Discussion Points (Cont'd)

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?**

  Answer: The CAFR and the recommended budget utilize different reporting methods to compile the patients' and residents' cost recoveries. In addition to the final revenue figures being drawn from the State accounting system at different times, the CAFR utilizes an accounts receivable factor for Patients' and Resident Cost Recoveries which is not utilized in the budget presentation.

  Reporting based upon the same method of accounting suggests that actual collections were $2 million higher than anticipated. Medicaid collections were $7 million in surplus primarily due to a few large positive settlement payments. Medicare Part A collections were $5 million short of anticipation, partially caused by a lag in claims due to the transition to new claim software.

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?**

  Answer: The CAFR and the FY 2012 recommended budget utilize different reporting methods to compile the FY 2010 patients' and residents' cost recoveries. In addition to the final revenue figures being drawn from the State accounting system at different times, the CAFR utilizes an accounts receivable factor which is not utilized in the budget presentation. These differences in reporting methodologies account for the differences in reported revenues.

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?**

  Answer: The increase for the Medicaid Uncompensated Care – Psychiatric is twofold. 1) Increase of $17.9 million for being able to claim Disproportionate Share

Discussion Points (Cont'd)

Hospital (DSH) match at a Hudson and Burlington County Institution for Mental Diseases (IMD's) and correcting an error involving claiming Medicare Part A recoveries. 2) Increase of $32.2m, assuming DSH can be claimed on costs for 95% of Medicare Part B clients without Part A coverage. DHS assumes the remaining 5% Part B clients without Part A coverage have exhausted their 190 days lifetime MH benefit making them under-insured (not DSH-able).

The increase in Medicaid Uncompensated Care-Acute revenue is mainly attributable to more recent audited cost reports showing that the State was able to claim DSH match on more costs at UMDNJ than was originally anticipated.

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?**

Answer: Federal Disproportionate Share Hospital (DSH) revenue ceilings that were temporarily raised as part of ARRA will return to a pre-ARRA level, lowering Schedule 1 revenue in State FY2012 by approximately $20 million. Additionally, increased hospital payments in State FY2011 produced federal claims exceeding the federal fiscal year maximum allotment. However, as the State and federal fiscal years are misaligned, this additional State FY2011 claiming does not have a negative impact on revenue collected until the first quarter of State FY2012 when the State exceeds its federal fiscal year 2011 maximum claim.

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?**

Answer: The Department has appealed this disallowance to the DHHS Departmental Appeals Board**.** The Department is seeking to enter into negotiations with CMS to resolve this matter. A letter to retain the disallowed funds dated June 17, 2010 was sent to CMS.

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.

Discussion Points (Cont'd)

- ***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?**

  Answer: Historically, the State had not included any School-based Medicaid revenue due to uncertainty regarding whether appropriate parental consent had been received in order to claim Medicaid match on these services. The $1.4 million for both FY10 and FY11 reflects the amount of School-based Medicaid receipts that had posted to the accounting system as of a certain date in FY10. The $27.1 million reflects the amount received by the State. The $6.9 million difference between the CAFRA and Schedule 1 is primarily a result of revenue recognition timing issues, most significantly a $5.2 million adjusting entry moving revenue from SFY 09 to SFY 10. The adjusting entry was not recognized in the cash basis on Schedule 1, but was recognized in the accrual basis CAFRA.

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?**

  Answers: The estimate at the time of the FY11 Budget was conservative due to uncertainties regarding the federal audit conducted on this program. Once DHS received more clarity on the audit findings, the Department felt comfortable enough to increase the revenue projection.

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?**

  Answer: Random drug testing of the DHS' current direct care employees began as of April 1, 2011. To date we have conducted 1,530 pre-employment drug tests of which 34 applicants tested positive and were rejected from employment. Additionally, we have conducted three reasonable suspicion drug tests of which two

Discussion Points (Cont'd)

staff tested positive. Twenty six (26) staff who returned from a leave of absence were tested, one staff person tested positive.

Discussion Points (Cont'd)

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?**

  Answer*:* As of 3/31/11 only $235K remains as an open obligation for the Fiscal Agent for Addiction Services' Fee for Service Provider Network related to SFY 10 contract deliverables pertaining to system development.

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?**

  Answer: As of 3/31/11, $77K of the above $900K has been paid leaving a balance of $823K. The remaining encumbered funds are still necessary for pending projects that are still under contract. Any final lapses are expected to be minor.

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?**

  Answer: $2.6 million represents less than one percent of the total FY 2010 Community Care account funding. Moreover, by mid-April, only approximately $125K of this total remains encumbered for two provider agency contracts, as well as some very minor balances applicable to a handful of county obligations for mental health administrator and/or county mental health board costs. Such minor prior year balances are normal at this time of year for several reasons including; outstanding claims and/or final expenditure reports, "hold" payment actions pending review/confirmation of actual costs, etc. We anticipate that after receipt of all outstanding reports and claim information, within the next 60 – 90 days, the Division will be closing out all of these remaining FY '10 encumbrances.

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.

Discussion Points (Cont'd)

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

  Answer: As of 3/31/2011 only $700K of the $2.1M is still open pending final expenditure report processing and contract closeout.

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

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

  Answers: In SFY 09, of the 26 audits identified, all 26 have been completed. The initial dollar findings were $168K. All audits with the exception of one have gone through complete administrative finalization. With regard to the finalized audits, recoveries were $62K. The administrative disposition process for the one remaining agency is in progress.

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?**

  Answers: A web-based billing module was effective July 1, 2010, for all DAS Fee for Service (FFS) Initiatives. DAS has contracted with Fiscal Agent, Covansys CSC, to develop and manage this billing system. The CSC system interfaces with DAS' managed NJ-SAMS client data system. All FFS services are prior authorized. The system for prior authorization blocks duplicate authorizations across DAS funded services. To date, $1M in claims have been denied by CSC based upon the various system edits.

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?**

  Answers: To date Addiction Services has received reimbursement for the 1st and 2nd quarter claim submission for FY '09. The total of these approved claims was approximately $105K.

  Claims for the 3rd and 4th quarters of FY '09 totaling $122,743 were deferred by the Center for Medicare / Medicaid Services (CMS) on 12/29/10 and are still pending

Discussion Points (Cont'd)

CMS review and approval. DMHAS has continued to submit claims to CMS through Dec 31 2010.

7. Approximately $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?**

  Answer: The DMHS practices regarding ICMS and PACT services are currently under revision and will include provision for terminating services when it appears that an individual will remain incarcerated in excess of six months. Revisions will be made to the Medicaid regulations to assure ongoing consistency with DMHS regulations. It should be noted that DMHS does not believe there to be a large volume of lost Medicaid revenue related to the described situation as, even though the consumer remains on the caseload, in practice, little face-to-face activity occurs until the consumer nears discharge.

  Retaining some level of engagement with ICMS and PACT consumers, albeit with minimal face-to-face contact, during brief periods of hospitalization or incarceration are important for continuity of care. ICMS and PACT serve as an active participant and necessary participant in the discharge planning process for individuals who are in our state and county hospitals, as well as the jail system if necessary. They work in concert with the consumer (and/or loved ones), hospital treatment team and other community-based providers to support and facilitate discharge. This is supported by the tenets of the Olmstead case. DMHS contract funds are utilized to cover costs such as those incurred as described when Medicaid cannot be legitimately billed.

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.

Discussion Points (Cont'd)

- ***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?**

  Answers: Yes, UBHC has provided all required financial reports to the Division and is appropriately accounting for total organization revenues and expenditures.

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?**

  Answer: The $3.5M reduction initiative relates to third party contracts funded via the Division's Community Care and Olmstead appropriations. It does not apply to the two discrete line-items for UBHC totaling approximately $18 million. The Division does fund some third party Community Care contracts with UBHC, none of which are presently high cost outliers, primarily because for the most part, fringe benefits and a significant portion of overall corporate overhead are not part of the contract.

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?**

  Answer: Funding for the processing the additional data being requested from "providers, suppliers, and/or wholesalers of pharmaceutical services" is not included in this increase (will be funded through realized savings).
  Breakdown of $4.4M request:

Need for Medicaid Management Information System re-procurement:	$2.3M
Need for State Medicaid HIT Planning:	$1.1M
Loss of Fiscal Agent carryforward:	$3.3M
Normal Increase in other Admin accounts:	$.37M
Reduction in salaries (vacant positions):	($2.6M)
Net Increase:	$4.4M

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?**

  Answer: The current formula (SFY11 and previous) requires a hospital to satisfy two independent criteria before being eligible to receive funds. The first eligibility criteria is an individual hospital's percentage of problem billed cases must be at or above the industry wide median. The second eligibility criteria is an individual hospital's percentage of low income days must be at or above the industry wide median.

Discussion Points (Cont'd)

In the new proposed formula (SFY12 and forward) these two independent eligibility criteria are removed and all general acute care hospitals received a percentage of the available funds based on their proportional number of discharges for inpatient stays related to pregnancies, deliveries, mental health and substance abuse.

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?**

  Answer: The current formula (SFY11 and previous) defines GME Subsidy eligibility as an acute care teaching hospital that has a combined Medicaid and NJ FamilyCare-Plan A fee-for-service utilization rate at or above the industry wide median.

  In the new proposed formula (SFY12 and forward) the utilization eligibility criteria is removed and all NJ acute care general hospital with resident FTEs (Full Time Equivalents) are eligible for GME subsidy funds. This change is the result of the bottom up funding review of the policies and goals of the state with regard to hospital funding. This new distribution, including the changes to GME funding, improves hospital efficiency and predictability.

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?**

  Answer: Yes. These additional monies will include National Settlements (estimated to be $18 million) and other recoveries realized by the federal government for NJ.

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

Discussion Points (Cont'd)

– 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.

- ***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?**

  Answer: The gross amount reported on the CMS-64, line Recoveries - Fraud, Waste & Abuse Efforts, for the FY2011 July-Dec period was $872,000. In addition to the fraud, waste & abuse amount submitted, there is an additional line for Collections: 3rd Party Liability. These recoveries (State portion) are also included within the FY12 recommended budget. State-only National Settlements, which are not included in the CMS-64 submission, are also included in the FY12 recommended budget amount.

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?**

  Answer: Currently the Division withholds payment from the individual pharmacy, but if that is not possible, the Division will withhold payment from another pharmacy with the same Federal Tax ID number that has sufficient payment activity to pay off the debt. As a last resort, the receivable can be sent to the Division of Revenue and ultimately to a collection agency if needed. The Division's current policy is not to suspend or terminate pharmacy provider agreements, but to utilize the aforementioned options to recoup any monies owed.

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.

Discussion Points (Cont'd)

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

  Answer: Yes, the current State policy meets minimum federal standards (NJ submitted and received federal approval of its State Plan Amendment).

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?**

  Answer: The Medicaid Fraud Division has begun to audit the Special Investigation Unit (SIU) of the MCO's and are making recommendations for improved MCO fraud, waste & abuse operations.

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?**

  Answer: The Division is currently in the process of voiding the claims that were incorrectly paid fee-for-service, primarily due to newborn babies that were born while the mother was enrolled in a Managed Care Organization (MCO). Once all the claims are voided, the MCO's will be responsible for all claims from birth and the claims will be referred to the MCO for payment. New edits have been adopted and implemented to prevent incorrect fee-for-service reimbursements for managed care covered services.

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.

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

Discussion Points (Cont'd)

Answer: The GA population will not be included into mandatory managed care at this time.

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?**

  Answer: No, the FY12 recommended budget for Managed Care is sufficient. Further, the budget includes language that allows the Division to consider all object accounts as one object. This will allow the Division to make the necessary transfers between objects as services and populations move into managed care.

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?**

  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.

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.

Discussion Points (Cont'd)

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

  Answer: All states are waiting for a federal resolution to this issue. NJ/DMAHS is working with a consortium of states to continue to pursue this issue at the federal level.

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?**

  Answer: The SPA approach was not approved by CMS. Instead CMS recommended the State pursue an 1115(a) Demonstration waiver which was approved by CMS effective April 15, 2011.

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?**

  Answer: The $1M federal grant is the CHIPRA Outreach and Enrollment Grant Cycle 1. Our grant ends December 2011. The project started this past November with 9 school districts to identify all uninsured children in their districts and piloting the Express Lane Eligibility process for children participating in the Free or Reduced Lunch Program.

  As of December 2010, 5,800 uninsured children were identified by their parents in the 9 school districts participating in this project. The majority of the uninsured children were also participating on the Free or Reduced Price lunch program. At that time about 300 completed applications were returned, resulting in about 200 children getting enrolled.

  The majority of those enrolled had no prior enrollment history with NJ FamilyCare/Medicaid in the past year. The primary reason children were denied coverage in NJ FamilyCare/Medicaid was because of citizenship.

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

Discussion Points (Cont'd)

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?**

  Answer: Taxation Express Lane – From 5/10/10 through 2/18/11, 53,893 ELE have been sent. During the same time frame, 2,558 (4.7%) ELEs have been returned and 153 (6% of the returned) children have been determined eligible for the program.

  Express Lane Free or Reduced Price - 6,370 students have been identified as being uninsured; 4,897 applications were sent (1 per household); 665 applications were returned from the uninsured families (+10%) and to date, 232 children were enrolled.

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?**

  Answer: There are four recipient cases:

  1. Recipient underreported her income to qualify for FamilyCare. She was prosecuted and pled guilty in Middlesex County where she was ordered to repay Medicaid $33,078.79. Her FamilyCare eligibility was terminated. We are receiving repayment through the Middlesex County Probation Office.

  2. The Medicaid Fraud Division (MFD) determined that the recipients falsified their income on their FamilyCare application to qualify for benefits. MFD issued a Notice of Claim in the amount of approximately $30,000. The case was referred to the Mercer County Prosecutor's Office where the recipient is facing criminal charges for Medicaid fraud and possible additional criminal charges unrelated to the Medicaid fraud charges.

  3. MFD determined that recipient falsified his income on his FamilyCare application to qualify for benefits. The case was referred to the Bergen County Prosecutor's Office where the recipient was charged and pled guilty to criminal charges and is required to repay Medicaid approximately $24,000.

  4. MFD investigation determined that recipient was using the identity of a deceased Medicaid recipient and utilized the identity to obtain medical services which were billed to Medicaid in the name of the deceased. Medicaid paid approximately $500,000 in claims pursuant to the recipient's unlawful use of identity. The case was referred to Jersey City Police Department where the recipient is facing criminal charges for her actions.

Discussion Points (Cont'd)

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?**

  Answer: The program was designed to add newborns born to Medicaid eligible moms to the Medicaid eligibility file within 60 days of birth. Currently, 90% of those newborns are placed on the system within 2 months. Over a 7 month period, hospitals identified 1,759 uninsured newborns. Of these, 876 were determined eligible through the Presumptive Eligibility (PE) Process. This is currently a pilot program being run through 14 hospitals state-wide.

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?**

  Answer: 1,400 adults without dependent children**.**

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?**

  Answer: Evaluation data for inclusion in the Governor's Budget was prepared prior to final decisions being made on all of the components included as part of the Comprehensive Waiver. At the time, enrollment was projected to increase. Programmatic changes (including additional capping

Discussion Points (Cont'd)

of populations) would change the evaluation data display and would likely result in a downward enrollment trend.

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?**

  Answer: The OIG recommendation was forwarded to CMS in October. The OIG letter was sent to CMS with our reasons for disagreeing with the recommendation. DHS has not heard anything from CMS, but expects to within a few months.

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?**

  Answer: The Division's Third Party Contractor, HMS, will expand efforts to implement RAC. The State's RAC has become operational.

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?**

  Answer: Acquisition data will be collected by the current State Upper Limit (SUL) vendor. The contract may have to be amended if we decide to reimburse based on the acquisition based model to collect brand acquisition data. None of the above mentioned entities currently provide this data to NJ. However, in

Discussion Points (Cont'd)

Alabama and Oklahoma Medicaid Programs, the vendor does collect acquisition data for drugs for reimbursement. Further, proposed language in the FY12 budget requires submission of this data.

Discussion Points (Cont'd)

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?**

  Answer: The reimbursement formula for drugs is still necessary for processing claims for General Assistance, Pharmaceutical Assistance to the Aged/Disabled, Sr. Gold, clients in the institutions, AIDS Drug Distribution Program, Long Term Care, and cystic fibrosis.

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?**

  Answer: The supplemental payments will amount to $16 million.

Discussion Points (Cont'd)

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?**

  Answer: The Department is re-examining the State's definition of PCA services and researching the potential impact on the existing PCA service package. The Affordable Care Act permits an increased federal matching rate; however, a beneficiary must also meet the nursing home level of care criteria for the service to be eligible for the higher federal matching rate.

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.

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

  Answer: A draft report entitled Review of Medicaid Personal Care Claims Submitted by Providers in New Jersey has recently been issued by the US Department of Health & Human Services. A response to the recommendations is currently in process.

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?**

  Answer: The most recent projection for this service is showing an upward trend in caseload.

Discussion Points (Cont'd)

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?**

  Answer: As of March 31, 2011, there is only $37,000 in FY 2010 remaining open encumbrances at Woodbridge Development Center. A recently completed review of these open encumbrances by the Center's Business Office has concluded that these remaining encumbrances are still needed.

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?**

  Answer: All FY 2010 payments to contracted agencies through the Office for Prevention of Mental Retardation and Developmental Disabilities have been processed. The $76,620 shown as uncommitted balance in this account is not needed and will revert to the General Fund.

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?**

  Answer: $6.4 million represents less than one percent of the Community Programs Grants-In-Aid accounts. As of March 31, 2011, Grant-in-Aid encumbrances totaling $4.4 million are being held open in anticipation of contract modifications. Some calendar year contracts, which span both the State's 2010 and 2011 fiscal years, have only closed 3 months ago and final modifications remain in the pipeline.

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.

Discussion Points (Cont'd)

- ***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?**

  Answer: In arriving at the $345.6 million anticipation for FY 2012, the following factors were assumed to increase the projection:

  - Salary increases related to the annualization of the 3.5% contractual raise granted on January 1, 2011
  - Salary increases resulting from cost of living adjustments and increments
  - Statutory increase to the ICF-MR Provider Tax from 5.3% to 5.8%

  The revenue impact of these increases are being offset by reductions due to (1) the closure of Vineland Developmental Center's West Campus, (2) the reduction of recommended overtime appropriations, and (3) the reduction of recommended equipment appropriations.

  The anticipated ICF-MR revenue in FY 2012 does not assume any impact of potential changes to health benefit costs and pension contributions.

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?**

  Answer: Of these 141 consumers placed over the last two years, eight have returned to a developmental center, one was admitted to a Skilled Nursing Facility, and two individuals passed away.

  Based on the Olmstead Unit's tracking of these placements, the Division calculates a 92.2% success rate of sustained community placement. If admissions to a Skilled Nursing Facility and deaths were not assumed to be failed community placements, the success rate of placement rises to 94.3%.

  Studies performed after the last Division closure of North Princeton Developmental Center did not indicate an increased mortality rate upon movement into the community. The Division monitors the consumer's placement through follow-up visits and evaluations at the 30 day, 60 day, 90 day, 180 day, 1 year, and 2 year anniversary of the consumer's placement into the community.

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.

Discussion Points (Cont'd)

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?**

  Answers: The closure plan calls for a census reduction of 72 in FY 2012 and 275 in FY 2013. Of the 347 total census reduction over the two years, the following assumptions have been made in the closure model:

  - 40 East Campus placements into Community PAFACOM vacancies
  - 24 assumed natural attritions (based on existing data, natural attritions at VDC averages 1 per month)
  - 30 East Campus placements into Community vacancies
  - 253 East Campus placements into newly developed capacity

  As of August 2010, 165 consumers at Vineland Developmental Center were deemed ready for community placement by virtue of all three deciding parties agreeing on the consumer's readiness for community placement (the three parties being (1) individual, (2) family/guardian, and (3) the Interdisciplinary Decision Team). Although this number is expected to change as all East Campus consumers are evaluated for placement, those deemed not appropriate for a community placement will be relocated to another developmental center. As a result of these consumers remaining in the system, another placement must occur from a non-Vineland center to facilitate the East Campus closure.

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?**

  Answer: The FY 2012 budget does not assume any impact of these provisions. The FY11 Budget moves staff from West Campus to East Campus and

Discussion Points (Cont'd)

fully staff's the PAFA homes which will reduce overtime. In FY12, 40 additional VDC clients will backfill the vacancies at the PAFA homes so the homes will be a needed resource in FY12 and a key component as part of the VDC closure process.

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?**

  Answer: The $8.1m of Community Grant-in-Aid growth represents new funding needed to begin the process of closing the East Campus at Vineland Developmental Center. In addition, the FY 2012 Governor's Recommended Budget reflects a $1.5 million reduction in Direct State Services at Vineland due to the Center's declining census. Therefore, the net "bridge fund" equals $6.6 million from the two different fund sources. These amounts reflect the impact on State funding only. The CCW and ICF/MR anticipation for FY12 was adjusted accordingly.

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?**

  Answer: The Division is committed to addressing those eligible for services residing at one of the State's five Psychiatric facilities in a community based living arrangement. The FY 2012 Governor's Recommended Budget provides $1.6 million (State) and $500,000 (Federal) for a total of $2.1 million. With this funding, the Division will collaborate with the Division of Mental Health Services to create appropriate community placements for the dually diagnosed population. Moving clients into a Developmental Center is contrary to the Division's Path to Progress initiative which has seen over 400 consumers moved into the community over the last four years. The Division's commitment to community placement is further evidenced by the FY 2012 proposed closure of Vineland Developmental Center.

Discussion Points (Cont'd)

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 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?**

  Answer: The FY 2012 Governor's Recommended Budget reflects two reductions associated with the Purchase of Care out-of-state population. Both of these initiatives result in additional Community Care Waiver revenue allowing for the reduction to Grant-in-Aid recommended appropriations.

  The two reductions are: (1) a $1.7 million Grant-in-Aid reduction for the continued efforts of the Division to return an additional 30 to 35 consumers back to New Jersey during FY 2012 and (2) a $1.6m reduction to be realized through the State's federal claiming for approximately 75 eligible out-of-State consumers in waiver eligible settings and services. These 75 consumers all reside in Pennsylvania and are targets for claiming as a result of recent Community Care Waiver amendments which allows for New Jersey to claim on consumers residing in Pennsylvania. The Division has begun internal discussions about a further amendment to the Community Care Waiver to gain the ability to claim for consumers that reside in states other than Pennsylvania.

  Lastly, as referenced in the dually diagnosed question, moving clients into a Developmental Center is contrary to the Division's commitment to deinstitutionalization as DHS proposes the closure of Vineland Developmental Center.

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?**

Discussion Points (Cont'd)

Answer: Due to anticipated prior year rate adjustments, the current FY 2010 CCW projection is currently $321,230. With the claiming period still open and the anticipated rate adjustment not finalized, the full realized amount of revenue is not complete.

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?**

  Answer: Approximately $10 million of the $32 million in additional revenues is attributable to anticipated rate adjustments. The remaining $22 million increase is projected as a result of the Division's Grant-in-Aid community growth that will be used to generate additional CCW revenue.

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?**

  Answer: The Division of Developmental Disabilities is currently developing the Supports Waiver in conjunction with the Division of Medical Assistance and Health Services. There is neither an assumption of approval nor any assumption of federal funds in the FY 2012 Governor's Recommended Budget.

Discussion Points (Cont'd)

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?**

  Answer: The Commission is partly reimbursed by the Department of Education for costs associated with educational services, not from school districts directly. The budget for the program is comprised of CBVI State and DOE funds; the reduction is to CBVI's portion of the funds. The Commission is moving to a 12-month school year model to better utilize 12-month teachers. Along with a 27% decrease in the number of students receiving educational services since FY05, the Commission can reduce the number of positions and still provide the same level of service to all students as it currently does.

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.

- ***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?**

  Answer: The revised FY 2011 total positions of 290 are based on FTE's as of PP#2 in 2011. The Budget Estimate for FY 2012 is 279 and includes the impact of the 20 teacher reduction. The Commission is moving to a 12-month school year model to better utilize 12-month teachers. As the trend for students requiring educational services declines (see updated chart below), the Commission can reduce the number of positions and still provide the same level of service to all students as it currently does. The $1.5 million reduction is for the 20 teachers. The services provided in the Commissions vocational rehabilitation, state habilitation, and prevention programs will not be reduced.

	FY09 (actual)	FY10 (actual)	FY11 (revised)	FY12 (Est)
Total # of Students Receiving Educational Services	2,645	2,494	2,059	2,000

Discussion Points (Cont'd)

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?**

  Answer: Actual receipts from the Social Security Administration Fund were $.034 million in FY 2010 and $.136 million collected to date in FY 2011. Projected receipts in FY 2012 are $.300 million. Social Security funds received by the Commission supplement all Vocational Rehabilitation programs.

Discussion Points (Cont'd)

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?**

  Answer: As of March 31, 2011, $2.9 million is still the balance of encumbered funds for the Grants-in-Aid accounts. As part of the DFD reconciliation and close out process, DFD has identified that only $103,025 of the outstanding encumbrances is still required and the remaining balance will lapse back to the General Fund. It should be noted that these are mostly FFY10 contracts and the amount encumbered represents less than 1% of the Division's contract base.

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?**

  Answer: The HP CASS Implementation Manager position has been filled by a current HP Team Member who has actively participated in the CASS Project since the start of CASS. As a result, this issue has had no impact on the CASS timetable and project costs. The statement in the Report notes that HP's work "has not been consistent" related to certain Phase 4 deliverables. Subsequent deliverables have been of a higher quality. The CASS Project Team has subsequently implemented a new process that should improve the quality of deliverables going forward. DFD has not filed any formal complaints with the Division of Purchase and Property regarding these issues. Additionally, a representative of the Division of Purchase and Property participates as a member of the committee which has oversight regarding the CASS Project; the CASS Quality Review Board (QRB).

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.

Discussion Points (Cont'd)

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

  Answer: The $36.3 million is not a reduction to overall TANF spending. The reduction in recorded expenses for TANF is attributed to DFD charging allowable expenditure to other funding sources. In FY10, DFD was able to charge allowable basic assistance expenses of $11.2 million and $1.8 million back to FY07 and FY02 respectively. Additionally, TANF (ARRA) – Emergency Funding provided an additional offset of $9.5 million. Lastly, an additional $12.2 million was recorded against the State funded TANF offset account.

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?**

  Answer: DFD currently requires the child's SSN and birth certificate when receiving an application for childcare, however, federal regulations prevent DFD from requiring applicants to provide their SSN. The applicant may voluntarily provide their SSN and if supplied, DFD uses it to conduct numerous wage matches. Wage Match reports identify those applicants that are currently over the 250% of the FPL due to working a job that was not reported at the time of application or redetermination. This report also identifies any unreported income such as unemployment or Social security payments. The Wage Match report conducts searches against such systems as Unemployment, Social Security and Department of Labor databases. DFD regulations require the parent to provide verification of employment (pay stubs), work hours, school schedules if attending an educational activity and child support if received.

  DFD and the Child Care Resource and Referral staff conduct monthly quality reviews of files to ensure that all eligibility supporting documentation is present and that regulations are applied as required.

  Lastly, DFD recognizes the challenges identified in the GAO report, and it was a major factor in the decision to develop the E-Child Care system. The E- Child Care system, once implemented in FY12, will allow DFD to reduce the incidence of improper payments, increase accuracy and accountability for federal reporting, and streamline and equalize the payment system.

Discussion Points (Cont'd)

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 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?**

  Answer: Federal requirements prevent DFD from making parents/applicants submit their SSN as part of the application process. Although it is not a mandatory requirement, DFD provides parents/applicants the opportunity to voluntarily submit their SSN. DFD does require supporting documentation for the work requirement and wage limits to substantiate eligibility. Submission of SSN would allow DFD to data match with Unemployment, Social Security Agency and other data bases.

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?**

  Answer: DFD estimates that about 4,770 children are subject to co-pay requirements between the FPL limits of 101% and 250%.

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?**

  Answer: Most recent projections for the DOE-Wrap program estimate that 13,218 children will be required to meet the income eligibility standard. As stated in the previous answer, DFD estimates that 4,770 children are subject to the co-pay 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?**

  Answer: New work requirement rules were introduced as part of the FY11 Budget. For FY12, it is estimated that approximately 1,300 children would not be

Discussion Points (Cont'd)

eligible for the wrap around child care program since the parents are not working the minimum 25 hours. However, these children would still be eligible to receive DOE preschool services since that program does not have a work requirement.

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?**

  Answer: In FY2010, DFD reverted $3.6 million back to the general fund due to actual expenses being significantly less than the appropriated funding level. For FY12, DFD estimates that caseload trends will increase but projected funding still exceeds the projected expense by $2.5 million. This reduction does not impact client 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?**

  Answer: If a person applies for federal benefits, they would have a medical (Med-1) which indicates that they are permanently disabled. This designation would indicate their medical condition is for a year or more. In this situation, there would be no waiting period for this recipient. If a GA recipient has filed for, and is awaiting determination of SSI they will continue to receive benefits until SSI benefits are received. The recommended change is designed to stop a person flipping from employable to unemployable several times during a year.

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

Discussion Points (Cont'd)

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.

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

  Answer: There are no new substance abuse requirements under the new procedure for GA although all new applicants will be referred to Department of Labor and Workforce Development for an extensive employment search during the first 30 days.

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?**

  Answer: Supplemental living support is a $150 a month additional cash payment for certain GA clients that exceed five years of received benefits. The elimination of SLS has no impact on the receipt of Emergency Assistance (temporary rental assistance, shelter/hotel/motel costs, etc.)

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?**

  Answer: The savings amount reflected in the FY12 recommended budget is actually a combination of projected growth in the SSI program being partially offset by savings attributed to an FY11 initiative for the SSI Living Arrangement C recipients. State supplemental funding will increase by $4.175 million and the SSI Administration funding will also increase by $.507 million, these increases will be offset by the annualized impact of the FY11 Living Arrangement C savings initiative of $7.631 million in FY12.

Discussion Points (Cont'd)

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?**

  ***Answe** r:* Per our review of outstanding FY10 encumbrances, DHS determined that as of April 1, 2011, there are only two accounts remaining with encumbrances over $100,000. These encumbrances are still needed for payments for services received in FY10 for the Office of Catastrophic Illness in Children Fund and for the design fee for the Hunterdon Developmental Center Water System capital project.

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?**

  Answer: The primary factors that increase overtime costs relate to the annual increases for all employee costs and in the number of vacant positions that are required to be filled. Vacancies occur each year due to attrition and overtime is authorized to cover staffing needs until such time as positions can be backfilled. Previous efforts to control overtime costs, in fact, have shown significant success toward the reduction of overtime use. Since FY08, overtime has been reduced by approximately 19%.

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)

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 Heath 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.

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?**

  Answer: DCF pharmacy services are not included in the DHS appropriation. We do not expect to see a significant change in pharmacy services until closures occur. Off system billing for over the counter items may, in fact, be higher because Medicaid will no longer pay for some of these drugs.