

Department of Human Services' Follow Ups
Assembly Budget Committee Hearing on April 7, 2011

During the hearing on the Department of Human Services before the Assembly Budget Committee on April 7, 2011, committee members asked the following questions for which a written response would be appropriate:

All Members:

Clarification would be appreciated concerning the elimination of itinerant teachers, in the Commission for the Blind and Visually Impaired (CBVI) particularly since the Program Data provided in the FY 2012 recommended budget, as displayed below, may be incorrect. The Executive Director of the CBVI cited different data from those included in the recommended budget.

	FY 2009 Actual	FY 2010 Actual	FY 2011 Revised	FY 2012 Est.
Total Number of school-aged children receiving itinerant services	2,429	2,322	2,325	2,350
Average direct service caseload size	40	37	38	39

Specifically, for the FY 2009 – 2011 period, provide the following information:

A breakdown as to the number of full and part-time itinerant teachers employed by CBVI.

A breakdown of the number of teaching hours provided per employee and the number of administrative hours per employee.

The number of school aged children who receive itinerant services.

The average caseload size per teacher.

With respect to FY 2012, please provide similar information as identified above with respect to the number of full and part-time itinerant teachers to be employed; the number of teaching hours and the number of administrative hours to be provided per employee, the number of school aged children expected to receive itinerant services, and the average caseload size per teacher.

Answer: The Commission employs only full time itinerant teachers. This breakdown is based on the total number of clients receiving educational services. The Average Number of Total Lesson Hours per Teacher per Pay Period and Office/Prep Hours (administrative) per Pay Period for 2009, 2010 and 2011 is based on the ten-month model CBVI has used for many years. The ten-month model has 2 office/administration days per Pay Period. The 2012 projected numbers use a twelve-month model and 1 office/administration day per Pay Period. The Average Number of Total Lesson Hours per Teacher per Year increases from 295 in FY 2011 to 423 in FY 2012. The reduction in teachers will not negatively impact the services conducted for the existing children.

	<u>2009 (actual)</u>	<u>2010 (actual)</u>	<u>2011 (revised)</u>	<u>2012 (projected)</u>
Total Number of Teachers (10 month/12 month)	65 (20/45)	65 (20/45)	65 (20/45)	45 (all 12 months)
Total Number of Students Receiving Educational Services	2645	2494	2059	2000
Average Number of Total Lesson Hours Per Teacher Per Year.	295 (10 months)	295 (10 months)	295 (10 months)	423 (12 months)
Office/Prep Hours Per Year	287 (10 months)	287 (10 months)	287 (10 months)	182 (12 months)
Teacher/Student Ratio	1:41	1:38	1:32	1:42
Average Number of Total Lesson Hours Per Student	7 (10 months)	8 (10 months)	9 (10 months)	10 (12 months)

Assemblyman Burzichelli:

- Please elaborate on the standards used with respect to counting unearned income in the Medicaid (Title XIX) and NJ FamilyCare (Title XXI) programs.

Answer:

Income which is not earned:

Net income from noneligible household members (except as stated in N.J.A.C. 10:69-10:12c), returns from capital investment such as dividends and interest, benefits and pensions, annuities, contributions from relatives, compensation payments, and any other payments not considered as earned income, shall be considered as unearned income. All such income shall be recognized in establishing eligibility.

Definition of earned income:

(a) Earned income refers to gross income earned by an individual through the receipt of wages, tips, salaries or commissions from activities in which he or she is engaged as an employee or from his or her self-employment. It includes earnings over a period of time for which settlement is made in one payment, as in the sale of farm crops.

(b) When an individual receives shelter in return for performing work duties, the monetary value shall be determined from Schedule VI in N.J.A.C. 10:69- 10:42(c) and included in the total amount of gross earned income. The amount of mandatory payroll deductions to be recognized shall be determined in relation to such total amount.

(c) When an individual is employed in a position where tipping is customary, a daily log or other acceptable documentation of tips received shall be used for income calculation. Tips income calculation shall not be based on estimated information as reported on W-2 forms.

Assemblyman Johnson:

- The number of psychiatric admissions to Bergen Regional has increased as follows: FY 2008 – 4,530; FY 2009 – 5,080; FY 2010 – 5,300; and FY 2011 – 5,740 (est.). The department attributes this increase to better management on the part of Bergen Pines in handling admissions.

Please provide information as to the number of billable days paid by the department for the care of patients at Bergen Pines for the FY 2008 – FY 2011 (est.) period. If there has been an increase in the number of billable days paid by the department, is the increase attributable to the increase in the number of admissions to Bergen Regional?

Answer: The actual and estimated number of billable inpatient days paid for State Aid funded psychiatric patients at Bergen Regional Medical Center during the years in question as follows;

- FY 2008 Actual – 74,440
- FY 2009 Actual – 74,355
- FY 2010 Actual – 76,177
- FY 2011 Estimated – 78,475

With regard to admissions, while they have increased somewhat over the period in question, this increase is not the cause of the increase in billable days paid as noted above, as discharges have similarly increased and the resulting total average census has remained relatively flat. Instead, the mix of patient payers has changed somewhat with a lesser number of Medicaid eligible patients yielding a somewhat higher level of billable days paid over this period.

Assemblywoman Pou:

- A supplemental appropriation for \$22.0 million is anticipated in FY 2011 for the department. The department indicated that the supplemental appropriation is needed as Direct State Services accounts throughout the department were under funded in the FY 2011 appropriations act.

As the department had indicated during the FY 2011 budget hearings that such accounts were adequately funded in FY 2011, why is a supplemental appropriation needed?

Can the department assure the committee that the recommended Direct State Services appropriations are adequate and that a supplemental appropriation will not be needed in the latter half of FY 2012?

Answer: While these amounts are reflected in the Division of Management and Budget section of the Department of Human Services, they actually pertain to one time needs throughout the department. The Supplemental needs were based on our most recent spending plan projections where spending is expected to exceed appropriation levels mostly within the facilities operated by the Divisions of Mental Health and

Addiction Services and Developmental Disabilities. Approximately 90% of the Department's FTE's are allocated to these Divisions where we operate seven Developmental Centers and five Psychiatric Hospitals that require 24/7 levels of care. The main reasons why these supplementals are needed and we believe are one time in nature are because of the following: (1) Overtime is slightly higher than projected as a result of greater than anticipated call outs from snow storms and the unanticipated utilization of Paid Leave Bank days which all employees were required to take by June 30, 2011. (2) Resources were not aligned in certain Divisions like Central Office where consolidations of programs like Licensing, Guardianship and the DC Investigators were moved from various Division's into Central Office. In these cases, supplemental appropriations are needed since the Appropriation's Act never accounted for these moves. (3) Higher than expected non-salaries fuel costs. The \$22M supplemental identified above represents a 2% overall DSS projection variance, most of which could not have been anticipated for reasons cited above. DHS believes these one time needs will not reoccur in FY12, therefore, supplemental funding in FY11 is not expected to continue into FY12.

Assemblywoman Quigley:

- The department indicated that utilization management of prescription drugs used by the disabled would be improved by having managed care organizations handle the dispensing of medications. It was specifically mentioned that managed care organizations can better monitor drug-to-drug interactions, duplicate therapies, and achieve greater generic drug utilization. Further, it was indicated that managed care companies receive better prescription drug prices and would be able to generate more rebates from drug manufacturers.

Medicaid's fiscal intermediary has hundreds of pharmacy edits intended to control and monitor prescription drug utilization. For example, Edit 0405 addresses "possible therapeutic class duplication." Further, as pursuant to federal law, the Medicaid program must receive the lowest possible price for prescription drugs, managed care organizations should not receive better prices than the Medicaid program. Finally, the Medicaid program receives rebates for prescription drugs provided by managed care programs.

Please clarify the department's response as to why prescription drugs for the disabled is being shifted to managed care providers.

Answer: We are proposing to include the prescription drug benefit under managed care, for the Aged, Blind & Disabled populations, to improve the quality of care and health outcomes. The managed Care Organizations (MCO) will be able to monitor and coordinate both physical health services and pharmacy utilization. MCO edits would provide a more complete care management system which will review claims for such items as: over dosage, multiple scripts for the same or similar drugs, identification of interactive drugs issues, age appropriate dosage, questionable off label usages and diagnosis/drug relationships. In addition, MCOs utilize pharmacy management and purchasing strategies that go beyond Medicaid Fee-For-Service such as: supplemental rebates, better purchase pricing and greater generic drug utilization.

Assemblywoman Watson-Coleman:

- Pursuant to budget language on D-213, the amount of monies made available to provide indigent patients at State institutions with a personal needs allowance is being reduced from \$1,375,000 to \$750,000.

What is the basis for this reduction?

Answer: This language pertains to the provision of Personal Needs Allowance for individuals in our State owned and operated facilities that have no resources of their own. The so called "State PNA" is set at \$40 per month. Previously the dollar threshold was estimated to be \$1,375,000. In reality, we have not needed more than \$750,000 for the past several years, so the language was modified to provide a more accurate presentation of need. The \$40 per month amount is unchanged.

- The department indicated that it had entered into a Memorandum of Agreement (MOA) with the four managed care organizations that provide services to Medicaid/NJ FamilyCare recipients to implement the Medical Home Model.

Please provide a copy of the MOA. Does the MOA identify the number of recipients who will participate or target specific individuals to be part of the Medical Home Model?

Answer: Attached is the template MOA that was used for all four MCOs. The MOA does not include the number of recipients that would be targeted but does require the MCOs to contract with providers that treat recipients with chronic disease and/or behavioral health condition. It also encourages the MCOs to target populations with frail elderly or disabled populations.

- In cooperation with the Division of Taxation, please identify how many families were affected by changes to the Earned Income Tax Credit (EITC) in FY 2011? Is it possible to identify how many of these families became eligible for TANF benefits as a result of the reduction in the EITC?

Answer: For tax year 2010, (thru March 31st) the number of EITC recipients increased by approximately 9,700 recipients from tax year 2009. The average EITC return for 2010 is \$542 which is \$130 less than tax year 2009. There is no way for DFD to ascertain how many families became eligible for TANF based on the EITC reduction.

MEMORANDUM OF AGREEMENT

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

AND

XXX HMO

FOR

DEVELOPMENT, ESTABLISHMENT AND ADMINISTRATION OF A THREE-
YEAR MEDICAL HOME DEMONSTRATION PROJECT

This agreement is made by and between the State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services (hereinafter referred to as "DMAHS") and XXX (hereinafter referred to as "the HMO").

I. PURPOSE

The purpose of this Agreement is to formally describe the relationship between the HMO and DMAHS relative to developing, implementing and administering a three-year Medical Home Demonstration Project in fulfillment of their respective responsibilities with P.L. 210 c. 74, and any applicable regulations and policy.

DMAHS's intent is to encourage value-based innovations within the HMO that will result in improved and documented clinical outcomes, patient and provider satisfaction, seamless integration of care services and cultural and health literacy.

II. IN CONSIDERATION OF THE RESPECTIVE STATUTORY MANDATES AND THE MUTUAL PROMISES CONTAINED HEREIN, IT IS AGREED AS FOLLOWS:

A. DMAHS agrees to:

- Review payment methodologies submitted by the HMO that support care coordination and reward quality and improved patient outcomes.
- Evaluate outcomes on quality, satisfaction and efficiency as reported by the HMO.
- Provide initial funding for start up in the amount of \$50,000. An additional payment of \$50,000 will be made upon successful Level I

Memorandum of Agreement: DMAHS and HMO XXX

accreditation by the National Committee for Quality Assurance (NCQA) end of year one of the pilot project.

B. The HMO agrees to:

- Identify and contract with primary care providers for participation in the Demonstration Project that provide care to their patients with a chronic health condition(s) and/or behavioral health condition using a medical home model.
- Encourage development of medical homes focused on persons with a developmental disability and frail elderly.
- Assure selected medical homes attain the following accreditation:
 - NCQA Level I by end of year 1 of the pilot
 - NCQA Level II by end of year 2 of the pilot
 - NCQA Level III is optional
- Assure that the medical home will provide the following services at a minimum but not exclusively, as appropriate:
 - Patient centered care using a multidisciplinary team of health care professionals that coordinate care through use of health information technology and chronic disease registries across all domains of the health care system and the patient's community, including active participation by patient and family in decision-making and care planning.
 - Individual customized care plans that promote self-management behaviors
 - Patient and family education for patients with chronic diseases
 - Home-based services
 - Telephonic communication
 - Group care
 - Oral health examination
 - Culturally and linguistically appropriate care
- The medical home will collect data and report in a format described by DMAHS on the following items for annual submission to DMAHS for review:
 - At a minimum two quality measures
 - One satisfaction survey
 - Efficiency measures
- Develop medical homes guided by the Joint Principles of the Patient Centered Medical Home (PCPCC). The principles are:

Memorandum of Agreement: DMAHS and HMO XXX

- **Personal physician:** "each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care."
- **Physician directed medical practice:** "the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients."
- **Whole person orientation:** "the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals."
- **Care is coordinated and/or integrated,** for example across specialists, hospitals, home health agencies, and nursing homes.
- **Quality and safety** are assured by a care planning process, evidence-based medicine, clinical decision-support tools, performance measurement, active participation of patients in decision-making, information technology, a voluntary recognition process, quality improvement activities, and other measures.
- **Enhanced access** to care is available (e.g., via "open scheduling, expanded hours and new options for communication").
- **Payment** must "appropriately recognize[s] the added value provided to patients who have a patient-centered medical home." For instance, payment should reflect the value of "work that falls outside of the face-to-face visit," should "support adoption and use of health information technology for quality improvement," and should "recognize case mix differences in the patient population being treated within the practice."

III. This agreement shall be effective on the date the last signatory signs below.

IV. This agreement may be amended only by a written addendum signed by all parties.

Valerie J. Harr
Director
Division of Medical Assistance and
Health Services