparable language provision.

Significant Language Changes (Cont'd)

2011 Appropriations Handbook	2012 Recommended Budget
Medicaid and Medicare. These funds shall only be available to cover copayments and non-formulary drugs to pharmacies participating in the federal Medicare Part D program. Payments for pharmaceuticals not included in the Part D formularies may be subject to prior authorization. The Department of Human Services may require proof of appeal or may appeal the Medicare Part D formulary decision on behalf of a dual-eligible client.	

Explanation

As a result of deleting the FY 2011 appropriations act language, Medicaid will: (a) no longer pay Medicare Part D co-payments on behalf of Medicaid recipients who have co-payments; and (b) no longer cover drugs that are not on a Medicare Part D formulary. This is expected to reduce prescription drug cost by $13.0 million and shift those costs to Medicaid recipients who are enrolled in the Medicare Part D program.

2011 Appropriations Handbook	2012 Recommended Budget
No comparable language provision.	p. D-187. Notwithstanding the provisions of any law or regulation to the contrary, of the amounts hereinabove appropriated in Managed Care Initiative, Payments for Medical Assistance Recipients - Dental Services, and NJ FamilyCare – Affordable and Accessible Health Coverage Benefits, comprehensive orthodontic treatment benefits for Plan A children under the age of 21 and Plan B, C and D Children under the age of 19 shall be limited to the correction of handicapping malocclusion, trauma or disease resulting in functional difficulties in speech and mastication, cleft palate and lip and/or craniofacial anomalies and deformities, and services required by federal law. Malposed teeth having a profound effect on the child's psychological development, if extreme, may **(continued on the next page)**

Significant Language Changes (Cont'd)

2011 Appropriations Handbook	2012 Recommended Budget
	be at the discretion of the Division in individual cases be considered handicapping.

Explanation

The FY 2011 appropriations act had eliminated orthodontic services for children, except in certain circumstances. The proposed language clarifies when such orthodontic services may be provided.

The following language provision has been reformatted for readability purposes.

2011 Appropriations Handbook	2012 Recommended Budget
	p. D-187.
No comparable language provision.	Notwithstanding the provision of any other law or regulation to the contrary, and subject to any federal approval that may be necessary, the amounts hereinabove appropriated in the Managed Care Initiative account are subject to the following condition: Effective July 1, 2011, assuming receipt of any applicable federal approval, the following services, which were previously covered by Medicaid fee-for-service, shall be covered and provided instead through a managed care delivery system for all clients served by and/or enrolled in that system: 1) home health agency services for the Aged, Blind , and Disabled (ABD) populations as well as individuals who are dually eligible for Medicaid and Medicare; 2) medical day care, including both adult day health services and pediatric medical day care; 3) personal care assistant services; **(continued on the next page)**

Significant Language Changes (Cont'd)

2011 Appropriations Handbook	2012 Recommended Budget
	4) prescription drugs for the ABD population as well as for individuals who are dually eligible for Medicaid and Medicare; and rehabilitation services, including occupational, physical, and speech therapies.

Explanation

The proposed language shifts various medical services that are currently reimbursed on a fee-for-service basis within the overall services provided by managed care organizations. The services to be shifted to managed care includes: home health services for the aged, blind, and disabled and Medicare-Medicaid dual eligibles; adult and pediatric medical day care; personal assistant services; prescription drugs for the aged, blind, and disabled and dual eligibles; and occupational, physical and speech therapy services. This is expected to save $41.4 million.

2011 Appropriations Handbook	2012 Recommended Budget
	p. D-187.
No comparable language provision.	Notwithstanding the provisions of any law or regulation to the contrary, of the amounts hereinabove appropriated to Payments for Medical Assistance Recipients – Inpatient Hospitals, effective January 1, 2012 the Medicaid Inpatient Fee-For-Service payment rates will not be adjusted to incorporate the annual excluded hospital inflation factor, also referred to as the economic factor recognized under the CMS TEFRA target limitations.

Explanation

The proposed language provision provides that hospitals would not receive an inflation adjustment in 2012. Savings of $2.0 million are anticipated as a result of this action.

Significant Language Changes (Cont'd)

The following language provision has been reformatted for readability purposes.

2011 Appropriations Handbook	**2012 Recommended Budget**
	p. D-187.
No comparable language provision.	Notwithstanding the provisions of any law or regulation to the contrary, and subject to any federal approval that may be necessary, the amounts hereinabove appropriated in the Managed Care Initiative account are subject to the following conditions: only the following individuals shall be excluded from mandatory enrollment in the Medicaid/NJ FamilyCare managed care program: 1) individuals who are institutionalized in an inpatient psychiatric institution, a long-term care nursing facility, or an inpatient psychiatric program for children under the age of 21 or in a residential facility including facilities characterized by the federal government as ICFs/MR, except that individuals who are eligible through DYFS and are placed in a DYFS non-Joint Committee on Accreditation of Healthcare Organizations (JCAHO) accredited children's residential care facility and individuals in a mental health or substance abuse residential treatment facility shall not be excluded from enrollment pursuant to this paragraph; 2) individuals in out-of-state placements; 3) special low-income Medicare beneficiaries (SLMBs); and individuals in the Program of All-Inclusive Care for the Elderly (PACE) program.

Explanation

The FY 2012 recommended budget will require various Medicaid beneficiaries, primarily the aged, blind and disabled, to enroll in a managed care program. This requirement, along with incorporating additional services into managed care, is expected to save $41.4 million.

The proposed language identifies those groups that will not be required to enroll in a managed care program. They include: individuals in psychiatric facilities, nursing homes, and ICF/MR

Significant Language Changes (Cont'd)

facilities; individuals in out-of-State facilities; individuals who qualify as "special low-income Medicare beneficiaries"; and elderly individuals enrolled in the PACE program.

2011 Appropriations Handbook	2012 Recommended Budget
	p. D-188.
No comparable language provision.	The amount hereinabove for Payments for Medical Assistance Recipients – Prescription Drugs and General Assistance Medical Services accounts is available to pay supplemental pharmacy payments to pharmacies in recognition of reduced claim payments for prescription drugs impacted by the First Data Bank Average Wholesale Price settlement, using drug utilization information and calculations to determine supplemental payments reflecting the differences in reimbursement resulting from the settlement.

Explanation

The First Data Bank Average Wholesale Price settlement (2009) resulted in a reduction in the published Average Wholesale Price for many drugs and would have reduced State prescription drug payments. The proposed changes to how prescription drugs are reimbursed in the fee-for-service program would result in a reduction in the amount pharmacies are reimbursed for prescription drugs. As the intent of the new prescription drug reimbursement policy is that it be "budget neutral," the proposed language would allow the two referenced accounts to make supplemental pharmacy payments.

Information is not available as to the amounts that may be transferred from these two accounts for supplemental payments.

Significant Language Changes (Cont'd)

Division of Developmental Disabilities

2011 Appropriations Handbook	2012 Recommended Budget
p. B-115.	p. D-194.
The State appropriation for the State's developmental centers is based on ICF/MR revenues of $322,552,000 provided that if the ICF/MR revenues exceed $322,552,000, an amount equal to the excess ICF/MR revenues may be deducted from the State appropriation for the developmental centers, subject to the approval of the Director of the Division of Budget and Accounting.	Similar language,except that the amount of federal ICF/MR revenues the State expects to realize is $345,584,000.

Explanation

The recommended budget anticipates a $23 million increase in federal ICF/MR revenues, to $345.6 million.

The basis for this estimated increase in federal revenue estimate is unclear as the overall census of the developmental centers is to be reduced by 120 residents during FY 2012 and personnel related costs at the developmental centers is unlikely to increase in FY 2012.

2011 Appropriations Handbook	2012 Recommended Budget
p. B-109.	p. D-194.
An amount not to exceed $223,000 from receipts from individuals for whom the Division of Developmental Disabilities in the Department of Human Services collects contribution to care reimbursements is appropriated for participation in the Foster Grandparents and Senior Companions programs.	Similar language, except the amount has been reduced to $60,000 and reference to Foster Grandparents is eliminated.

Explanation

Administration of the Foster Grandparent program was transferred from the Department of Human Services to the Department of State. The language is amended to reflect the transfer of the program.

Significant Language Changes (Cont'd)

2011 Appropriations Handbook	2012 Recommended Budget
p. B-110, B-111	p. D-200.
Cost recoveries from skill development homes during the current fiscal year, not to exceed $12,500,000, are appropriated for the continued operation of the Skill Development Homes program, subject to the approval of the Director of the Division of Budget and Accounting.	Cost recoveries from developmentally disabled consumers collected during the current fiscal year, not to exceed $52,057,000, are appropriated for the continued operation of the Group Homes program, subject to the approval of the Director of the Division of Budget and Accounting.
Cost recoveries from developmentally disabled consumers collected during the current fiscal year, not to exceed $38,954,000, are appropriated for the continued operation of the Group Homes program, subject to the approval of the Director of the Division of Budget and Accounting.	

Explanation

The two language provisions that deal with cost recoveries realized on behalf of persons with developmentally disabilities are consolidated into one language provision. Elimination of the language provision that deals with Skill Development Homes should have no impact as persons in such settings are considered "developmentally disabled consumers."

2011 Appropriations Handbook	2012 Recommended Budget
p. B-111.	p. D-200.
Notwithstanding the provisions of any law or regulation to the contrary, $321,411,000 of federal Community Care Waiver funds is appropriated for community-based programs in the Division of Developmental Disabilities. The appropriation of federal Community Care Waiver funds above this amount is **(continued on the next page)**	Similar language, except the amount of Community Care Waiver revenues expected to be realized is $352,425,000.

Significant Language Changes (Cont'd)

2011 Appropriations Handbook	2012 Recommended Budget
conditional upon the approval of a plan submitted by the Department of Human Services that must be approved by the Director of the Division of Budget and Accounting.	

Explanation

The $352.4 million figure, an increase of $31.0 million from FY 2011, represents the amount of federal Community Care Waiver revenues the State expects to realize for community programs provided to persons with developmentally disabilities. How much of the $31.0 million increase reflects additional persons who receive waiver services and how much reflects retroactive rate adjustments is not known.

2010 Appropriations Handbook	2012 Recommended Budget
p. B-110.	
Of the amount hereinabove appropriated for Addressing the Needs of the Autism Community, $500,000 is appropriated to the Autism Center at the University of Medicine and Dentistry of New Jersey - New Jersey Medical School.	No comparable language provision.

Explanation

The Autism Center at UMDNJ received $500,000 of the $4.0 million Addressing the Needs of the Autism Community appropriation in FY 2011. In FY 2012, the entire $4.0 million appropriation will be available for services to the autism community, as UMDNJ will not receive any monies from the appropriation.

2011 Appropriations Handbook	2012 Recommended Budget
p. B-111.	
Expenditure of funds appropriated for Private Institutional Care shall be condition on the **(continued on the next page)**	No comparable language provision.

Significant Language Changes (Cont'd)

2011 Appropriations Handbook	2012 Recommended Budget
following: on or before January 1, 2011, the Commissioner of the Department of Human Services shall prepare and submit a report to the Governor and Legislature addressing out-of-State placements of persons with disabilities. The report shall address the Department's efforts to repatriate these persons into New Jersey private community settings. The report shall set forth a plan to increase repatriation of out-of-State placements into private community based settings. The plan will set forth a course of action to repatriate no less than 50% of the current population of out-of-State placements into New Jersey community based programs, but only where such placements would be in the best interests of the persons with disabilities. The report shall include, but not be limited to, the following information: (1) the number of persons with developmental disabilities currently living in out-of-State facilities; (2) the annual cost of each person by placement in each out-of-State facility; (3) the number of persons who were relocated from an out-of-State facility to an in-State placement during fiscal year 2010 and the average cost of such placement; (4) the strategy for redirecting additional persons who are awaiting relocation to out-of-State facilities by developing alternative in-State community placements; (5) the number of new persons who were placed in out-of-State facilities during fiscal year 2010 and the reason for such placement; and (6) the number of persons who are not willing to relocate from out-of-State facilities and the reasons such persons do not wish to relocate. The report shall be general in nature and shall not disclose the names or any other private information about particular clients.	

Explanation

The budget language had been included in the FY 2011 appropriations act by the Legislature to obtain a report on out-of-State placements. As a report was submitted on the subject, the language is not continued.

Significant Language Changes (Cont'd)

Division of Family Development

2011 Appropriations Handbook	2012 Recommended Budget
p. B-118.	p. D-209.
Notwithstanding any law or regulation to the contrary, in addition to the amounts hereinabove for the Work First New Jersey Child Care, an amount not to exceed $45,000,000 is appropriated from the Workforce Development Partnership Fund established pursuant to section 9 of P.L.1992, c.43 (C.34:15D-9), subject to the approval of the Director of the Division of Budget and Accounting.	Similar language, except the amount has been reduced to $31,000,000.

Explanation

The FY 2012 recommended budget provides $310.7 million (gross) for Child Care, including $31.0 million from the Workforce Development Partnership Fund. In FY 2011, $45.0 million was provided by the Workforce Development Partnership Fund. The decreased transfer from the fund reflects cost reduction measures totaling $42.7 million in the program.

Available information is that in FY 2012, approximately 53,600 children will receive child care services, compared to 55,700 in FY 2011. The reduction will primarily affect children who receive "Abbott" wraparound child care services.

2011 Appropriations Handbook	2012 Recommended Budget
p. B-118.	
Notwithstanding the provisions of any law or regulation to the contrary, in addition to the amounts hereinabove appropriated for Work First New Jersey Support Services, an amount not to exceed $20,000,000 may be appropriated from the Workforce Development Partnership Fund established pursuant to section 9 of P.L.1992, c.43 **(continued on the next page)**	No comparable language provision.

Significant Language Changes (Cont'd)

2011 Appropriations Handbook	2012 Recommended Budget
(C.34:15D-9) to the Division of Family Development for Work First New Jersey Support Services in the event federal funding is reduced pursuant to work participation requirements as specified in section 7102 of the federal Deficit Reduction Act of 2005 (Pub.L.109-171), subject to the approval of the Director of the Division of Budget and Accounting.	

Explanation

Under the FY 2011 budget language, the $76.9 million State and federal appropriation for Work First New Jersey Support Services could be supplemented with up to $20 million in funds from the Workforce Development Partnership Fund. As the language is not continued in FY 2012, the total amount available for Support Services will be $76.9 million. The adequacy of the $76.9 million to provide Support Services to eligible recipients is not known.

2011 Appropriations Handbook	2012 Recommended Budget
p. B-118.	p. D-209.
Notwithstanding the provisions of any law or regulation to the contrary, no funds hereinabove appropriated for before-school, after-school and summer "wrap around" child care shall be expended except in accordance with the following condition: Effective September 1, 2010, families with incomes between 101% and 250% of the federal poverty level who reside in districts who received Preschool Expansion Aid or Education Opportunity Aid in the 2007-2008 school year shall be subject to a co-payment for "wrap around" child care, based upon a schedule approved by the Department of Human Services and published in the New Jersey Register, and effective September 1, 2010, families who reside in districts who received Preschool Expansion Aid or Education Opportunity Aid in the 2007-2008 **(continued on the next page)**	Notwithstanding the provisions of any law or regulation to the contrary, no funds hereinabove appropriated for before-school, after-school and summer "wrap around" child care shall be expended except in accordance with the following condition: Effective September 1, 2010, families with incomes between 101% and 250% of the federal poverty level who reside in districts who received Preschool Expansion Aid or Education Opportunity Aid in the 2007-2008 school year shall be subject to a co-payment for "wrap around" child care, based upon a schedule approved by the Department of Human Services and published in the New Jersey Register, and effective September 1, 2010, families who reside in districts who received Preschool Expansion Aid or Education Opportunity Aid in the 2007-2008 **(continued on the next page)**

Significant Language Changes (Cont'd)

2011 Appropriations Handbook	2012 Recommended Budget
school year must meet the eligibility requirements under the New Jersey Cares For Kids child care program (N.J.A.C. 10:15-5.1 et. seq.) in order to receive free or subsidized "wrap around" child care, except that families enrolled for their first year of "wrap around" child care during the 2009-2010 school year will be exempt from the work requirement and the revised income eligibility criteria.	school year must meet the eligibility requirements under the New Jersey Cares For Kids child care program (N.J.A.C. 10:15-5.1 et. seq.) in order to receive free or subsidized "wrap around" child care.

Explanation

The FY 2011 budget language had exempted families enrolled for their first year of Abbott "wrap around" child care during the 2009 -2010 school year from the work requirement and the revised income eligibility criteria to determine any co-pay due. In FY 2012, the proposed language would eliminate this exemption, and thus all families would be subject to the work requirements and co-pays.

Approximately $2.1 million will be generated as a result of these co-pays, though it is not known how many families will be affected by this requirement.

2011 Appropriations Handbook	2012 Recommended Budget
	p. D-210.
No comparable language provision.	Notwithstanding the provisions of any law or regulation to the contrary, no fund hereinabove appropriated for Payments for the Cost of General Assistance shall be expended except in accordance with the following conditions: The fiscal 2012 monthly cash benefit level shall be reduced by $15.00 from the fiscal 2011 monthly cash benefit level for both employable and unemployable recipients; no funds shall be expended for supplemental living support payments; and individuals applying for benefits as an unemployable recipient must prove they are medically unable to work for six continuous months.

Significant Language Changes (Cont'd)

Explanation

The proposed language would:

- Reduce benefits for approximately 42,800 "employable" recipients from $140 per month to $125 per month;
- Reduce benefits for approximately 17,700 "unemployable" recipients from $210 per month to $195 per month;
- Prohibit payments for "supplemental living supports"; and
- Require unemployable recipients to document that they are "medically unable to work for six continuous months" in order to be considered unemployable.

It is not clear whether "supplemental living supports" includes temporary rental assistance payments, housing in hotels/motels or rent payments. Whether unemployable GA recipients who have applied for either federal Social Security Disability benefits or federal SSI benefits would have to provide medical documentation that they are unable to work for six continuous months is not clear.

2011 Appropriations Handbook	**2012 Recommended Budget**
	p. D-210.
No comparable language provision.	Notwithstanding the provisions of any law or regulations to the contrary, no funds hereinabove appropriated for Work First New Jersey – Client Benefits shall be expended for supplemental living support payments.

Explanation

The proposed language would prohibit the Work First New Jersey – Client Benefits appropriation to be used for "supplemental living supports".

It is not clear whether "supplemental living supports" includes temporary rental assistance payments, housing in hotels/motels or rent payments.

Significant Language Changes (Cont'd)

Division of Management and Budget

2011 Appropriations Handbook	2012 Recommended Budget
p. B-120.	p. D-213
Revenues representing receipts to the General Fund from charges to residents' trust accounts for maintenance costs are appropriated for use as personal needs allowances for patients/residents who have no other source of funds for these purposes; except that the total amount herein for these allowances shall not exceed $1,375,000 and any increase in the maximum monthly allowance shall be approved by the Director of the Division of Budget and Accounting.	Similar language, except that the amount referenced is $750,000.

Explanation

The amount of funds appropriated for personal needs allowances of patients/residents, who have no other source of funds, in State institutions is reduced from approximately $1.4 million to $750,000. Although no information has been provided regarding this reduction, the $750,000 amount may reflect the actual amount of funds required to provide personal needs allowances to patients/residents at State institutions.

Department of Human Services (General)

2011 Appropriations Handbook	2012 Recommended Budget
p. B-121.	p. D-214.
In order to effectuate the orderly consolidation of the West Campus of the Vineland Developmental Center, amounts hereinabove appropriated for the Vineland Developmental Center may be transferred to accounts throughout the Department of Human Services in accordance with the plan adopted pursuant to section 2 of P.L.1996, c.150 (C.30:1-7.4) to consolidate the West Campus of the Vineland Developmental Center and subject to the approval of the Director of the Division of Budget and Accounting.	In order to effectuate the orderly consolidation or closure of a developmental center or psychiatric hospital, amounts hereinabove appropriated for the state developmental centers and state psychiatric hospitals may be transferred to accounts throughout the Department of Human Services in accordance with the plan adopted pursuant to section 2 of P.L.1996, c.150 (C.30:1-7.4) to consolidate or close a developmental center or state psychiatric hospital, subject to approval of the Director of the Division of Budget and Accounting.

Significant Language Changes (Cont'd)

Explanation

The amended language would enable the use of the $367.0 million psychiatric hospital appropriation and the $483.0 million developmental center appropriation to facilitate the closing of a developmental center and a psychiatric hospital.

The Vineland Developmental Center has been designated as the developmental center that will close, while no specific psychiatric hospital has been designated. Available information indicates that either the Hagedorn or Trenton facility may be closed.

Discussion Points

Department of Human Services – General

1.a. According to the NJ Comprehensive Annual Financial Report (CAFR), in FY 2010, $80.6 million in Patients' and Resident Cost Recoveries from the psychiatric hospitals was realized, compared to the $88.1 million that had been anticipated.

- ***Question:*** **What accounts for the $7.5 million shortfall?**

1.b. The CAFR report indicates that in FY 2010 approximately $20.1 million and $80.6 million, respectively, had been recovered on behalf of developmental centers and psychiatric hospitals. Schedule 1 of the FY 2012 recommended budget lists $15.3 million and $85.4 million, respectively.

- ***Question:*** **What accounts for the different amounts cited in CAFR and Schedule 1?**

2.a. The FY 2011 recommended budget estimated that $268.2 million in Medicaid Uncompensated Care – Acute and $126.4 million in Medicaid Uncompensated Care – Psychiatric would be realized in FY 2010. Actual amounts realized were $301.1 million (Acute) and $176.6 million (Psychiatric) according to Schedule 1.

- ***Question:*** **What accounts for the increase in Medicaid Uncompensated Care revenues on behalf of Acute and Psychiatric hospitals in FY 2010?**

2.b. Despite an overall increase in FY 2012 Charity Care funding, Schedule 1 indicates that Medicaid Uncompensated Care – Acute revenues will decrease from $288.4 million (FY 2011) to $222.6 million (FY 2012).

- ***Question:*** **What accounts for reduction in Medicaid Uncompensated Care – Acute revenues?**

3.a. The department had previously reserved about $51.3 million in General Fund School-Based Medicaid revenue to repay the federal government for an audit disallowance for School-Based Medicaid services.

- ***Question:*** **What is the status of the federal disallowance?**

3.b. The FY 2011 recommended budget estimated FY 2010 and FY 2011 School Based Medicaid Revenues at $1.4 million, for each year (Schedule 1).

The FY 2012 recommended budget indicates that actual FY 2010 School Based Medicaid Revenues were $27.1 million. The FY 2010 CAFR cites $20.2 million in School-Based Medicaid revenues.

- ***Questions:*** **What accounts for the $25.7 million increase in FY 2010 School Based Medicaid revenues between what was initially reported and what was actually realized? What accounts for the $6.9 difference between what CAFRA and Schedule I reports as the amount of School Based Medicaid revenues realized in FY 2010?**

Discussion Points (Cont'd)

3.c. The FY 2012 recommended budget indicates $13.5 million in School Based Medicaid Revenues compared to an initial estimate of $1.4 million. Available Medicaid data indicates that in FY 2011 over $18 million in federal School Based Medicaid revenues may be realized.

- ***Questions:*** **What accounts for the $12.1 million increase in projected School Based Medicaid revenues in FY 2011? As available Medicaid data indicates that over $18 million in federal School Based Medicaid revenues will be realized, is the $13.5 million estimate identified in Schedule 1 understated?**

4. P.L.2009, c.220 requires the department to conduct a minimum of 500 random drug tests on direct care staff at developmental centers and psychiatric hospitals.

- ***Question:*** **How many drug tests were conducted? What were the findings of those random drug tests with respect to the use of illegal substances among direct care staff?**

Division of Mental Health and Addiction Services

5.a. At the end of December 2010, the FY 2010 Direct State Services account for Addiction Services had encumbered funds of approximately $8.6 million.

- ***Question:*** **Is the $8.6 million in encumbered funds still valid?**

5.b. At the end of December 2010, the FY 2010 the Direct State Services accounts at the following State psychiatric hospitals had $0.9 million in encumbered funds as follows:

- Greystone - $0.2 million.
- Trenton - $0.2 million.
- Forensic - $0.2 million.
- Ancora - $0.3 million.

- ***Question:*** **Are these encumbered funds still valid?**

5.c. At the end off December 2010, the FY 2010 Community Care account had $2.6 million in encumbered funds.

- ***Question:*** **Is the $2.6 million in encumbered funds still valid?**

5.d. At the end of December 2010, various FY 2010 Grants-in-Aid accounts, including the Community Based Substance Abuse Treatment and Prevention – State Share account, had $2.1 million in encumbered funds.

- ***Question:*** **Is the $2.1 million in encumbered funds still valid?**

6.a. During FY 2009, the Addiction Services program initiated 26 audits.

- ***Questions:*** **Have all the audits been completed? How much was recovered?**

Discussion Points (Cont'd)

6.b. By July 1, 2009, the Addiction Services program was to implement an "encounter module" to minimize or eliminate possible double billing between services funded by the division and similar services provided by other divisions.

- ***Questions:*** **Was the "encounter module" implemented? How much in potential double billings were avoided as a result of the system?**

6.c. At one time, the Addiction Services program anticipated $1.0 million in federal Medicaid administrative reimbursement.

- ***Questions:*** **What is the status of the attempt to obtain Medicaid funding? How much, if any, Medicaid revenues were realized?**

7. Approximately in $20.7 million is provided for Integrated Case Management and $17.7 million is provided for Program for Assertive Community Treatment services.

When a patient is discharged from a State hospital and certain other facilities, the patient may be enrolled in one of the two programs. If the person is incarcerated or admitted to a State or county hospital, the program must continue to provide these services to such individuals. During this six month period, the agency is not reimbursed by the State, and the agency cannot bill Medicaid for services (if the client is Medicaid eligible).

When an individual is incarcerated, the agency that provides services can determine whether the person will be jailed or hospitalized for more than six months. In cases where the client will be incarcerated or hospitalized more than six months, terminating such clients would make services available to new clients, some of whom can be billed to Medicaid.

- ***Question:*** **Should current ICMS/PACT policy be amended to provide services to other clients, some of whom may be billed to Medicaid?**

8.a. To hold UMDNJ's University Behavioral Healthcare Centers (UBHC) accountable for monies provided by the division and to ensure that UBHC accounted for its mental health expenditures and revenues, budget language has been included as to the types of financial reports and other documentation UBHC must provide as a condition of receiving funds.

- ***Questions:*** **Has UBHC provided all necessary and appropriate financial reports requested by the division? Is UBHC accounting for its mental health related expenditures and revenues appropriately? If not, what actions have been taken to correct the financial reporting problems?**

8.b. In FY 2011, $3.5 million in savings were anticipated by adjusting high unit cost community mental health provider agency contracts to the median unit cost for that service. Services provided by UBHC fall into the high unit cost category due to UBHC compensation levels.

- ***Question:*** **How much was saved by reducing UBHC's contracts to the median unit cost?**

Discussion Points (Cont'd)

Division of Medical Assistance and Health Services

9. Approximately $4.4 million is requested for the Medicaid Management Information System and IT Upgrades. No specifics are provided. For example, it is not known how much of the increase is related to processing the additional data being requested from "providers, suppliers, and/or wholesalers of pharmaceutical services" or how much is related to the preparation of a Request for Proposal concerning fiscal intermediary services.

- ***Question:*** **Please provide a breakdown as to the specific tasks associated with this funding increase.**

10.a. Available information indicates that while the total amount of monies to be distributed to hospitals under the Hospital Relief Subsidy Fund (HRSF) is unchanged at $166.0 million (gross), the formula by which funds are to be distributed will change. In FY 2011, 26 hospitals received funds, in FY 2012, 64 will receive funds. Thus, many hospitals that received HRSF monies in FY 2011 will receive less in FY 2012. For example, University Hospital (UMDNJ) will receive $5.3 million less. Deborah Heart and Lung Center, which did not receive any HRSF funds in FY 2011, will receive $572 in FY 2012.

- ***Questions:*** **What specific changes to the formula by which HRSF monies are distributed are being implemented to increase the number of hospitals that qualify for funds? Is the distribution of small amounts of HRSF funds to hospitals cost effective?**

10.b. The total amount of monies to be distributed for Graduate Medical Education (GME) will increase from $60. 0 million to $90.0 million (gross). Under the new formula, 13 hospitals which had not received GME funds in the past will now receive monies. Several of the new hospitals that receive GME funds will receive less than $100,000.

- ***Questions:*** **What specific changes to the formula by which GME monies are distributed are being implemented to increase the number of hospitals that qualify for funds? Is the distribution of small amounts of GME funds to hospitals cost effective?**

11.a. The FY 2012 recommended budget cites $39.0 million in Medicaid fraud and settlement recoveries. It is unclear if the $39 million includes monies recovered by the federal government and returned to the State.

- ***Questions:*** **Does the $39 million figure include monies that will be received from the federal government? If so, how much is expected to be received from the federal government?**

11.b. The State submits a quarterly Medicaid report to the federal government which includes the amount of fraud and abuse recovered.

Between FY 2006 – FY 2010, the amount of fraud and abuse reported to the federal government ranged from $1.5 million (gross) to $5.3 million (gross). For the FY 2011 (July – December 2010), approximately $4.0 million (gross) in fraud and abuse recoveries was reported. The amounts reported are significantly less than the amount the State anticipates in FY 2012.

Discussion Points (Cont'd)

- ***Question:*** **What accounts for the difference in fraud and abuse recoveries reported to the federal government and the amount of fraud and abuse recoveries assumed as part of the FY 2012 recommended budget?**

11.c. In FY 2010, the division undertook an initiative to collect outstanding receivables owed Medicaid.

A recent review of outstanding receivables finds a significant number of chain pharmacies who must reimburse the Medicaid program for claims that were paid in error. It appears that rather than recoup from all pharmacies operated by the chain, the division attempts to recover funds from the specific pharmacy that caused the error. Further, the division has not sought to suspend or terminate the provider agreement with the individual pharmacy as a way to persuade a pharmacy to refund the monies at issue.

- ***Questions:*** **Should reimbursement be withheld from all pharmacies operated by the chain, rather than the individual pharmacy? Should Medicaid suspend or terminate the provider agreement with any pharmacy that does not reimburse the Medicaid program on a timely basis for monies due the Medicaid program?**

12. Effective July 1, 2011 federal regulations require the Medicaid program to deny payments for hospital acquired conditions. At a minimum, hospital-acquired conditions identified by Medicare must be used. While the State already has a policy in place that denies Medicaid reimbursement for preventable hospital errors, the federal policy may be more expansive than the current State policy.

- ***Question:*** **Does current State policy meet minimum federal standards? If not, how much will the State save by complying with the Medicare requirement?**

13.a**.** For the year ending December 2010, the four Medicaid managed care organizations were paid over $1.7 billion in premiums. The companies reported about $2.3 million in fraud and abuse recovered or referred to the State for follow-up.

- ***Question:*** **What steps are being taken to increase fraud and abuse recoveries by the four managed care organizations?**

13.b. It had been reported that services for some persons enrolled in Medicaid managed care, particularly pregnant women and newborns, were being paid on a fee-for-service basis even though a managed care entity was to pay for the services. The division was to adopt new edits to prevent fee-for-service reimbursement and was to recoup monies from managed care companies for such services.

- ***Question:*** **What amount did Medicaid recover from managed care providers during FY 2010?**

13.c. Most persons are to be enrolled in a Medicaid managed care plan. Proposed budget language on p. D-187 lists various groups that would be exempt from the mandatory enrollment requirement, and the General Assistance (GA) population is not one of the exempted groups. However, various provider groups were under the impression that the GA population would be exempt from mandatory managed care enrollment.

Discussion Points (Cont'd)

- ***Question:*** **Will the GA population be included in mandatory managed care enrollment?**

13.d. The budget recommends approximately $1.1 billion for the Managed Care Initiative. The division's independent actuary was asked to reexamine the adequacy of the preliminary reimbursement rates with respect to providing additional services through managed care and enrolling additional people into managed care.

- ***Question:*** **Will additional funding for the Managed Care Initiative be needed?**

13.e. In the early 2000's the division excluded prescription drugs provided to the disabled from the services provided through managed care. Such prescription drugs were to be provided on a fee-for-service basis.

The FY 2012 recommended budget would have managed care companies provide prescription drugs to the disabled and end fee-for-service reimbursement.

- ***Question:*** **As there have been no problems associated with providing prescription drugs to the disabled on a fee-for-service basis, what is the rationale for having prescription drugs for the disabled again being provided through managed care?**

14.a. The FY 2011 appropriations act provided $54.2 million for Medicare Premium payments and assumed $107.3 million in federal reimbursement for such costs based on a pending federal lawsuit in New York. These additional federal funds are not forthcoming and a $107.3 million supplemental appropriation is now anticipated.

- ***Question:*** **Why are these federal funds not forthcoming?**

14.b. The FY 2011 appropriations act assumed federal approval of a State Plan Amendment (SPA) to obtain Medicaid reimbursement for the General Assistance Medical Services program. These federal funds are not forthcoming, and a $50.7 million supplemental appropriation is now anticipated.

- ***Question:*** **Why has the State Plan Amendment not been approved by the federal government?**

15.a. The department was awarded a $1.0 million federal grant to increase enrollment efforts in schools. A school-based NJ FamilyCare facilitator was to be hired to perform these activities.

- ***Questions:*** **What is the status of this program? How many children have been enrolled in NJ FamilyCare as a result of the work of a facilitator?**

15.b. To increase enrollment in the NJ FamilyCare program, a FamilyCare Express Lane application process was initiated. Materials were mailed to families who indicate on their State income tax forms that a least one child in the family was uninsured. Available information is that only 5% of households that received applications returned those applications.

- ***Questions:*** **What percentage of applications are now being returned? Of those applications that are returned, what percent have been found eligible for NJ FamilyCare?**

Discussion Points (Cont'd)

15.c. The division has initiated various new programs to identify and follow-up on unreported income of FamilyCare applicants. The department previously indicated that these efforts resulted in only three cases being referred to authorities for investigation.

- ***Questions:*** **What was the disposition of the three cases? How many additional cases have been referred to authorities for investigation?**

15.d. In October 2009, the Departments of Health and Senior Services and Human Services announced an "Insured for Sure" program under which no newborn would leave the hospital without health insurance. Under the program, hospital staff would verify if a newborn has health insurance coverage and, if no coverage is present, submit a one-page NJ FamilyCare application. The Department of Health and Senior Services has deferred all questions and answers on the program to Human Services.

- ***Question:*** **To date, how many newborns have been enrolled through this program?**

15.e. Proposed budget language terminates NJ FamilyCare coverage for certain adults whose costs are funded entirely with State funds. This is expected to save $4.0 million.

- ***Question:*** **How many adults, by category of eligibility, are affected by this policy?**

15.f. In FY 2012, the number of adults enrolled in NJ FamilyCare is expected to increase by about 15,700, to over 219,900.

The department intends to eliminate coverage for certain adults supported entirely with State funds which may reduce enrollment by upwards of 10,000 persons . In addition, the number of adults enrolled in the program with incomes between 134% and 200% of the federal poverty level (FPL) is expected to continue to decrease. While the number of adults with income under 133% FPL has increased, the annual increase in this income group is insufficient to result in an additional 15,700 adults being enrolled in the program.

- ***Question:*** **Is the increase in the number of adults that will enroll in NJ FamilyCare in FY 2012 overstated?**

16. The federal Office of the Inspector General in a September 2010 report recommended that the division refund approximately $0.9 million in disallowed costs related to the Medicaid Management Information System. The division disagreed with respect to about $0.5 million in disallowed costs.

- ***Question:*** **What is the status of the disallowance?**

17. Pursuant to federal law states must establish programs to contract with Recovery Audit Contractors (RACs) by December 31, 2010 to identify underpayments, overpayments and to recoup overpayments in the Medicaid program. States may seek an exemption from the federal government with respect to RACS.

- ***Questions*** **What is the status of the RAC requirement? As the division already contracts with various entities on these matters, will an exemption from the requirement be sought?**

Discussion Points (Cont'd)

18.a. Proposed budget language on pp. D-187 to D-188 changes the methodology for reimbursing pharmacies for prescription drugs. Under the proposed language, significant amounts of "drug acquisition data" would have to be submitted by "providers, suppliers, and/or wholesalers of pharmaceutical services" for reimbursement purposes. Currently, such data is not submitted to the division. It is not known whether this type of data are submitted to any other states for purposes of determining reimbursement for prescription drugs.

- ***Questions*** **What additional costs will the division incur to process the "drug acquisition data" being requested? Do "providers, suppliers, and/or wholesalers of pharmaceutical services" currently provide this type of data to any other state Medicaid programs?**

18.b. The methodology for reimbursing for prescription drugs under the fee-for-service program would change pursuant to the proposed budget language. However, as almost all persons who receive services through the division will be required to enroll in a manage care program, there will be relatively few people left whose prescription drugs will be reimbursed on a fee-for-service basis.

- ***Questions*** **Is the proposed change as to how fee-for-service prescription drugs will be reimbursed necessary as most recipients will be enrolled in a managed care program and the managed care program will be responsible for the reimbursement of prescription drugs?**

18.c Proposed language would allow the Payments for Medical Assistance Recipients – Prescription Drugs and General Assistance Medical Services accounts to be used to make supplemental payments to pharmacies to offset the impact of the First Data Bank Average Wholesale Price settlement (2009).

- ***Question*** **What is the dollar amount of supplemental payments that are anticipated to be made to pharmacies as a result of this proposed budget language?**

Division of Disability Services

19. The federal Patient Protection and Affordable Care Act allows states to provide home and community-based attendant services and supports at an increased federal matching rate. For New Jersey, the matching rate would be 56%.

Some specific activities currently provided under Personal Care at 50% federal reimbursement could qualify for the 56% matching rate if those activities were provided separately, and not as part of Personal Care.

- ***Questions:*** **Will Personal Care services be redefined to enable the State to obtain the higher federal reimbursement? How much may the State save through such a redefinition of Personal Care?**

20**.** A recent federal audit of Medicaid personal care services in New York State identified numerous problems involving nursing assessments and supervision, physician orders, documentation, etc. related to New York's personal care program. New York has been asked to reimburse the federal government over $100 million.

Discussion Points (Cont'd)

- ***Question:*** **Do the problems identified in New York State exist in personal care services provided in New Jersey?**

21. Personal Care services are to be included within the services to be provided by managed care organizations in FY 2012. It is assumed that provision of Personal Care services through managed care will result in better monitoring of utilization and will reduce overall costs. However, overall Personal Care costs are expected to increase by about $12.1 million in FY 2012, from $304.7 million to $316.8 million.

- ***Question:*** **As Personal Care services are to be provided through managed care, why are overall program costs expected to increase in FY 2012?**

Division of Developmental Disabilities

22.a. At the end of December 2010, various FY 2010 Direct State Services accounts at the Woodbridge Developmental Center had over $0.3 million in encumbered funds.

- ***Question:*** **Is the $0.3 million in encumbered funds still valid?**

22.b. At the end of December 2010, the Office for Prevention of Mental Retardation and Developmental Disabilities had about $100,000 in encumbered funds.

- ***Question:*** **Is the $0.1 million in encumbered funds still valid?**

22.c. At the end of December 2010, various Community Programs Grants-in-Aid accounts had $6.4 million in encumbered funds, including the Olmstead Residential, Group Homes and Purchase of Adult Activity Services accounts.

- ***Question:*** **Is the $6.4 million in encumbered funds still valid?**

23. Schedule 2 indicates that federal ICF-MR revenues will increase by $12.5 million, to $345.6 million, in FY 2012. The two main factors in ICR-MR revenues are: billable days and personnel related expenses at developmental centers. As the number of patients at the centers is expected to decrease in FY 2012, there should be a reduction in billable days. Personnel related expenses may remain unchanged and may in fact decrease if recommendations concerning health benefit costs and pension contributions are adopted in some form.

- ***Question:*** **What is the basis for the $12.5 million increase in federal ICF-MR revenues given the overall census reduction and the likelihood that employee compensation and benefits will not increase?**

24. During CY 2009, 81 developmental center clients were transferred to community programs. In CY 2010, 60 clients were transferred to community programs.

- ***Question:*** **Of the clients transferred to community programs, how many are still in a community program? How many have returned to a developmental center or other residential facility?**

Discussion Points (Cont'd)

25.a. The recommended budget would begin the process of closing the East Campus of VDC which currently has about 330 clients, including 60 medically involved clients in the Wolverton building.

As of this writing , information is not available as to how many clients will be relocated during either FY 2012, or FY 2013; how many clients will be relocated to other developmental centers, to nursing homes or to community programs; whether new residential programs will be developed or whether clients can be placed into vacant residential beds.

- ***Question:*** **How many patients will be relocated during FY 2012 and subsequent fiscal years? How many patients will be transferred to: other developmental centers? nursing homes? community programs? How many patients will be placed in: new residential programs to be developed? in existing residential facilities?**

25.b. As part of the State's contract with the applicable union, upwards of 200 direct care personnel from VDC staff group homes operated by a private organization, PAFACOM. As the group homes are staffed by State employees, the operating costs of the group homes are significantly greater than the costs of group homes operated without State employees. Overtime costs attributed to these 200 employees account for nearly 50% of VDC's $8.0 million in overtime costs. Eliminating or phasing out this staffing requirement could reduce State costs.

- ***Question:*** **What does the FY 2012 recommended budget assume with respect to this contract provision?**

25.c. The Grants-in-Aid recommended appropriation includes either $6.6 million or $8.1 million for "bridge funding" related to the closure of the East Campus of the Vineland Developmental Center (VDC) according to available budget documents.

- ***Questions:*** **Which amount is correct? Does the amount include any federal funds that may be realized?**

26.a. There are upwards of 45 patients at Ancora and Trenton Psychiatric Hospitals who are classified as "dually diagnosed." Such individuals are either DDD clients or are eligible for DDD services. While the department's goal is to relocate these patients to community programs, it is difficult to find appropriate community placements for such individuals.

The 45 dually diagnosed patients at Ancora and Trenton are not eligible for Medicaid reimbursement. However, the patients would qualify for federal ICF-MR reimbursement at a developmental center until a community placement is available. As the State receives about $300 per day in federal ICF-MR reimbursement, over $4.9 million in additional federal revenue would be realized.

- ***Question:*** **To maximize federal ICF-MR reimbursements, should the 45 dually diagnosed patients at Ancora and Trenton be relocated to vacant beds at the developmental centers pending placement into community programs?**

26.b. For many years, the division has attempted, with limited success, to reduce the number of clients in Private Institutional Care (PIC) placements, primarily located out-of-State, and for

Discussion Points (Cont'd)

which no or limited federal reimbursement is available. Part of the difficulty in relocating these clients is that they compete with other DDD clients for community placements in the State.

Given the reduction in the census of developmental centers, it may be possible to relocate PIC clients to vacant developmental center beds to reduce State PIC expenditures and maximize federal ICF-MR revenues. For every 10 PIC clients relocated to a developmental center, savings of over $1 million may be realized, and an additional $1.1 million in federal ICF-MR revenues would be realized.

- ***Question:*** **To maximize federal reimbursement and reduce State expenditures, has consideration been give to relocating PIC clients to vacant development center beds pending community placement?**

27.a. The amount of federal Community Care Waiver (CCW) revenues realized in FY 2010 was $309.7 million. This amount is $7.7 million less than the $317.3 million that had been previously estimated.

- ***Questions:*** **What accounts for the $7.7 million decrease in FY 2010 CCW revenues?**

27.b. The FY 2012 recommended budget estimates $353.4 million in federal CCW revenues, a $32 million increase from FY 2011 revised estimates.

- ***Question:*** **How much of the increase reflects retroactive rate adjustments, as opposed to an increase in the number of clients who receive CCW services?**

28. The division was developing a federal waiver application to obtain federal reimbursement for Family Support services.

- ***Questions:*** **What is the status of this waiver request? Does the FY 2012 recommended budget assume approval of the waiver and include new federal funds the waiver may generate?**

Commission for the Blind and Visually Impaired

29.a. Available information is that 20 teaching positions will be eliminated. As the commission is reimbursed for such costs by the school districts that receive services, it is not clear why teaching positions are being eliminated.

- ***Question:*** **As the commission is reimbursed by school districts for the cost of teaching services, why are the number of teaching positions being reduced?**

29.b. The recommended appropriation for Services for the Blind and Visually Impaired program is reduced by $1.5 million, to $8.7 million, and the number of filled positions is expected to decrease by 8, to 223. Despite this funding and personnel reduction, available data do not indicate any reduction in the number of clients who receive vocational rehabilitation, State habilitation services, prevention services or instruction services.

Discussion Points (Cont'd)

- ***Question:*** **Are data on the number of clients that receive services accurate in view of the projected reduction in staff? How will fewer staff and less funding provide services to more clients?**

30. The amount of Appropriated Receipts available to the commission is reduced by $200,000 from over $0.5 million to $0.3 million.

- ***Question:*** **What accounts for the reduction?**

Division of Family Development

31. At the end of December 2010, various FY 2010 Grants-in-Aid accounts had approximately $2.9 million in encumbered funds.

- ***Question:*** **Is the $2.9 million in encumbered funds still valid?**

32. The division is in the process of implementing a new welfare eligibility system known as CASS. It will replace a computer system that was implemented during the mid-1980s.

A recent quarterly Quality Assurance report notes that Hewlett Packard (HP), the CASS vendor, has been unable to fill the Implementation Manager position for about a year. The report further notes that HP's overall work "has not been consistent."

- ***Question:*** **What impact have these issues had on the overall timetable to develop/implement CASS and project costs? Has the division filed any formal complaints with the Division of Purchase and Property with respect to these issues?**

33. In FY 2010, the division estimated federal TANF expenditures (Schedule 2) at $457.3 million. Actual FY 2010 federal TANF expenditures were $421.0 million.

- ***Questions:*** **What accounts for the $36.3 million reduction in actual FY 2010 TANF expenditures?**

34.a. A September 2010 GAO report noted that subsidized child care programs in five states were vulnerable to fraud and abuse. Among the problems identified were:

- No requirement for a Social Security Number (SSN).
- The ability to use the SSN of deceased individuals.
- The ability to cite work at non-existent employers.
- The ability to claim that child care services were provided by non-existent providers.
- The ability of child care providers to bill for more hours of service than provided.

- ***Question:*** **What controls does the division have in place to prevent improper payments due to factors identified in the GAO report?**

34.b. The division's Child Care and Early Education Service Eligibility Application states that the provision of a SSN by parents/applicants is voluntary. Thus, the division has limited means to verify the financial information provided by parents/applicants, which may result in child

Discussion Points (Cont'd)

care services being provided to children with household income that exceeds guidelines or results in a lower co-payment than warranted.

- ***Question:*** **To minimize the possibility of children who are not financially eligible for child care services receiving services, should the provision of a SSN be mandatory rather than voluntary?**

34.c. The FY 2011 appropriation acts required parents with income between 101% and 250% of the federal poverty level who live in certain designated school districts who receive "wrap around" child care services to be subject to a co-payment, effective September 2010.

- ***Question:*** **How many families were affected by this co-payment requirement?**

34.d. Equalizing child care income eligibility standards is expected to save over $5.0 million and equalizing wrap around co-payments is expected to save $2.1 million.

- ***Question:*** **How many families will be affected by these requirements?**

34.e. A 25 hour per week work requirement will generate $6.0 million in savings..

- ***Question:*** **How many families will be affected by these requirements?**

35. The Substance Abuse Initiative account is being reduced by $2.5 million, to $30.6 million (gross), based on "caseload trends." Available program data do not reflect any significant reduction in the number of General Assistance and Temporary Assistance to Needy Families recipients being referred to the program, assessed by the program, and referred to substance abuse treatment services.

- ***Question:*** **What is the basis for the $2.5 million savings based on "trends" as there has not been a significant reduction in the number of persons referred to and assessed by the program and referred to substance abuse treatment services?**

36.a. Proposed changes to the General Assistance program would require unemployable recipients to provide medical evidence that they are unable to work for "six continuous months."

There are currently over 17,300 unemployable recipients. A fair number have applied for and are awaiting a determination as to whether they are eligible for either federal Social Security Disability benefits or federal SSI benefits.

- ***Question:*** **Will the requirement apply to unemployable recipients who have filed an application for federal benefits?**

36.b. New applicants for General Assistance would be required to undergo a "job search and, as appropriate, substance abuse treatment during an initial evaluation period."

General Assistance recipients are already required to participate in the division's Substance Abuse Initiative program. Available data indicate that in FY 2011, over 7,700 recipients will be referred to the program, over 5,500 recipients will be assessed by the program, and nearly 4,900 recipients will receive substance abuse treatment services.

Discussion Points (Cont'd)

- ***Question:*** **As General Assistance recipients already participate in the Substance Abuse Treatment program, is anything new being required of such persons?**

37. Proposed budget language provisions on D-210 would prohibit the expenditure of Payments for Cost of General Assistance and Work First New Jersey – Client Benefits for "supplemental living support payments." It is not clear what "supplemental living support payments" consist of.

- ***Questions:*** **Would "rent," "temporary rental assistance payments," shelter/hotel/motel costs, and security deposits be precluded from being paid under the proposed language provisions? What other payments would be affected?**

38. Savings of $2.9 million in the Payments for Supplemental Security Income program are anticipated due to "trends." Yet available data indicate that the number of persons who will receive State supplemental payments will increase by nearly 6,800, to over 178,700 recipients, while the number of persons expected to receive "emergency assistance" will increase to over 2,300.

- ***Question:*** **What is the basis for the $2.9 million savings based on "trends" in view of the increase in the number of persons expected to receive benefits?**

Division of Management and Budget

39. At the end of December 2010, various FY 2010 Direct State Services accounts had encumbered funds in excess of $0.1 million.

- ***Question:*** **Is the $0.1 million in encumbered funds still valid?**

40. Overtime costs associated with Institutional Security Services are expected to increase in FY 2012 despite an overall reduction in the number of patients at State institutions. It also appears that efforts by the department to better control overtime costs associated with this program have not been successful.

- ***Questions:*** **What factors contribute to the increase in overtime costs? Why have previous efforts to control overtime not been successful?**

41. A supplemental appropriation of $22.0 million is anticipated in FY 2011: Personnel Services - $7.6 million; Materials and Supplies - $0.8 million; and Maintenance and Fixed Charges - $13.6 million.

While no information has been provided in support of a $22.0 million supplemental, it appears that the overall accounts may have been underfunded.

- ***Question:*** **Please provide information as to why $7.6 million is required in the Personnel Services account, why $0.8 million is required in the Materials and Supplies account, and why $13.6 million is** required **in the Maintenance and Fixed Charges account?**

Discussion Points (Cont'd)

42. The overall census at the State developmental centers and psychiatric hospitals is to be reduced in FY 2012 and the Ewing and Vineland Residential Centers operated by the Department of Children and Families will close. These changes should reduce costs associated with the Consulting Pharmacy Services and the Unit Dose Contracting Services contracts, yet overall costs are unchanged at about $8.5 million.

- ***Question:*** **Are recommended appropriations for Consulting Pharmacy Services and Unit Dose Contracting Services overstated based on projected patient populations at State institutions in FY 2012 and the closing of the remaining residential treatment centers?**

Background Paper: Overtime at State Institutions, FY 2007 – FY 2011

SUMMARY

FY 2011[2] overtime expenditures at State psychiatric hospitals and developmental centers are estimated at $75.9 million, and overtime hours are projected at 2.3 million hours.

Overtime expenditures and hours peaked in FY 2008. Reductions in both overtime expenditures and hours from FY 2008 levels are due to:

- A reduction in the overall census at the State institutions, which enabled units and buildings to be closed. Direct care staff were then reassigned, and provided more coverage and reduced the need for overtime to cover personnel who called in sick or were out on vacation;

- Fewer patients who require one-to-one staffing as more uniform criteria for one-to-one staffing was adopted; and

- The opening of a new Greystone Park Psychiatric Hospital.

BACKGROUND AND ANALYSIS

Overtime is an operational reality at the 12 institutions administered by the Department of Human Services. It is necessary to maintain minimum staffing standards mandated by the federal government and with limits on the hiring of additional staff, overtime becomes necessary.

As employee compensation is set through the State's union contract agreements, managing the number of overtime hours worked is the only way to control overtime expenditures. Managing overtime hours, in turn, depends on maintaining minimum staffing requirements, the number of patients, and the clinical condition of patients. It is noted, however, that since the salary level and job titles of personnel who work overtime determine overtime expenditures, a 10% reduction in overtime hours will not reduce overtime costs by 10%.

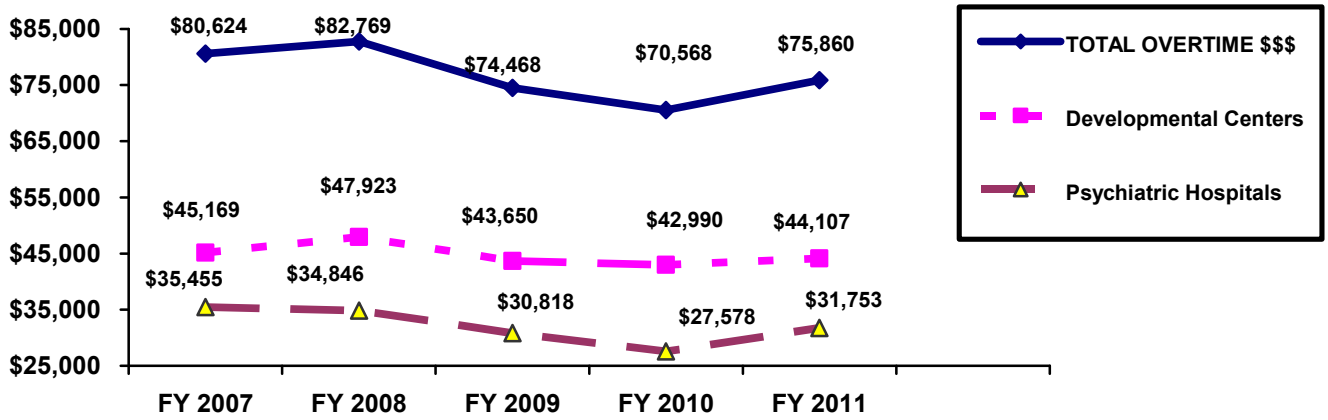
Figure 1 summarizes **overtime expenditures** at State institutions for the FY 2007 – FY 2011 (est.) period. During this period, overtime expenditures decreased by about 6.0% from $80.6 million to a projected $75.9 million.

Though overtime expenditures have declined, available data indicate that in FY 2011 overtime expenditures may increase from $70.6 million (FY 2010) to $75.9 million. This increase is primarily due to an increase in overtime expenditures at the State psychiatric hospitals.

[2] Based on expenditures through pay period 26. Actual FY 2011 overtime expenditures and hours may exceed the estimate based on data through pay period 26 due to weather conditions in late December and January. Also, the closing of Vineland's West Campus and the reassignment of staff to the East Campus may reduce Vineland's overtime costs in FY 2011.

Background Paper: Overtime at State Institutions, FY 2007 – FY 2011 (Cont'd)

Figure 1: Overtime Expenditures at Developmental Centers and Psychiatric Hospitals ($000) FY 2007 - FY 2011 (est.)



Psychiatric Hospitals. Overtime expenditures decreased by over 10%, from $35.5 million to $31.8 million (est.) during the period FY 2007 – FY 2011 (est.). The reduction is attributable to: a 23% decrease in overtime hours and an approximate 23% decrease in the overall census at hospitals.

While available data indicate that overtime expenditures at Ancora, Greystone, Hagedorn and Trenton have generally decreased, overtime expenditures at Klein Forensic Hospital have increased. This increase is due to a combination of factors: (1) the hospital's census has not decreased and is relatively constant at around 200 due to the type of patient the facility treats, (2) the hospital has more patients who require more one-to-one staffing than other hospitals, and (3) the hospital uses a unique direct patient care job title, Medical Security Officer, that receives higher compensation than other direct patient care job titles used at other hospitals.

Developmental Centers. Projected overtime expenditures of $44.1 million in FY 2011 represents a 2.4% reduction from FY 2007 levels of $45.2 million. The reduction is attributable to: a 16% decrease in overtime hours and a nearly 13% decrease in the overall census at the hospitals.

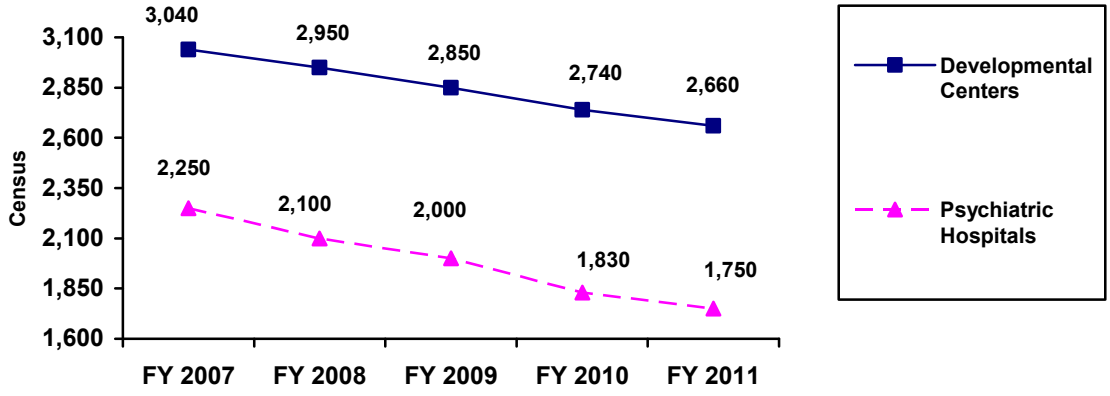
While overtime expenditures, in general, at the developmental centers were reduced during the period, several developmental centers saw an increase in overtime expenditures due to unique situations at each facility. Hunterdon and Woodbine have more patients that require one to one staffing. Vineland staffs certain community residential facilities, and the personnel who staff these group homes have a unique job title that merits higher compensation than other direct patient care job titles.[3]

Figure 2 provides **census data** for the State developmental centers and psychiatric hospitals for the FY 2007 – FY 2011 (through December 2010) period:

[3] Pursuant to the union contract, residential programs operated by a private, non-profit organization known as PAFA are staffed by Vineland Developmental Center employees. These employees receive higher pay than comparable employees at the Vineland Developmental Center, which would increase overtime costs.

Background Paper: Overtime at State Institutions, FY 2007 – FY 2011 (Cont'd)

Figure 2: Census at Developmental Centers and Psychiatric Hospitals FY 2007 – FY 2011 (avg. thru Dec. 2010)



Psychiatric Hospitals. The overall census during the FY 2007 – FY 2011(December 2010) period decreased by 22.2%, from about 2,250 to 1,750.

With the exception of the Klein Forensic Hospital, all psychiatric hospitals saw census reduction. Ancora had a 260 person census reduction in order to address U.S. Department of Justice concerns about conditions at the hospital. This was accomplished by having patients admitted to other facilities, such as Hampton Hospital, Carrier Clinic and Lakeland (Camden County Hospital). At Greystone, the supervision of certain units and patients in those units was transferred to a community mental health provider and the patients are no longer considered to be part of Greystone's census. At Trenton, there has been a gradual reduction in total admissions, coupled with an increase in the number of patients discharged from the facility. At Hagedorn, the division took steps to reduce the census as part of its plan to close a State hospital.

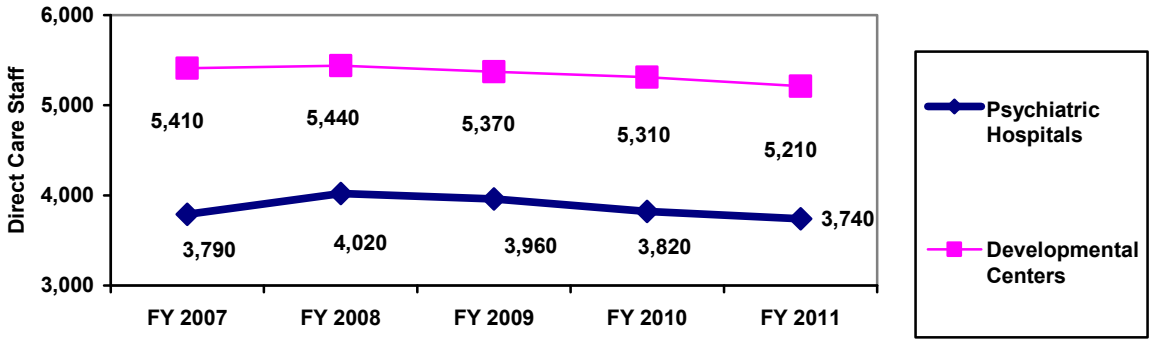
Developmental Centers. The overall census during the FY 2007 – FY 2011 (December 2010) period decreased by 12.5%, from about 3,040 clients to about 2,660 clients.

Reductions at New Lisbon (100) and Woodbridge (90) were due to settlements with the U.S. Department of Justice. In addition, the department's Olmstead Plan resulted in the relocation of clients into community programs. Also, in any given year there are upwards of 100 client deaths due to the age and medical conditions of the patients. The only facility that did not see a census reduction was North Jersey, as the facility has received a number of court ordered admissions.

Figure 3 provides information on **direct care staff** for the FY 2007 – FY 2011 (as of December):

Background Paper: Overtime at State Institutions, FY 2007 – FY 2011 (Cont'd)

Figure 3: Direct Care Staff at Developmental Centers/Psychiatric Hospitals, FY 2007 – FY 2011 (as of December).



Psychiatric Hospitals. Overall staffing declined by about 50, or over 1%, between December 2006 – December 2010 period to approximately 3,740. As the overall census at the psychiatric hospitals decreased by nearly 23%, the relatively stable staffing has contributed to a reduction in overtime and expenditures at the facilities.

Developmental Centers. The overall reduction in overtime expenditures and overtime hours was achieved despite a 3.7% reduction in the number of direct care staff, from about 5,410 to 5,210 workers[4]. The 12.5% reduction in the census at the developmental centers enabled the division to close units and buildings at many facilities and to reassign staff to other units and buildings.

[4] The total number of employees excludes over 200 Resident Living Specialists employed by Vineland who work at community groups homes, not in a developmental center.

Background Paper: Closing a State Psychiatric Hospital

Budget Page.... D-169

Funding ($000)	Expended FY 2010	Adj. Approp. FY 2011	Recomm. FY 2012
Psychiatric Hospitals	**$303,052**	**$371,153**	**$363,521**

BACKGROUND AND ANALYSIS

The FY 2012 recommended budget proposes to save $9.0 million by closing a State psychiatric hospital. The hospital that would be closed is not identified.

The State Mental Health Facilities Evaluation Task Force, established by P.L.2010, c.81, reviewed two hospitals for possible closure: Senator Garrett W. Hagedorn Gero-Psychiatric Hospital and Trenton Psychiatric Hospital. The Task Force did not reach a decision as to which hospital should be closed.

The tables below provide various data on both hospitals with respect to expenditures, census and admissions.

Table I. Gross Expenditure and Appropriations ($000), FY 2008 – FY 2012 est.[5]

	FY 2008	FY 2009	FY 2010	FY 2011 adj.	FY 2012 est.
Hagedorn	$40,306	$41,468	$39,415	$51,381	$50,815
Trenton	$73,078	$72,747	$71,121	$85,724	$85,117

Approximately 85% of total expenditures are for personnel costs, including overtime.

Table II. Average Daily Population, FY 2007 – FY 2011[6]

	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Hagedorn	293	277	273	267	244
Trenton	467	451	441	397	399

The census at Hagedorn has been reduced by about 17%, compared to a 15% reduction at Trenton during the FY 2007 – FY 2011 period.

Table III. Number of Admissions, FY 2007 – FY 2011

	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Hagedorn	469	472	442	357	197 (est.)
Trenton	696	770	677	655	742 (est.)

The number of admissions to Hagedorn has decreased by about 58% during the period. While admissions to Trenton decreased between FY 2007 – FY 2010 by about 6%, available

[5] The Governor's Recommended Budget does not provide detailed budget information with respect to individual psychiatric hospital; however, other budget information provided to the office does provide expenditure data for each psychiatric hospital.

[6] July 2010 – February 2011.

Background Paper: Closing a State Psychiatric Hospital (Cont'd)

data indicates that in FY 2011 the number of admissions to Trenton may increase from FY 2010 levels.

Available information indicates that Hagedorn is the likely facility to be closed for a variety of reasons:

- The grounds of the Trenton facility are home to the Klein Forensic Psychiatric Hospital and a Department of Corrections facility. Thus, closing Trenton Psychiatric Hospital would not allow the State to declare the Trenton property surplus and sell the property. If Hagedorn was closed, the State could sell the property in the future.

- Of the 244 patients currently at Hagedorn, 146 are elderly who have other medical issues. As it may be possible to place many elderly patients in nursing homes or other psychiatric hospitals, the cost to develop new community placements is reduced.

- In anticipation of the Governor's FY 2011 Recommended Budget to close Hagedorn, actions were taken steps to reduce the overall census of and reduce the number of admissions to Hagedorn. Even though closing Hagedorn was eliminated as part of the FY 2011 appropriations act, efforts have continued to reduce admissions to and reduce the census of Hagedorn.

  While the census at Trenton has been reduced, there are at least 150 more patients at Trenton for whom community placements would have to be developed. As there has not been a significant reduction in admissions to Trenton, new and expanded programs to divert admissions would have to be developed to handle some of the 700 patients currently admitted to Trenton.

Background Paper: Dually Diagnosed Patients at Ancora

SUMMARY

The State would realize $2.4 million to $3.6 million in federal Medicaid revenue if the 20 – 30 dually diagnosed patients currently at Ancora Psychiatric Hospital were transferred to a developmental center until placed into community programs.

BACKGROUND AND ANALYSIS

There are between 20 and 30 patients at Ancora who are dually diagnosed - - patients with both a developmental disability and a mental illness. While at Ancora, State funds pay for the cost of care for the patients, as federal law precludes Medicaid reimbursement for patients between the ages of 21 – 64.[7] The goal is to place these patients in community programs. However, their multiple medical issues make it difficult to find or develop an appropriate community placement.

As the 20 – 30 patients have a developmental disability, and may even be clients of the Division of Developmental Disabilities, the patients could receive services at a developmental center as opposed to a psychiatric hospital. The benefit to providing services to the 20 – 30 patients at a developmental center is primarily monetary: the State would obtain federal ICF-MR reimbursement for these patients[8] while they wait for a community placement.

The total average ICF-MR per diem rate is over $650, with about $325 reimbursed by federal Medicaid funds. Thus, between $2.4 and $3.6 million in federal reimbursement would be realized by providing services to these dually diagnosed clients at the developmental centers as opposed to at Ancora.

Due to the reduction in the overall census at the various developmental centers over the past few years, the 20 – 30 dually diagnosed patients can be accommodated at minimal additional cost to the State.[9] Once community placements are developed for the dually diagnosed patients, the patients would be placed in such programs, but until then, the State would be able to generate federal reimbursement to offset their costs.

[7] The State receives federal reimbursement for patients at State and county hospitals through the federal DSH program. However, as total expenditures at State and county hospitals exceed the $178.7 million in federal DSH reimbursement available for mental health services, it would be difficult for the State to claim that federal DSH monies are received on behalf of these specific clients.

[8] It is assumed that the patients meet ICF-MR standards and would receive ICF-MR level services.

[9] Even though the census at the developmental centers has been reduced, most direct care staff has been retained to provide better staffing and to reduce overtime costs.

Background Paper: Impact of the NJ FamilyCare Adult Enrollment Freeze

Budget Page.... D-181.

Background and Analysis

The Governor's FY 2011 recommended budget and the FY 2011 appropriations act included savings of $55.5 million to the NJ FamilyCare program as follows:

- Effective March 2010, no adults with incomes between 134% - 200% of the federal poverty level (FPL) would be enrolled in the program. This would affect 39,000 adults and save $24.6 million.[10]

- Effective April 2010, restricted adult aliens would be terminated from the program. This would affect about 12,000 persons and save $29.8 million.[11] (No federal reimbursement is available for this eligibility group.)

- NJ FamilyCare premiums would be increased by $1.1 million.

NJ FamilyCare, Adults with Incomes Between 134% - 200% FPL

The table below summarizes NJ FamilyCare enrollment for adults with incomes between 134% - 200% FPL between January 2010 and December 2010:

	Jan. 2010	March 2010	Dec. 2010	Change, Jan. - Dec. 2010	% Change, Jan. – Dec. 2010
Adults, 134% - 150% FPL	43,100	45,000	33,700	(9,400)	(21.8%)
Adults, 151% - 200% FPL	20,900	22,000	14,100	(6,800)	(32.5%)

Data are not readily available as to the number of adults whose application for NJ FamilyCare was denied due to the freeze on enrollment, or the number of adults who did not apply for NJ FamilyCare since March 2010 because they knew about the enrollment freeze.

Based on the enrollment reduction between January - December 2010, it is estimated that NJ FamilyCare expenditures were reduced by approximately $55 million[12] ($19.3 million State/$35.8 million federal).

NJ FamilyCare enrollment for adults with incomes under 133% FPL increased by 9,500, to 131,900, between January 2010 - December 2010.[13] It is possible that some of the 16,200

[10] The department also changed the manner in which certain unearned income was accounted which resulted in some adults being disqualified from the program upon renewal.
[11] The Commissioner of Human Services subsequently indicated that some restricted adult aliens would be allowed to remain in the program if they were being treated for certain medical conditions.
[12] Calculated as follows: December 2010 per recipient expenditures X Enrollment Reduction X 12 months or $283 X 16,200 X 12 months.

Background Paper: Impact of the NJ FamilyCare Adult Enrollment Freeze (Cont'd)

adults with incomes between 134% - 200% FPL may have transferred to this component of NJ FamilyCare due to lower household income.

Legal Aliens

Although savings of $29.8 million was assumed by removing legal aliens from NJ FamilyCare, data are not readily available as to the program's legal alien enrollment.

The reporting category which includes legal aliens also includes other NJ FamilyCare eligibility groups, such as adults who are eligible for the program as a result of the NJ ACCESS program. Thus, even though legal aliens were to be removed from NJ FamilyCare, effective April 2010, the number of eligible persons in the enrollment category that includes legal aliens increased between March – December 2010, from 12,300 to 13,300.

[13] To determine how many of the 16,200 persons with incomes above 133% FPL are now enrolled in the under 133% FPL income group, one would have to cross match the names of NJ FamilyCare eligibles at a certain point in time.

Background Paper: Hospital Relief Subsidy Fund Payments

Budget Page.... D-181, D-183.

Funding ($000)	Expended FY 2010	Adj. Approp. FY 2011	Recomm. FY 2012
Hospital Relief Offset Payments (HROP)	**$63,991**	**$62,645**	**$62,645**

BACKGROUND

In FY 2012, hospitals will receive $166.6 million (gross) in Hospital Relief Subsidy Fund payments, including monies for Hospital Relief Offset Payments (HROP). The formula by which such funds are distributed will differ in FY 2012 from the one used in FY 2011. The revised distribution formula appears on p. D-183. The changes to the formula are intended to make "funding more equitable and predictable" and allow "more funds to go to patient care rather than administrative costs."

Under the revised formula, certain hospitals that did not receive funds in FY 2011 will receive funds in FY 2012, while hospitals that received funds in FY 2011 may receive more or less HROP funds in FY 2012.

On the following pages is a breakdown of the amount hospitals received in 2011 and will receive in FY 2012 according to the department.

Background Paper: Hospital Relief Subsidy Fund Payments

Table 1. Hospital Relief Offset Payments, FY 2011 and FY 2012

	HROP ($000)		
HOSPITAL	**FY 2011**	**FY 2012**	**CHANGE**
Atlantic City Regional Medical Center	$7,612	$6,790	**($822**)
Bayonne Medical Center		$10	$10
Bayshore Community Hospital		$25	$25
Bergen Regional Medical Center	$13,021	$14,277	$1,256
Cape Regional Medical Center (Burdette Tomlin)		$328	$328
Capital Health System at Fuld	$4,907	$3,612	**($1,295)**
Capital Health System at Mercer	$2,403	$2,004	**($399)**
Centrastate Medical Center		$470	$470
Chilton Memorial Hospital		$133	$133
Christ Hospital	$1,964	$2,241	$277
Clara Maass Medical Center	$2,256	$2,877	$621
Community Medical Center		$465	$465
Cooper Hospital/Univ. Medical Center	$7,757	$6,218	**($1,539**)
Deborah Heart & Lung Center		$1	$1
East Orange General Hospital	$3,902	$2,750	($1,152)
Englewood Hospital		$426	$426
Hackensack Hospital/Univ. Medical Center		$1,463	$1,463
Hackettstown Community Hospital		$177	$177
Hoboken University Medical Center		$1,079	$1,079
Holy Name Hospital		$300	$300
Hunterdon Medical Center		$127	$127
Jersey City Medical Center	$8,906	$7,701	**($1,205)**
Jersey Shore Medical Center		$3,578	$3,578
JFK Medical - Yelensics		$424	$424
Kennedy Hospitals	$7,550	$6,182	**($1,368)**
Kimball Medical Center	$5,264	$5,133	**($131)**
Lourdes Medical Center (Burlington)	$2,213	$2,059	**($159)**
Meadowlands Hosp Medical Center		$225	$225
Memorial Hos. Salem County		$193	$193
Monmouth Medical Center	$9,223	$7,915	**($1,308)**
Morristown Memorial Hospital		$465	$465
Mountainside Hospital		$275	$275
Newark Beth Israel Medical Center	$15,751	$12,509	**($3,242)**
Newton Memorial		$151	$151
Ocean Medical Center		$285	$285
Our Lady of Lourdes Medical Center	$2,919	$2,413	**($506)**
Overlook Hospital		$282	$282
Palisades Medical Center of New York		$947	$947
Raritan Bay Medical Center	$2,238	$2,466	$228
Riverview Hospital		$285	$285
RWJ University Hosp at Hamilton		$218	$218
RWJ University Hospital (New Brunswick)	$5,899	$4,009	**($1,890)**
RWJ University Hospital at Rahway		$2	$2
Shore Memorial Hospital		$367	$367
Somerset Medical Center		$337	$337

Background Paper: Hospital Relief Subsidy Fund Payments (Cont'd)

HOSPITAL	FY 2011	FY 2012	CHANGE
South Jersey Healthcare Regional	$2,532	$4,440	$1,908
South Jersey Hospital - Elmer		$65	$65
Southern Ocean County Hospital		$146	$146
St. Barnabas Medical Center		$492	$492
St. Clare's Hospital/Denville	$5,350	$5,650	$300
St. Clare's Hospital/Sussex		$4	$4
St. Francis Medical Center	$1,798	$1,277	**($521)**
St. Joseph's Hospital	$11,027	$10,877	**($150)**
St. Mary's Hospital (Passaic)	$1,977	$2,316	$339
St. Michael's Medical Center	$7,991	$6,758	**($1,233)**
St. Peter's Medical Center	$6,719	$4,564	**($2,155)**
Trinitas Hospital	$6,374	$9,682	$3,308
Underwood Memorial Hospital		$768	$768
University Hospital (UMDNJ)	$19,049	$13,797	**($5,252)**
University Medical Center At Princeton		$332	$332
Valley Hospital		$153	$153
Virtua Health Sys., Burlington		$712	$712
Virtua – West Jersey Health System		$347	$347
Warren		$27	$27
TOTAL (may not add due to rounding)	**$166,600**	**$166,600**	

Background Paper: Graduate Medical Education Funding

Budget Page.... D-181, D-183 to D-184.

Funding ($000)	Expended FY 2010	Adj. Approp. FY 2011	Recomm. FY 2012
Graduate Medical Education	**Not displayed as a distinct line item.**	**$30,000**	**$45,000**

BACKGROUND AND ANALYSIS

The FY 2012 recommended budget provides for a $30 million (gross) increase in the amount hospitals are reimbursed for Graduate Medical Education (GME), from $60 million to $90 million and revises the distribution formula for GME funding. The changes to the Charity Care formula are intended to make "funding more equitable and predictable" and allow "more funds to go to patient care rather than administrative costs."

Table I provides information as to how much hospitals received in GME in FY 2011 and the amount hospitals will receive in FY 2012. Even though the total amount of GME to be distributed will increase in FY 2012, one hospital, Hackensack University Medical Center, will receive less GME funds in FY 2012 than it received in FY 2011. Why under the new distribution formula Hackensack is the only hospital to see a decrease in GME funds is not known.

The formula by which GME funds will be distributed in FY 2012 is changed from the one used in FY 2011. Thirteen hospitals which did not receive GME in FY 2011 will receive GME in FY 2012. Many hospitals will see significant dollar or percentage increases in the amount of GME they will receive between FY 2011 and FY 2012.

Table 1. Graduate Medical Education Reimbursement, by Hospital, FY 2011 and FY 2012 (est.) ($000)

HOSPITAL	FY 2011	FY 2012	CHANGE
Atlanticare Regional	$1,085	$1,622	$537
Bergen Regional		$371	$371
Capital Health (Fuld)	$474	$950	$476
Capital Health (Mercer)	$47	$76	$29
CentraState Medical	$143	$144	$1
Christ Hospital	$210	$340	$130
Cooper Hospital	$7,587	$9,709	$2,122
Deborah Heart and Lung		$96	$96
Englewood Hospital		$157	$157
Hackensack University	$3,198	$3,117	($81)
Hoboken University	$285	$495	$210
Hunterdon Medical Center		$31	$31
Jersey City Medical	$2,059	$3,881	$1,822
Jersey Shore University	$1,868	$2,549	$681
JFK Medical – Yelencsics		$103	$103
Kennedy Hospitals	$3,516	$4,381	$865

Background Paper: Graduate Medical Education Funding (Cont'd)

Lourdes Medical (Burlington)	$71	$124	$53
Monmouth Medical	$2,251	$3,308	$1,057
Morristown Memorial		$662	$662
Mountainside Hospital		$127	$127
Newark Beth Israel	$9,770	$11,964	$2,194
Our Lady of Lourdes	$658	$1,049	$391
Overlook Hospital		$179	$179
R. W. Johnson University	$7,825	$10,593	$2,768
Raritan Bay Medical	$398	$628	$230
St. Barnabas Medical		$472	$472
St. Francis Medical	$236	$383	$147
St. Joseph's Regional	$7,384	$9,225	$1,841
St. Mary's Hospital		$3	$3
St. Michael's Medical	$1,798	$2,910	$1,112
St. Peter's University	$2,254	$2,670	$416
Somerset Medical		$72	$72
South Jersey Healthcare Regional		$29	$29
Trinitas	$1,359	$2,188	$829
Underwood Memorial		$57	$57
University Hospital (UMDNJ)	$5,298	$14,804	$9,506
University Medical (Princeton)	$254	$338	$84
	$60,000	**$90,000**	**$30,000**

Background Paper: Medicaid/NJ Family Care Managed Care Revenues and Expenditures, FY 2008 – FY 2010

Budget Page.... D-181.

Funding ($000)	Expended FY 2010	Adj. Approp. FY 2011	Recomm. FY 2012
Managed Care	**$742,988**	**$1,070,047**	**$1,080,540**
NJ FamilyCare - - Affordable and Accessible Health Coverage Benefits[14]	**$227,674**	**$223,763**	**$249,588**

Summary

The FY 2012 budget recommends $1.08 billion (State) for the Managed Care Initiative. Also, much of the $249.6 million (State) recommended for NJ FamilyCare is for managed care programs. The recommended budget would require about 121,000 Medicaid recipients who currently are not enrolled in managed care to enroll in a Medicaid managed care program. This group includes 95,000 aged, blind and disabled persons who are Medicare eligible, 10,000 aged, blind and disabled persons who are not Medicare eligible. and over 5,000 children under DYFS supervision. Savings of $41.4 million are anticipated.

The State contracts with four managed care organizations[15] to provide various healthcare services. During December 2010, managed care enrollment was 981,400 including various Medicaid eligibles – 523,500, NJ FamilyCare Children – 154,000, NJ FamilyCare Adults – 184,900, various disabled groups – 103,200, and other categories -15,800.

Table I (subsequent) summarizes revenue and expenditure data for managed care organizations for the FY 2008 – FY 2010 period, as reported to the Division of Medical Assistance and Health Services. The data indicate that between FY 2008 – FY 2010:

- Total revenues to managed care organizations increased 32.5%, from approximately $2.0 billion to over $2.6 billion.
- Medical and hospital expenses paid by managed care organizations increased nearly 36%, from about $1.7 billion to $2.3 billion.
- The Medical Loss Ratio, a key figure in determining the percentage of premium income spent on health care, ranged from 85.3% to 87.5%.
- Administrative costs of the managed care organizations increased 6.1%, from over $226.1 million to nearly $240 million.

[14] Most of the appropriation is for managed care services, although until a recipient is enrolled in a managed care program, reimbursement is on a fee-for-service basis. Also, the appropriation includes monies for medical services that are not provided through managed care, such as mental health services which are reimbursed on a fee-for-service basis.

[15] In FY 2008 and FY 2009 five managed care organizations participated in the program: Horizon NJ Health; University Health Plan; Health Net of New Jersey; AmeriChoice of New Jersey; and Amerigroup Community Care New Jersey. During FY 2010, a sixth managed care company, healthfirst NJ, began operations, though its operations are limited to the northern portion of the State. Two managed care organizations, University Health Plans and Health Net of New Jersey discontinued operations during FY 2010. At present, there are four managed care organizations participating in the Medicaid/NJ FamilyCare programs.

Background Paper: Medicaid/NJ FamilyCare Managed Care Revenues and Expenditures, FY 2008 – FY 2010 (Cont'd)

In addition, the following is noted concerning **Table 1**:

- As a snapshot of expenditures/revenues, the reported data may be revised in subsequent quarterly reports. For example, several managed care organizations reported no administrative costs related to Compensation. As it is highly unlikely that the managed care organizations had no Compensation expenses, Compensation cost may have been reported as some other administrative expenses.

- Revenues from Premiums increased at a faster rate than Enrollment categorized as member months, 34.4% versus 21.7%. As premiums are based on the type of client who enrolls in managed care program, if more high cost recipients, such as pregnant women and the disabled, enroll in managed care than low cost recipients, such as children, revenues from premiums would increase faster than enrollment growth.

- Total reported expenditures increased 32.4%: Medical and Hospital expenditures - 35.9% and Administrative costs - 6.1%. Thus, while Premium revenues increased by 34.4%, the percentage increase in Premiums closely tracks the increase in overall expenditures.

- Managed care organizations have discretion in reporting Medical and Hospital Expenses. For example, while reported "family planning" expenditures increased over 310%, from $1.5 million to $6.2 million, several managed care organizations reported no expenditures on family planning services. "Family planning" costs are likely being reported in other service categories such as "primary care," "physician specialty services," or "outpatient hospital"[16].

- Administrative costs related to "subcontracted/delegated administrative services" increased 66.3% between FY 2008 – FY 2010. Specific information regarding what administrative functions have been subcontracted or delegated is not available though informal information indicates that "claims processing" is frequently subcontracted.

- Reported Net Income for the managed care organizations increased by over 1,200%, from $3.7 million to $48.6 million between FY 2008 – FY 2010. On an individual basis, three managed care organization reported losses ranging from less than $0.1 million to $15.8 million; three managed care organizations reported profits ranging from $3.4 million to $52.1 million.

- For reporting purposes, Horizon NJ Health reports income taxes on the line Provision for State, Federal and Other Governmental Income Taxes, even though Horizon is not subject to such taxes due to its non-profit status. This enables the department to compare Horizon NJ Health with other managed care organization which are required to pay income taxes.

[16] Proper reporting of "family planning" expenditures is important as federal reimbursement of 90% is available for such expenditures on behalf of Medicaid clients. The 90% federal match does not apply to the NJ FamilyCare program where all expenditures are reimbursed at a 65% federal rate.

Background Paper: Managed Care Revenues and Expenditures, FY 2008 – FY 2010 (Cont'd)

Table 1. Summary Income Statement for Managed Care Providers, FY 2008 – FY 2010 ($000)[17]

	FY 2008	FY 2009	FY 2010	% CHANGE, FY 08 -10
Member Months	**8,976,160**	**9,955,816**	**11,352,757**	**26.5%**
REVENUES:				
Capitated Premiums	$1,699,169	$1,953,667	$2,301,795	35.5%
Maternity	248,984	293,603	321,450	29.1%
Reimbursable HIV/AIDS Drugs and Blood Products	13,229	14,769	16,209	22.5%
EPSDT Incentive Payment	4,157	4,975	5,272	26.8%
Other	2,184	250		(100%)
Total Premium Income	**1,967,723**	**2,267,264**	**2,644,726**	**34.4%**
Interest	26,308	21,155		(100%)
COB	573			(100%)
Reinsurance Recoveries	1,370	1,734		(100%)
TOTAL REVENUES	**$1,995,974**	**$2,290,153**	**$2,644,726**	**32.5%**
EXPENSES:				
Medical and Hospital				
Inpatient Hospital	$516,767	$563,110	$650,092	25.8%
Primary Care	151,239	166,974	199,667	32.0%
Physician Specialty Services	182,569	226,744	260,669	42.8%
Outpatient Hospital (excludes Emergency Room)	113,538	129,809	170,238	49.9%
Other Professional Services	6,782	8,668	14,932	120.2%
Emergency Room	138,650	172,431	208,991	50.7%
DME/Medical Supplies	43,872	68,320	73,692	68.0%
Prosthetics and Orthotics	4,821	6,099	8,215	70.4%
Covered Dental	35,193	42,662	38,659	9.8%
Pharmacy (excluding reimbursable HIV/AIDS Drugs and Blood Products)	191,573	211,692	232,929	21.6%
Reimbursable HIV/ADS Drugs and Blood Products	11,828	14,708	15,211	28.6%
Home Health, Hospice and PDN	10,339	11,315	11,799	14.1%
Transportation	20,858	23,922	27,615	32.4%
Lab and X-Ray	137,217	171,526	199,197	45.2%
Vision Care including Eyeglasses	18,784	21,591	30,291	61.3%

[17] Dollar amounts may not add due to rounding.

Background Paper: Managed Care Revenues and Expenditures, FY 2008 – FY 2010 (Cont'd)

Mental Health/Substance Abuse	7,172	10,347	10,009	39.6%
Reinsurance Expenses	3,256	3,354	1,316	(59.6%)
EPSDT Medical and PDN	40,511	45,119	53,492	32.0%
EPSDT Dental – EPD	60,462	75,561	94,740	56.7%
Family Planning	1,510	2,383	6,195	310.3%
Other Medical	4,634	23,441	5,287	14.1%
TOTAL MEDICAL AND HOSPITAL	**$1,701,575**	**$1,999,776**	**$2,313,236**	**35.9%**
MEDICAL LOSS RATIO (TOTAL MEDICAL AND HOSPITAL/TOTAL REVENUES)	**85.3%**	**87.3%**	**87.5%**	
ADMINISTRATION:				
Compensation	$57,428	$53,855	$57,764	0.6%
Occupancy/Depreciation/Amortization	5,495	6,175	7,392	34.5%
Interest Expense	1,203	3,213	1,359	13.0%
Education/Outreach/Marketing	8,876	8,725	8,872	0%
Sanctions	679	364	959	41.2%
Corporate Overhead Allocations	90,315	99,634	87,809	(2.8%)
Subcontracted/Delegated Administrative Services	7,335	7,104	12,196	66.3%
Other	54,786	58,764	61,688	12.6%
TOTAL ADMINISTRATION	**$226,117**	**$237,834**	**$239,942**	**6.1%**
TOTAL EXPENSES: MEDICAL AND HOSPITAL AND ADMINISTRATION	**$1,927,692**	**$2,237,610**	**$2,553,178**	**32.4%**
OPERATION INCOME(LOSS)	**$68,282**	**$52,543**	**$91,548**	**34.1%**
Extraordinary Item			30,368	N.A.
Provision for State, Federal and Other Governmental Income Taxes[18]	6,470	4,510	26,121	303.7%
Other Than Income Taxes	39,095	45,309	48,874	25.0%
Adjustment for prior period IBNR estimates	19,001	(31,437)	(1,716)	(109.0%)
Non-claim adjustments for prior periods				
NET INCOME(LOSS)	**$3,716**	**$34,161**	**$48,637**	**1,208.9%**

[18] Includes amounts reported by Horizon NJ Health for comparative purposes. Horizon NJ Health is not subject to such taxes due to its non-profit status.

Background Paper: Vineland Developmental Center Information

Budget Page.... D-192 to D-194; D-199.

Funding ($000)	Expended FY 2010	Adj. Approp. FY 2011	Recomm. FY 2012
Developmental Centers[19]	**$465,782**	**$498,680**	**$482,987**
Grants-In Aid:	**$962,049**	**$939,078**	**$991,069**

The FY 2012 recommended budget proposes to close the Vineland Developmental Center (VDC) – East Campus over the next several years. The West Campus is currently in the process of being closed.

The FY 2012 recommended budget includes $2.2 million in savings from the closure of the West Campus and $1.5 million in savings from the closure of the East Campus. The Grants-in-Aid budget includes either $6.6 million or $8.1 million[20] in funds to develop and facilitate the transfer of patients to community facilities. The East campus has about 330 residents, and as of this writing, information is not available as to how many residents will be placed into community programs, how many residents will transfer to other developmental centers or how many residents will be placed into nursing facilities.

This Background Paper provides general information concerning VDC.

Census. Since FY 2006, the average number of residents at Vineland has decreased from 478 to 400 (July 2010 – February 2011 average). In February 2011, there were 375 patients: East Campus - 43 and West Campus - 332.

A July 2002 point in time survey[21] of residents at the various developmental centers classified Vineland residents at the "low" competency range: only 14% of the residents could care for themselves and only 12% were mobile. Vineland residents had the following medical conditions or medical issues:

- Cerebral Palsy – 36%
- Psychiatric Diagnoses – 35%
- Epilepsy – 50%
- Visual Impairments – 27%
- Hearing Impairments – 13%

The most medically involved residents, about 60, reside in the Wolverton building. All are non-ambulatory and many are confined to bed. Their medical conditions may preclude nursing home placement as their complex medical conditions may exceed the type of care nursing homes generally provide. Placement of these residents into community programs may

[19] In FY 2010, $90.9 million was expended on behalf of Vineland. The FY 2012 recommended budget allocates approximately $79 million for Vineland.

[20] These figures are cited in two different budget documents.

[21] Descriptive Characteristics of Consumers Residing in DD Centers (July 2002). It is unlikely that the characteristics of residents have changed significantly. If anything, the percentage of residents with various medical conditions has likely increased, as higher functioning residents were placed into community programs.

Background Paper: Vineland Developmental Center Information (Cont'd)

be very expensive, as the residents may require 24 hour nursing supervision due to their medical condition.

Due to the medical conditions of its residents, VDC recorded the most patient deaths of all the developmental centers in 2009 (12) and 2010 (16).

Background Paper: Resident Living Specialist Job Title at Vineland Developmental Center

Budget Page.... D-192 to D194.

Funding ($000)	Expended FY 2010	Adj. Approp. FY 2011	Recomm. FY 2012
Vineland Developmental Center (VDC) (Est.)[22]*	**$90,896**	**$89,111**	**$78,989**

SUMMARY

Irrespective of whether the Vineland Developmental Center (VDC) should or should not be closed, the State would achieve savings by modifying or eliminating the union contract provision that requires VDC employees to staff privately operated group homes.

BACKGROUND AND ANALYSIS

For many years, as part of the State's labor agreement with the applicable union, over 200 VDC employees are assigned to staff the 23 residential programs operated by a private non-profit entity, PAFACOM. The 200 employees are classified as Resident Living Specialists (RLS), and the pay scale for the RLS job title is at a higher pay grade than other comparable VDC direct care job titles.

FY 2010 personnel costs associated with the RLS job title were $13.4 million, including $3.7 million for overtime costs[23], according to available information.

The union contract expires June 30, 2011. Eliminating or modifying this provision in the new union contract would reduce State costs associated with the PAFACOM residential programs.

Option 1 - Eliminate Vineland Staffing. Eliminating the requirement that VDC staff these residential facilities would reduce Vineland expenditures by about $13.4 million (gross)[24], assuming that staff are not retained.

PAFACOM would then have to hire its own staff to staff the residential facilities. While it is not known how much it would cost to staff the current group homes, as the salary and benefits costs of State employees are around 33% greater than the costs at non-profit agencies, the State would have to provide about $10 million to PAFACOM to staff the facilities. This would result in a $3.4 million (gross) savings, assuming that the State personnel are not retained.

Option 2 – Phase-Out Vineland Staffing. If the contract provision is continued, it could be modified so that during the course of the year, if a RLS leaves the position, PAFACOM would hire its own staff to replace the State employee.

[22] The Governor's recommended budget does not provide budget information for individual developmental centers. The amount identified comes from other documents available to this office.
[23] The $3.7 million in overtime represents nearly 50% of total overtime costs at the VDC.
[24] Additional savings would be realized in health benefits.

Background Paper: Resident Living Specialist Job Title at Vineland Developmental Center (Cont'd)

This would reduce overall costs as the personnel costs associated with non-State employees is significantly less than the cost of State employees. Assuming savings of $15,000 per employee in salary and benefit costs, savings of between $150,000 - $300,000 would be realized based on turnover of 10 – 20 State employees per year.

Option 3- Eliminate Vineland Staffing and Reassign Staff within Vineland. As indicated in **Option 1**, the approximate cost to staff the group homes with State personnel is approximately $13.4 million (gross). Requiring PAFACOM to hire its own staff to staff the residential facilities may cost $10 million. Thus, the State would save about $3.4 million in the operation of these community residential facilities.

Reassigning the 200+ staff to other positions at VDC would provide better staffing and could reduce VDC overtime costs of about $8.0 million. As some of the 200+ staff may retire or resign, costs associated with the reassignment will be less than $13.4 million.

A potential issue concerning the reassignment of staff from the PAFACOM facilities is that the job title - - Resident Living Specialist - - is not a job title currently used at VDC or other developmental centers. Thus, the job title would have to be restructured to fit into the job titles used at developmental centers. Alternatively, the RLS job title can be eliminated and personnel in those job titles can convert to other direct care job titles. However, this may result in a reduction in pay as the RLS job title is at a higher pay level than other direct care job titles used at developmental centers.

Background Paper: Community Care Waiver Background Materials

Schedule 2 Other Revenues ($000)	FY 2010 Actual	FY 2011 Estimated	FY 2012 Estimated
Title XIX Community Care Waiver (Federal)	**$309,718**	**$321,400**	**$353,425**

BACKGROUND

The Community Care Waiver (CCW) program enables persons with developmental disabilities to receive various community-based services as an alternative to being placed in a developmental center, and enables the Sate to receive federal Medicaid reimbursement for these services. CCW originated in the early 1980s. Even though all services available under CCW can now be provided to persons with developmental disabilities as part of the regular Medicaid program, the State continues to operate CCW as a waiver program[25].

This paper provides CCW information for the FY 2008 – FY 2010 period on:

- **Total Expenditures, by Service**
- **Recipients (Unduplicated), by Service**
- **Cost Per Recipient, by Service**

The following is noted regarding the data that are presented:

- The data are based on when a claim is paid, not when a service was provided. Thus, FY 2008 – FY 2010 data include expenditures and utilization data for services provided in prior fiscal years.[26] The data are not adjusted to reflect retroactive rate reimbursements. As such, a retroactive rate adjustment processed during FY 2010 is reported as a FY 2010 expenditure even if the expenditure relates to services provided in prior fiscal years.

- The data are based on a specific CCW report produced at a certain date during a given month. There are other CCW reports for the same time period which may provide different expenditure data, client data, etc. No attempt was made to reconcile different CCW data reported by different Medicaid reports.

Total CCW expenditures increased 14.8% between FY 2008 – FY 2010, to $582.9 million, as shown in **Table 1 (next page)**.

[25] By operating CCW on a waiver basis, the State is able to control the number of people who receive services and the related cost of providing those services. If CCW type services were provided as a regular Medicaid service, all developmentally disabled clients on Medicaid would be able to receive CCW services. This could result in a significant increase in the number of persons who use services and a related increase in program costs.

[26] In FY 2010, nearly 14% of total FY 2010 expenditures were for services provided in prior fiscal years. In FY 2009, over 18% of total expenditures were for services provided in prior fiscal years.

Background Paper: Community Care Waiver Background Materials (Cont'd)

Table 1. Total CCW Expenditures, by Service, FY 2008 – FY 2010 ($000)

CCW Service	FY 2008	FY 2009	FY 2010
Case Management	$9,605	$34,379	$17,628
Habilitation	109,917	116,536	124,868
Habilitation, Non-Adult Activities	3,627	4,090	4,859
Habilitation, Supported Employment	8,620	7,102	5,470
Individual Supports, Group Home	348,505	385,069	404,385
Individual Supports, Specialized Skill	6,243	10,079	7,183
Individual Supports, Self Determination	6,849	9,750	6,461
Other CCW Services[27]	14,279	12,839	12,027
TOTAL	**$507,645**	**$579,844**	**$582,881**

The $507.6 million, the $579.8 million and the $582.9 million reported for each of the past three fiscal years does not represent the total cost of services provided by the Division of Developmental Disabilities to CCW recipients or the total cost of services provided to CCW clients. For example, the federal CCW program does not reimburse for "room and board," and such costs are paid entirely with State funds. Also, the health care services utilized by CCW clients, such as prescription drugs, physician services, etc., are not reported as a CCW cost and are reflected in the Medicaid budget.[28]

Within the array of CCW services available to recipients, 70% of total CCW expenditures are for Individual Supports Group Home services and another 20% of total CCW expenditures are for Habilitation services. The remaining CCW services represent 10% of CCW expenditures.

Most of the increase in CCW expenditures between FY 2008 – FY 2010 occurred in FY 2009 and was due to a retroactive rate adjustment processed during FY 2009. The retroactive rate adjustment of approximately $105 million accounted for 18% of total CCW expenditures and affected Case Management, Habilitation, and Individual Supports Group Homes services.

Despite **Table 2** (next page) indicating that the number of unduplicated CCW recipients[29], decreased by 1.0% between FY 2008 – FY 2010, to 10,535, there may not have been any reduction in the overall number of people receiving services because the data reflects when a claim is paid, not when a service was provided. It is likely that some claims for CCW

[27] Other CCW Services include: Habilitation and Individual Supports, Keystone PA; Individual Supports, Skill Development Homes/Over Two Years; Individual Support, Supportive Living; Respite Care, Hourly and Daily; and Enviornmental/Vehicle Accessibility Modifications. Integrated Therapeutic Network Service is no longer a covered CCW service.

[28] Although available data indicates that in FY 2010, CCW clients incurred approximately $85 million in other Medicaid expenses, it is not known what these specific Medicaid services and costs were.

[29] The waiver identifies the maximum number of unduplicated clients to receive services in a fiscal year. The actual number of unduplicated clients served may exceed the number identified in the waiver as clients may be removed and added to the program.

Background Paper: Community Care Waiver Background Materials (Cont'd)

recipients will be paid during FY 2011 and that such individuals will be counted in FY 2011 data.

Within the array of CCW services available to recipients, virtually all recipients receive Case Management Services and over 50% of CCW recipients receive Habilitation and Individual Supports Group Home services.

Table 2. CCW Recipients (Unduplicated) by Service, FY 2008 – FY 2010

CCW Service	FY 2008	FY 2009	FY 2010
Case Management	10,605	10,451	10,509
Habilitation	5,844	5,826	5,778
Habilitation, Non-Adult Activities	521	556	696
Habilitation, Supported Employment	653	589	578
Individual Supports, Group Home	5,454	5,512	5,691
Individual Supports, Specialized Skill	332	323	320
Individual Supports, Self Determination	213	205	203
Other CCW Services	2,998	2,901	2,648
TOTAL[30]	**10,639**	**10,478**	**10,535**

Table 3 (next page) provides information on the CCW cost per recipient. Per recipient costs increased 16%, to over $55,300 per recipient, between FY 2008 and FY 2010.[31] Due to the retroactive rate adjustment that was processed in FY 2009. the per recipient cost increased by nearly 16% between FY 2008 – FY 2009.

[30] Total unduplicated number served will not equal the number of recipients who received individual CCW services.

[31] The per recipient cost was calculated by dividing CCW expenditures (Table 1) by CCW recipients (Table 2).

Background Paper: Community Care Waiver Background Materials (Cont'd)

Table 3. CCW Cost Per Recipient, by Service, FY 2008 – FY 2010

CCW Service	FY 2008	FY 2009	FY 2010
Case Management	$906	$3,676	$1,677
Habilitation	$18,809	$20,003	$21,611
Habilitation, Non-Adult Activities	$6,962	$7,356	$6,981
Habilitation, Supported Employment	$13,201	$12,058	$9,463
Individual Supports, Group Home	$63,899	$69,860	$71,057
Individual Supports, Specialized Skill	$18,804	$31,204	$22,446
Individual Supports, Self Determination	$32,157	$47,561	$31,830
Other CCW Services	$4,763	$4,426	$4,542
TOTAL	**$47,715**	**$55,339**	**$55,328**

The most expensive CCW service provided is Individual Supports Group Home, at an annual cost of over $71,000 per recipient.

As was noted, the per recipient cost of CCW services, $55,328, in FY 2010 does not include the cost of other DDD services provided, most notably "room and board." The per recipient cost also does not include Medicaid expenditures made on behalf of the individual or the cost of other federal assistance the recipient may receive, such as SNAP (Food Stamp) benefits and SSI benefits. Such costs would increase the overall per capita cost of providing community-based services to clients in the CCW waiver.

Background Paper: Proposed General Assistance Changes

Budget Page.... D-208.

Funding ($000)	Expended FY 2010	Revised FY 2011	Recomm. FY 2012
General Assistance Emergency Assistance Program	**$84,950**	**$97,200**	**$81,740**
Payments for the Cost of General Assistance	**$90,730**	**$106,042**	**$91,867**

SUMMARY

The FY 2012 recommended budget restructures the General Assistance (GA) program, saving $30.8 million. According to the Budget Summary: "The new program will provide monthly cash assistance and 18 months of emergency assistance. The program will require new applicants to undergo a job search and, as appropriate, substance abuse treatment during an initial evaluation period."[32]

Pursuant to budget language on page D-210, the monthly benefit GA recipients receive would be reduced by $15 per month. Thus, "employable" GA recipients would receive $125, rather than $140, while "unemployable" GA recipients would receive $195, rather than $210. In addition, "unemployable" GA recipients must "prove that they are medically unable to work for six continuous months" to receive benefits[33].

December 2010 data indicates the following:

- There are nearly 55,500 GA recipients: Employable – 37,500 and Unemployable – 18,000.

- Annualized expenditures approximate $207.8 million (gross) as follows: Employable - $122.4 million and Employable - $84.8 million. Approximately $85.4 million represents emergency assistance expenditures.

BACKGROUND INFORMATION

GA provides financial assistance primarily to single persons and married couples without children who are not eligible for Temporary Assistance for Needy Families or Supplemental Security Income (SSI), or whose application for federal SSI or Social Security disability benefits is pending.

GA recipients receive $140 per month, if classified as "employable," or $210 per month, if classified as "unemployable." GA recipients may be eligible for emergency assistance benefits, on a case-by-case basis and are also eligible for SNAP (food stamp)

[32] GA recipients are already required to participate in the Substance Abuse Initiative program. In FY 2011, over 7,700 employable GA recipients may be referred to the program, over 5,500 recipients may be assessed by the program and nearly 4,900 recipients may be referred for substance abuse treatment services.

[33] It is not known whether this requirement applies to individuals who filed for federal Social Security Disability benefits or SSI benefits and are awaiting a decision on their application..

Background Paper: Proposed General Assistance Changes (Cont'd)

benefits[34]. Though GA recipients are not eligible for federal Medicaid benefits, they receive State funded health services, excluding inpatient and outpatient hospital services. (Hospital costs incurred by GA recipients qualify as hospital Charity Care.[35]

In December 2010, 37,500 persons were considered "employable" and 18,000 persons were classified as "unemployable." **Table I** below provides a breakdown of the December 2010 caseload by county. The data indicate that nearly 68% of the Statewide caseload is classified as "employable," but that percentage ranges widely: In Hudson, 48% of the caseload is classified as "employable" while 77% of the cases in Essex are classified "employable." **Table I** also indicates that nearly 40% of the "employable" caseload reside in three counties (Camden, Essex and Passaic).

Table I. December 2010 General Assistance Recipients, by County

COUNTY	TOTAL	EMPLOYABLE	UNEMPLOYABLE
Atlantic	3,100	2,200	900
Bergen	1,800	1,000	800
Burlington	2,200	1,500	700
Camden	6,600	4,200	2,400
Cape May	1,100	1,000	200
Cumberland	2,800	2,100	700
Essex	9,200	7,100	2,100
Gloucester	1,800	1,200	600
Hudson	4,200	2,000	6,200
Hunterdon	500	200	200
Mercer	3,000	2,000	1,000
Middlesex	1,600	900	700
Monmouth	1,400	800	500
Morris	1,100	600	500
Ocean	2,900	1,900	1,000
Passaic	5,000	3,600	1,400
Salem	500	400	200
Somerset	600	300	300
Sussex	400	200	200
Union	3,200	1,800	1,400
Warren	500	300	200
STATE TOTAL	**55,500**	**37,500**	**18,000**

(Totals may not add due to rounding.)

[34] The proposed $15.00 per month reduction in GA benefits may result in a $4.00 increase in SNAP benefits.

[35] The FY 2012 recommended budget assumes that the federal government will allow federal Medicaid funds to be used for this population group.

Background Paper: Proposed General Assistance Changes (Cont'd)

Table II provides GA expenditure data for December 2010.

Table II. December 2010 General Assistance Expenditures ($000)

	TOTAL	EMPLOYABLE	UNEMPLOYABLE
Non-Emergency Assistance Costs			
Maintenance	$9,925	$5,715	$4,210
Burial	52	32	20
Transportation	161	85	75
Work Related Expenses	13	12	1
Emergency Assistance Costs			
Temp. Rental Assist.	$2,673	$1,350	$1,323
Shelter/Motel/Housing	3,196	2,230	966
Utilities	133	85	48
Rent	728	451	278
Relocation Costs	9	3	6
Security Deposit	257	170	87
Storage Cost	3	1	3
Emergency Food	1	1	0
EF Homeless	1	1	0
Essential Furnishings	96	52	44
Emergency Clothing	1	0	0
Citizen Application Fee	14	8	6
STATE	**$17,265**	**$10,197**	**$7,068**

(Totals may not add due to rounding.)

On an annual basis, based on December 2010 expenditure data, GA expenditures approximate $207.2 million: Employable - $122.4 million and Unemployable - $84.8 million. Annual Emergency Assistance expenditures are estimated at $85.4 million. These gross costs are reduced $22 to $23 million in SSI recoveries.

OFFICE OF LEGISLATIVE SERVICES

The Office of Legislative Services provides nonpartisan assistance to the State Legislature in the areas of legal, fiscal, research, bill drafting, committee staffing and administrative services. It operates under the jurisdiction of the Legislative Services Commission, a bipartisan body consisting of eight members of each House. The Executive Director supervises and directs the Office of Legislative Services.

The Legislative Budget and Finance Officer is the chief fiscal officer for the Legislature. The Legislative Budget and Finance Officer collects and presents fiscal information for the Legislature; serves as Secretary to the Joint Budget Oversight Committee; attends upon the Appropriations Committees during review of the Governor's Budget recommendations; reports on such matters as the committees or Legislature may direct; administers the fiscal note process and has statutory responsibilities for the review of appropriations transfers and other State fiscal transactions.

The Office of Legislative Services Central Staff provides a variety of legal, fiscal, research and administrative services to individual legislators, legislative officers, legislative committees and commissions, and partisan staff. The central staff is organized under the Central Staff Management Unit into ten subject area sections. Each section, under a section chief, includes legal, fiscal, and research staff for the standing reference committees of the Legislature and, upon request, to special commissions created by the Legislature. The central staff assists the Legislative Budget and Finance Officer in providing services to the Appropriations Committees during the budget review process.

Individuals wishing information and committee schedules on the FY 2012 budget are encouraged to contact:

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