1.a. The FY 2012 appropriations act had assumed savings and/or increased federal Medicaid revenues of $300 million through a Comprehensive Medicaid Waiver.

As federal approval of all, or part, of the waiver may not be realized by June 30th, the department indicated that savings within its overall budget will offset the $300 million that had been assumed.

**Question:** What specific offsetting savings would offset the $300 million?

**Answer:** To clarify, the Department did not indicate that savings within its overall budget will offset the $300 million that had been assumed. Rather, the Department indicated that it had realized significant savings in other areas within its budget to offset part of the $300 million and that it did not impose across the board cuts to providers or services as an additional savings measure. The specific offsetting savings include lower than projected enrollment ($20-$30 million), higher than projected savings from the carve-in of services/populations into managed care ($15-$25 million), and higher than anticipated manufacturer drug rebates (approximately $50-$60 million).

1.b. Available information is that the Administration will request $223 million in supplemental funds for the new Department of Health and the Department of Human Services. The supplemental appropriation appears related to the $300 million that had anticipated as part of the waiver.

**Question:** As the commissioner indicated that internal savings would offset the $300 million in federal funds the waiver had anticipated, why are $223 million in supplemental appropriations being requested?

**Answer:** The supplementals, as they pertain to the waiver, are $205 million, not the $223 million cited above (the difference being a Supplemented reflected in the Division of Developmental Disabilities that is not waiver related). After accounting for the offsetting savings and anticipated lapses between the Departments of Health and Human Services, the net deficit as a result of the waiver is approximately $65 million. Consistent with past budgets, only supplementals are displayed in the Budget book.

2.a. A joint DHS/DCA/HMFA initiative was to provide 100 people with developmental/mental disabilities with housing by December 2011.

**Questions:** How many people were actually provided housing by December 31, 2011? How many homes/condominiums were purchased, at what average cost? Of the homes/condominiums that were purchased, how many were foreclosures? Are any federal funds anticipated to offset these costs?
We continue to work with DCA and HMFA to secure housing commitments. To date, we are aware that 16 municipalities have made commitments – the majority of which materialized after December 2011. None of the sites currently identified are foreclosures. No federal funds are anticipated to offset these capital costs.

**Question:** Will this goal be achieved? What is the anticipated cost of acquiring the necessary housing?

**Answer:** As previously noted, there are 16 municipalities who are now committed to funding our housing needs, and we anticipate continuing to work with DCA to fulfill our housing needs during the remainder of FY12 and FY13.

3. The FY 2013 recommended budget estimates $195.9 million in Medicaid Uncompensated Care – Acute revenues (Schedule 1) compared to $223.4 million in FY 2012.¹

**Question:** As there have been no apparent reductions in hospital related expenditures for which federal reimbursement can be claimed, what accounts for the $27.5 million reduction?

**Answer:** The majority of the shift is explained by the following: Of the $223.4 million estimated in fiscal year 2012, $9.9 million represents a one-time, non-recurring revenue item. In addition, there was an $18 million shift in Medicaid Uncompensated Care – Acute revenue from Schedule 1 in fiscal year 2012 to Schedule 2 in fiscal year 2013.

4. The federal government has disallowed approximately $65 million in School Based Medicaid claims as follows: May 2006 - $51.3 million; April 2010 - $8.1 million; and September 2010 - $5.6 million. The first two claims are for work done by Maximus. The third claim is for work done by Public Consulting Group (PCG).

**Questions:** What is the current status of each disallowance? Can the State recoup any incentive payments paid to Maximus and PCG for these disallowed claims? Can the State recoup any monies that may be refunded to the federal government from the two contractors?

**Answer:** The May 2006 School-based Medicaid finding was the result of an audit conducted by the Office of the Inspector General for claims between July 1, 1998 and June 30, 2001. The original finding was for $51.5M. After the State legally challenged the initial findings, the amount was ultimately reduced to a $44.5 million refund that was returned to the federal government on January 31, 2012. This did not have a current fiscal year General Fund impact since the State reserved resources from a prior fiscal year to offset the refund.

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¹ These monies are federal funds received for Disproportionate Share Hospital expenditures.
The April 2010 and September 2010 School-based Medicaid findings resulted from audits conducted by the Office of the Inspector General for claims from July 27, 2003 to October 4, 2006 and from April 6, 2005 to June 27, 2007, respectively. To date, the federal government has not formally asked the State to refund the $13.7 million associated with these audit findings. Their resolution has been on hold pending the resolution of the May 2006 finding/disallowance. The Department is reviewing these two findings in order to determine whether it can settle them at a reduced amount.

According to the contracts, the Department can recoup incentive payments made to each vendor, and the issue of recouping any of the amounts refunded to the federal government is currently being reviewed by the Attorney General’s office.
Division of Mental Health and Addiction Services

5.a. Two federal audits, November 2011 and March 2012, recommended that the State refund $13.0 million and $22.5 million, respectively, for Medicaid administrative reimbursement obtained for contracted mental health agencies between 2005 – 2007. As it will take several years before the issues raised by the audit are resolved, there is no immediate financial impact. The claims in question were submitted by Maximus.

- **Questions:** Can the State recoup any incentive payments paid to Maximus for these disallowed claims? Can the State recoup any monies that may be refunded to the federal government from Maximus? In the event the State refunds monies to the federal government, will contract agencies that benefitted from this additional federal Medicaid revenue be required to return any monies they received?

  **Answer:** See response to #4 regarding incentive payments and recoupments related to Maximus. The Division has submitted three letters to providers communicating the scope of the audit, the initial OIG findings, and a request for documentation that support the claims during the audit period that are in question. The reviews of the providers work papers are ongoing and may result in a recovery from that organization.

5.b. As the State obtained federal Medicaid administrative reimbursements for subsequent fiscal years, it is possible that the federal government will disallow such reimbursement. Similarly, Addiction Services has also obtained federal Medicaid administrative reimbursement for work done by Maximus.

- **Questions:** How much Medicaid funding is at risk for FY 2008, FY 2009, etc.? How much monies are at risk at Addiction Services?

  **Answer:** The OIG audits essentially disallowed the entire value of claims for the years at issue (FY05 – FY07). The State is challenging these disallowances and will be pursuing administrative disposition with CMS should the entire value of all the claims ultimately be disallowed. For FY08 – FY10, the disallowance could be $16.5M, however, the OIG has not yet targeted this time period.

6.a. At the end of December 2011, nearly $2.4 million in FY 2011 Direct State Services funds at the division and at the State psychiatric hospitals were encumbered.

- **Question:** How much encumbered funds can be lapsed?

  **Answer:** The encumbered funds cannot be lapsed. As of March, only $356K remains encumbered. These funds are still needed for outstanding obligations where the work is not complete or is pending acceptance of final work.

6.b. At the end of December 2011, approximately $8.1 million in FY 2011 Grants-in-Aid funds were still encumbered, including $6.7 million in Community Care, and $1.1 million in Community Based Substance Abuse Treatment and Prevention Services – State Share funds.
• **Question:** How much encumbered funds can be lapsed?

**Answer:** Of the $1.1 million in Community Based Substance Abuse Treatment and Prevention Services – State Share funds, to date, $300,000 has been paid and the remaining encumbrances are pending final expenditure report processing and contract closeout on County grants.

The Community Care encumbrances cannot be lapsed. As of March, the Community Care funds remaining encumbered were $2.4M. The majority of those funds ($1.6M) are for capital renovations with one of our providers for which the work has not been finalized. The remainder of the encumbrance is comprised of small amounts for a number of providers where final reports of expenditures reconciled with audits have recently been received and are being evaluated for payment.

7.a. The FY 2012 appropriations act provided $2.0 million to “phase-in” the involuntary outpatient commitment legislation. A Request For Proposal was issued January 2012; bids were submitted the end of February 2012; and contracts are to be awarded in April. The number of contracts to be awarded and number of counties affected are not known.

• **Question:** How many contracts will be awarded and which counties will be affected? Is the entire $2.0 million appropriation needed as contracts will not be awarded until April?

**Answer:** The full annualized appropriation will not be used in FY 12 and the Division has already accounted for this planned lapse as part of the Governor’s proposed budget.

The Division is currently reviewing proposals submitted in response to the Request For Proposal (RFP) for Involuntary Outpatient Commitment (IOC). It is anticipated that programs will be awarded in up to five (5) counties with an annualized value of $1.7M. Preliminary award letters will be issued in April. An RFP for one additional county will be reissued within two weeks such that it is anticipated that the full annualized appropriation will be consumed in FY 13.

7.b. The FY 2013 budget recommends $337.9 million for Community Care and Olmstead Support Services including $15.6 million for new community placements and related services. The amount provided to continue the involuntary outpatient commitment legislation in FY 2013 is not identified. Whether additional counties will be phased-in during FY 2013 is not known.

• **Questions:** How much funding is allocated for the involuntary outpatient commitment legislation in FY 2013? Will additional counties be added during FY 2013?

**Answer:** Additional counties beyond those supportable with the $2M in base appropriations will be phased in during future years as additional appropriations are made available.

8. The FY 2013 budget recommends $79.0 million for Olmstead Support Services, a $13.3 million increase from FY 2012 levels.
Available information indicates that the program is unable to expend its entire appropriation: In FY 2010, $2.5 million was unspent and in FY 2011, $9.5 million was unspent. It is probable that actual FY 2012 expenditures will be less than the $65.6 million appropriated for the program.

- **Question:** As actual expenditures are less than the amount appropriated, should the $79.0 million recommendation be reduced?

  **Answer:** The Division does not believe the appropriation should be reduced. The unspent $9.5M cited above related to FY 11 is incorrect and should be $5.2M.

The annualized value of Olmstead awards continues to match the full annualized value of the appropriation. The Division is developing lists of qualified providers to reduce the length of the current procurement process as it relates to new placements.

Moreover, the State would be in potential jeopardy of non-compliance with the Olmstead settlement agreement if the required bed growth cannot be achieved. The Department plans to maximize opportunities for additional housing and support services in accordance with the provisions of the settlement agreement regarding length of time individuals can remain on such status until discharge.

9. The FY 2013 budget recommends $24.265 million for Community Based Substance Abuse Treatment and Prevention – State Share. It does not appear as if the recommendation takes into account monies that may be transferred to the Department of Children and Families (DCF) as part of the reorganization. Available data indicates that 11,800 children may be affected by this reorganization. Personnel may also be transferred to DCF to effectuate the transfer.

- **Questions:** Of the $24.265 million, how much may be transferred to DCF? How many children are affected by this reorganization? How many staff may be transferred to DCF?

  **Answer:** DCF and DHS are working to finalize the transition of services and funding that will support this proposed restructuring; including the specific contracts that will be integrated into the DCF service system. Once this planning is finalized, the appropriate resources, services and staff will be realigned to DCF. The General Provisions section of the FY 2013 Recommended Budget includes language to allow the transfers necessary to operationalize the proposed restructuring. This proposed realignment is expected to go into effect in January 2013.

10. During Fall 2011, two large mental health/social services agencies merged. The division anticipated savings of about $500,000. In general, the division neither encourages nor discourages agencies from exploring merger options.

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2 The $0.5 million reduction in the merged agency contract ceiling may not represent the total amount expected to be saved.
In many counties, multiple agencies provide mental health services. The administrative and overhead costs of these agencies are funded, in total or in part, by the division. Agency mergers could generate administrative savings.

**Question:** Should the division encourage agency consolidations by sharing any savings that may be realized?

**Answer:** The Division does not believe there should be direct intervention with the methods that independent business entities choose to organize and operate. However, if we become aware of opportunities for consolidation, the Division would be helpful in assisting with such efforts. As organizations choose to reorganize, the Division will continue to evaluate whether any efficiencies should contribute to a reduction in the Division’s contribution to the new organization.

11. The division received a federal grant to implement a “behavioral health home pilot project.” Also, a private foundation grant was received to enable two federally qualified health centers to integrate behavioral and primary health care services.

**Question:** What is the status of these two projects? How much federal/private foundation monies were received? How many clients will each project serve?

**Answer:** The Division of Mental Health and Addiction Services did not receive a federal grant to implement behavioral health homes. Two private not for profit agencies received federal Substance Abuse and Mental Health Services Administration (SAMHSA) grants to develop and implement behavioral health homes; Catholic Charities of Trenton received funds as the lead agency of a consortium providing this service in Mercer County and Care Plus in Bergen County received a similar grant. The Division does not have data on the exact amount of their funding or the numbers of individuals served.

Similarly, DMHAS did not receive foundation dollars for the implementation of Behavioral Health Homes in FQHCs. Those agencies were funded directly from the foundation for their integrated care projects. DMHAS does not have data on the amount of the funding received by these agencies or the numbers of individuals served.

12. During Spring 2011, the division, in conjunction with the City of Trenton, submitted a grant application to the federal government for a five year, $8.3 million, grant to support community-based early treatment of substance abuse.

**Question:** What is the status of the grant application?

**Answer:** In May 2011, the Office of the Governor, with the NJ Department of Human Services as its designee, submitted a grant application to the federal Substance Abuse and Mental Health Services Administration (SAMHSA) for a new five-year, $8.3 million initiative to support community-based alcohol and drug use early intervention and treatment services in the City of Trenton. In late summer 2011, the NJDHS received
notification from the federal government that the grant application was not approved for funding.

In March 2012, the NJDHS was contacted by the federal government, and informed that the original grant application was being reconsidered for funding. The federal government requested a revised budget from the State, which was submitted to SAMHSA in March, 2012.

13. Proposed budget language would allow the Commissioner of Human Services to set the rates for State and county psychiatric hospitals and eliminate the statutory requirement that the State House Commission approve the rates. This approval generally occurs during December.

Though no information has been provided regarding the proposed change, some counties have complained that the December approval date creates difficulties with respect to finalizing the county budget. Further, as the State House Commission has never modified or rejected any rates developed by the department, some Commission members have questioned the need for the Commission’s approval.

- **Question:** In view of county concerns about the December approval date, has the department ever considered asking the Commission to meet in October or November?

**Answer:** The concerns from counties have less to do with the State House Commission (SHC) December date and more to do with receiving the rate earlier in the process, which the Department has committed to doing prospectively. The Department has conducted several meetings with the counties to understand their concerns. This has resulted in a commitment to provide the counties with an initial rate for the State and county psychiatric hospitals in October as opposed to the historical December date. The feedback from these meetings have been positive, including the proposed FY13 Budget language that would move the rate approval process out of the State House Commission’s authority. It should be noted that State House Commission members have historically questioned why this rate setting process is under their purview as the SHC’s primary responsibility is to manage the sale and leasing of State-owned properties. The State and county psychiatric hospital rate is not real estate related but is more of a budgetary issue similar to other programs that reimburse based on a rate.
Division of Medical Assistance and Health Services

14.a. The federal Office of the Inspector General had requested a refund of approximately $0.9 million in disallowed costs related to the Medicaid Management Information System (MMIS).

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

**Answer:** The State responded to the draft audit on September 7, 2010. OIG made status “final” in September 2010. The State disagrees with this finding and the majority of the requested refund is applicable to claiming Medicaid-eligible expenses at the incorrect enhanced match rate of 75% instead of 50%. The State believes $491,941 of the requested $875,838 refund was correctly claimed.

14.b. The division is in the process of developing a Request for Proposal to rebid the MMIS.

**Question:** What is the current timeframe to implement a new MMIS and its estimated cost?

**Answer:**
Timeline:
- July 2012 – RFP Release
- October 2012 – Proposals due to the State
- March 2013 – Contract Award
- June 2013 – Start of System Design and Development (2.5 Years)
- December 2015 – Start of New MMIS Operations
- December 2016 – CMS Certification

State and federal development costs will be $119M over a four year period (FY13 – 16) and the State will receive an overall federal match of 88% for these costs.

15. Through February 2012, upwards of $39 million in Medicaid Electronic Health Record Incentive payments have been distributed to hospitals and health care providers.

**Question:** How much has been distributed to hospitals and health care providers, respectively? With respect to health care providers, which type of provider has received most of the incentive payments? How much have federally qualified health centers received in incentive payments?

**Answer:** Through March, 2012, $41.0 million in New Jersey Medicaid Electronic Health Record incentive payments have been distributed. Of this amount, $37.3 million went to 31 hospitals and $3.7 million went to 177 health care providers representing 65 health care entities (clinics, FQHCs, and individual and group practices). Of the $3.7 million of incentive payment distributed to health care providers, $1.7 million went to FQHCs with the remaining $2.0 million distributed to health care practices and providers.
across the state representing many different specialties, including pediatricians, psychiatrists, dentists, OB/GYNs, cardiologists, and ear, nose and throat doctors.

16. The FY 2012 appropriations act assumed $39.0 million (State) in “fraud and settlement recoveries.” During federal FY 2011, total reported fraud recoveries totaled $10.4 million. For the July – September 2011 quarter, less than $1 million in fraud recoveries was reported to the federal government.

• **Question:** Are $39.0 million in “fraud and settlement recoveries” attainable in FY 2012?

**Answer:** Yes, the fraud and settlement recoveries may be attainable. The fraud recoveries reported for the quarter ending Dec 2011 were approximately $7.7M. This amount only represents the cash recoveries collected during the period. Additional savings are achieved by voiding claims and setting up receivables to be offset by future payments to the providers. When combined with the cash recoveries the total should approach $39M for the year.

The assumed $39 million in fraud and settlement recoveries also includes recoveries by the Medicaid Fraud Division of the Office of the State Comptroller (OSC). We anticipate that state recoveries attributable to OSC’s audits and investigations should equal or surpass recoveries from previous years. OSC has expanded its investigative efforts to include various provider types. Additionally, OSC anticipates that its collaboration with the federally-mandated Recovery Audit Contractor will bring additional recoveries to the State. As a result, we anticipate that OSC recoveries will be consistent with expected recoveries.

Moreover, given the state’s move to managed care, as part of which the state expects to receive more from its contract partners in the areas of fraud detection and prevention, the state’s overall savings in terms of recoveries and cost savings should continue to increase in FY 2012 and beyond.

In addition to the $39 million that was proposed in the FY 2012 budget, the Legislature included an additional $18 million during the Budget process for “fraud and settlement recoveries” without guidance on how these additional funds would be recovered.

17.a. Effective July 2011 various Medicaid services such as Adult Medical Day Care were shifted from fee-for-service to managed care. Effective October 2011, Medicaid recipients in the various waiver programs were shifted to managed care.

Significant reductions in fee-for-service expenditures and utilization occurred between June 2011 and December 2011. However, no information is available regarding managed care expenditures, recipients who received services, or service utilization for those services and
persons shifted to managed care. Similarly, no information is available as to the number of fee-for-service providers enrolled in the various managed care networks.
Questions: Using Adult Medical Day Care as an example, what were TOTAL Adult Medical Day Care expenditures (fee-for-services and managed care) in December 2011 compared to June 2011? What was the total number of recipients who received services in December 2011 compared to June 2011? How many units of services were provided in December 2011 compared to June 2011? How many Adult Medical Day Care providers are in the managed care networks compared to the number of providers in June 2011?

Answer: Due to normal claims lag and encounter data processing, our latest complete month of data is November 2011.

In June 2011: $21M in total expenditures; 13,221 recipients; 237,188 units of service.
In November 2011: $18M in total expenditures; 12,723 recipients; 216,417 units of service.

In June 2011 there were 157 Medical Day Care providers. The number of providers under contract by each plan varies, but one plan has 126 providers (highest) currently providing Medical Day Care services.

17.b. Effective July 2011 prescription drugs for the disabled was **shifted from fee-for-service to managed care**.

In June 2011, fee-for-service drug expenditures totaled $41.1 million on behalf of 90,300 disabled persons. In December 2011, expenditures totaled $1.3 million for approximately 3,000 recipients. No information is available regarding managed care expenditures, recipients, and the number of prescriptions filled on behalf of the disabled population.

Questions: With respect to prescription drugs for the disabled, what were TOTAL expenditures (fee-for-services and managed care) in December 2011 compared to June 2011? What was the total number of recipients who received services in December 2011 compared to June 2011? How many prescriptions were filled in December 2011 compared to June 2011?

Answer: With the July 1, 2011 elimination of the Medicare Part D co-pay, the data from June 2011 does not provide a reasonable comparison. In addition, due to the normal claims lag and encounter data processing, our latest complete month of data is November 2011.

In July 2011: $39M in total expenditures; 90,478 disabled recipients; 403,018 Rx filled.
In November 2011: $39M in total expenditures; 88,976 recipients; 438,413 Rx filled.

17.c. The July and October 2011 shift to managed care from fee-for-service has resulted in some providers not being reimbursed in a timely manner. Until a provider is “credentialed” by individual managed care plans, a provider will not be reimbursed for services.
Available information is that few providers are denied being “credentialed.” However, the delay has caused one provider organization to take legal action over the delays.

A presumptive eligibility process is in place to enroll certain individuals into the Medicaid/NJ FamilyCare programs to assure that services are provided, pending receipt and review of an application. A presumptive eligibility process for providers may expedite the process, particularly if a provider is already part of other managed care networks.

• **Questions:** What steps are being taken to expedite the enrollment of providers into the various managed care networks? Is a presumptive provider enrollment process feasible?

**Answer:** Health Plans are implementing a variety of initiatives to expedite their contracting process with various providers, including: provider training, webinars and entering into short-term and single case agreements while the credentialing process takes place.

17.d. Most Medicaid/NJ FamilyCare recipients receive services through four managed care companies under contract to the State. However, financial and statistical reports reflect fee-for-service expenditures and do not reflect services provided through managed care. Accordingly, little information is available on the number of Medicaid/NJ FamilyCare recipients who use services such as inpatient or outpatient hospital services, how many and what type of prescriptions are filled, what physician services are provided, etc. The Legislature does not have timely expenditure or utilization data on managed care.

• **Question:** What steps are being taken to provide timely managed care expenditure and utilization data?

**Answer:** Through the shared data warehouse, there is both expenditure and utilization data available for managed care services.

17.e. The HMO Performance Report (December 2011) notes that “emergency department (ED) utilization among the aged, blind, and disabled Medicaid members [in managed care] was similar to overall ED utilization within the [fee-for-service] Medicaid program.”

Providing services through managed care was intended to reduce ED overutilization as recipients would have access to primary care physicians. Finding that ED utilization under managed care was “similar” to fee-for-service utilization, not reduced, is noteworthy.

• **Questions:** What steps have managed care organizations taken to reduce inappropriate ED utilization and costs among all groups, including the aged, blind, and disabled, particularly at night and on weekends when significant utilization of EDs occur?

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3 Managed Care organizations do provide quarterly expenditure and utilization data.
**Answer:** The citation from the 2011 HMO Performance Report compared the Aged, Blind and Disabled (ABD) Medicaid Managed Care population to the total Medicaid Managed Care Population responding to the Consumer Assessment of Health Plans Survey (CAHPS). There is no comparison to the Fee-for-Service Medicaid program. The CAHPS was the source of the data, and CAHPS does not survey Fee-for-Service.

The 2011 HMO Performance Report was comparing ABD utilization of ED in Medicaid Managed Care and overall ED utilization within Medicaid Managed Care and found that ED utilization was similar between the two groups. This suggests that the ABD population, which has more complex medical needs, does not experience higher ED utilization than beneficiaries with less complex needs.

Article 4.8.2 (A) 1 of the NJ Medicaid Managed Care Contract requires that all PCPs maintain “24/7” access. Each health plan confirmed that their PCPs are maintaining “24/7” access. This access allows a PCP to be informed of any issues which may arise during the weekend or at night and can advise the member of the proper treatment protocol.

Additionally, 3 of the 4 health plans have confirmed utilization of a nurse advice line. This advice line is another means in which a member can get medical advice prior to visiting the ED.

Finally, each health plan has provided a brief summary of the initiatives they have implemented to reduce unnecessary ED utilization:

Members chronically utilizing the ED are outreached by a care/case manager to determine the reason for ED utilization. Their PCP is also informed of the ED utilization by the care/case manager or by a health plan report.

The health plans have implemented ongoing educational programs for members frequently utilizing the ED for non-emergent reasons which includes an interactive voice response outreach intended to educate, offers alternatives and informs members of available resources as well as an opportunity to connect directly to health plan member services. In some instances, a health risk assessment may be administered. Members are also provided assistance with scheduling needed follow-up care.

One health plan placed care managers at four of their highest volume EDs to provide post-utilization member education and guidance. Members that visited the ED three times during a month and received narcotic analgesics were referred to the pharmacy department for further follow up. The health plan determined that a large portion of inappropriate ED usage was linked to members utilizing the ED for non-emergent dental services. To that end, dental outreach was provided to members on a monthly basis to help facilitate appointments at proper in-network private practices or FQHCs’ dental facilities. Members were also educated about proper ER utilization. With the implementation of this initiative, the health plan has seen a drastic reduction of dental ED visits.
17.f. Federal healthcare reform requires managed care organizations to provide additional expenditure information on “fraud and abuse activities” and “expenses for activities that improve health care quality.” Though Medicaid managed care was exempt from these requirements, the managed care plans that contract with the State will have this information as they provide managed care services to non-Medicaid recipients.

**Questions:** Does the State intend to require managed care plans to provide expenditure information related to “fraud and abuse” and “activities that improve health care quality”?

**Answer:** The State currently requires, through its contract with the managed care plans, that each plan's Special Investigative Unit provide case and claim information and designate any findings as either: 1) fraud, waste or abuse; 2) quality of care; or 3) combination of fraud, waste or abuse and quality of care.

17.g. The Medicaid Fraud Division had initiated an audit of fraud and abuse operations of the various managed care plans.

For the year ending September 2011, the four managed care plans received over $2.7 billion in premium payments from the Medicaid/NJ FamilyCare programs. During this period, only one managed care plan reported any fraud and abuse collections or third party liability recoveries totaling $0.4 million and $10.8 million, respectively.

**Questions:** What is the status of this review? As only $0.4 million in fraud recoveries and $10.8 million in third party liability recoveries were reported by the four managed care plans, are managed care plans properly reporting these types of recoveries?

**Answer:** The Medicaid Fraud Division of the Office of the State Comptroller (OSC) recently issued an audit report finding in October 2011 and we understand that additional audits are underway. DHS defers to the OSC for additional information with respect to their anti-fraud initiative.

18.a. Unlike previous budgets submitted by the Administration, the FY 2013 recommended budget does not identify the amount of rebates from prescription drug manufacturers the Medicaid program anticipates receiving.

**Questions:** How much in Medicaid drug rebates are anticipated for FY 2013? Of the amount or rebates anticipated, how much represents drugs provided by managed care entities?
Page D-172 of the Governor’s Proposed Budget shows $330,981,000 in anticipated Medicaid drug rebates for FY 2013. We are still in the process of collecting and evaluating the drug rebate information from the managed care entities, but we anticipate that approximately 60% of the total will be collected through their claims.

18.b. During FY 2010, the State collected $49.2 million in rebates on behalf of the General Assistance (GA) program (Schedule 1). In FY 2011, reported GA rebates totaled $21.0 million (Schedule 1). Though some of the reduction is attributable to crediting the federal government with its share of rebates, this would not account for the $28.2 million reduction.

**Question:** What accounts for the reduction in GA rebates received in FY 2011?

**Answer:** During FY 2010, the Division was able to collect additional GA rebates that were invoiced during prior quarters. These additional rebates represented a one-time increase.

18.c. The issue of staffing of the rebate unit had been raised in previous budget materials and in a recent State Auditor report. The division has indicated that a new accounting system should correct many of the problems. Yet staffing remains an issue, as the unit has too few staff to identify and follow-up on problems such as verifying prescription drug information provided by managed care plans or resolving disputes with manufacturers.

**Question:** What steps have been taken to fill vacant positions with appropriate staff in a timely manner?

**Answer:** The Division is currently in the process of adding 2 additional staff to this Unit and is working with the pharmaceutical manufacturers to begin transmitting data electronically which will help reduce a large portion of the manual inputting.

19.a. The number of adults enrolled in the NJ FamilyCare program has declined since adults with incomes between 133%-200% FPL were no longer permitted to enroll in the program in March 2010. Between March 2010 and December 2011, the number of adults enrolled in NJ FamilyCare decreased from 195,000 to 167,200 adults. For FY 2013, the number of adults enrolled in NJ FamilyCare is estimated at 192,600 at a per capita cost of approximately $3,400.

**Questions:** What is the basis for an enrollment increase of nearly 25,000 adults? Can the recommended appropriation be reduced?

**Answer:** The frozen 133%-200% population continues to decline, but this decline is being offset by the increase in the population up to 133% that is funded through the CHIP program and included in the Evaluation Data in the Governor’s proposed budget (D-172).

19.b. The number of children enrolled in NJ FamilyCare is estimated at about 162,100 in FY 2013. During December 2011, there were over 165,300 children enrolled in the program.
• **Question:** Is the enrollment estimate too low?

**Answer:** The estimate for FY 2013 that appears in the Governor’s proposed budget (D-172) is a monthly average estimate over the course of the year for children enrolled in NJ FamilyCare managed care.
20. At the end of December 2011, over $1.3 million in FY 2011 Direct State Services funds and over $1.3 million in FY 2011 Community Based Senior Programs funds were still encumbered.

- **Question:** How much of these encumbered funds can be lapsed?

  **Answer:** Currently the obligated balances are as follows:

  - Direct State Services (DSS): $635,064.00
  - Community Based Senior Program (CBSP): $952,954.00
  - Total: $1,588,018.00

- Of the total obligated funds, $250,000 in Direct State Services funds and $896,876 of the Community-Based Senior Programs are obligated to Public Partners, Liability (PPL), the Fiscal Management Services agent, for the Jersey Assistance to Community Caregiving (JACC) program. PPL traditionally bills late in the FY and obligated funds must be maintained for future billing (historically all JACC funds have been spent by the end of the FY).

- Of the remaining DSS funds, $192,309 are obligated balances for the Division of Aging and Community Services (DACS) grants that run from 1/1/11 to 12/31/11 and have yet to be closed out. These balances may be due to pay for expenses incurred by 2 Area Agencies on Aging, and therefore, must remain open to process payments.

- Of the remaining CBSP balance, $56,078 is needed for Statewide Respite.

- In total, $442,309 in DSS funds and all $952,954 in the CBSP funds need to remain open.

- $150,558 of the obligated DSS funds are for the SFY11 Alzheimer Day Care program. The balance will not be spent; therefore, the funds will lapse.

- $42,197 of obligated funds DSS funds are reserved for audit fees that DHSS Financial Services historically has not charged the division, therefore, the funds will lapse.

- In total, $192,755 will lapse in DSS funding, which has already been accounted for as a lapse in the Governor’s proposed budget.

21.a. The FY 2012 appropriations act assumed that Global Budget for Long Term Care expenditures would total $209 million (gross) and would provide services to 12,900 persons.
Available fee-for-service data indicates that Global Budget expenditures may total $180 million (gross) and that 10,000 – 11,000 persons will receive services. As managed care expenditure and utilization data on the Global Budget program are not available, it is not known whether expenditures will exceed or will be below the $209 million estimate and whether 12,900 persons will receive services.

• Question: Including fee-for-service and managed care, will Global Budget expenditures total $209 million and will 12,900 persons receive services?

Answer: The revised projection for spending is $199 million, with 11,700 served as displayed on page D-149 of the FY13 Budget Recommendation. The $10M difference has been reflected as a resource that offsets the nursing home supplemental need.

21.b. The FY 2013 budget recommends $140.7 million for the Global Budget program. Beginning October 2011, Global Budget recipients were to be transferred to managed care plans. By March/April 2012, most Global Option recipients should be enrolled in a managed care plan. The FY 2013 recommended appropriation should only reflect fee-for-service costs of persons waiting to enroll into a managed care plan.

• Question: What costs do the $140.7 million represent as most recipients should be enrolled in a managed care plan?

Answer: The recommended amount includes Global Budget service costs incurred in both fee-for-service and managed care settings. As managed care costs are incurred, funding will be moved to the appropriate Medicaid line item using flexibility language recommended on page D-185 of the FY13 Budget.

22.a. Revised FY 2012 data estimates the number of Medicaid nursing home days 10,289,000. Available Medicaid data through indicates that the Medicaid program will pay for 10,333,000 patient days.

• Question: What accounts for the increase in the number of Medicaid nursing home days?

Answer: The Department of Health is accurately displaying the 10,289,000 FY12 Revised figure for nursing home patient days.

22.b. The Nursing Home hold harmless budget language is being reduced from $10.00 per patient per day to $5.00 per patient per day. Information is not available whether this $5.00 change has any significant financial impact on overall nursing home expenditures.

• Question: What is the financial impact of going from a $10.00 to a $5.00 per day hold harmless?
Answer: In FY 2012, appropriations language stated that no facility’s rate (including Special Care Nursing Facility’s), could vary more than $10 from their June 30, 2010 rates. The proposed Governor FY 2013 budget calls for a $10 million dollar infusion into the nursing home budget. In addition, it recommends that, after calculating the rates with the new system, a nursing facility rate shall not increase or decrease more than $5.00 from the last rate received by that facility in FY 2012.

Models indicate that the $10 million infusion, along with a $5 corridor, will yield a majority of nursing homes with increased rates over those in FY 2012.

23. PAAD enrollment in FY 2013 is unchanged from FY 2012 levels of 142,300 persons. In December 2011, PAAD enrollment was 140,100 persons. PAAD enrollment decreased 12.4% between FY 2009 and FY 2011.

• Question: Is the 142,300 enrollment estimate too high?

Answer: The Department of Health feels this estimate will be accurate. Beginning in 2012, the PAAD program is using information sent to us from Social Security to outreach individuals that are likely to be eligible for PAAD. The Medicare Improvement for Patients and Providers Act provides that any person, who consents, when applying for the Medicare Part D Low-Income Subsidy, will have their application information forwarded to be screened for Medicare Savings Plans eligibility such as the Specified Low-Income Medicare Beneficiary Program. The PAAD program does this screening and now has the ability to outreach these individuals for PAAD eligibility. As a result, we believe our enrollment figures will be maintained, or increase slightly, in the next fiscal year.
Division of Disability Services

24.a. Personal Care services were shifted from fee-for-service reimbursement to managed care, July 2011.

**Question:** What oversight has the division taken to assure that problems identified in the December 2011 federal Inspector General report\(^4\) do not occur under managed care?

**Answer:** The problems identified in the OIG audit related to the lack of documentation for claims. Since the HMO’s require documentation before payment is processed, this should address the audit finding.

24.b. In June 2011, $35.2 million in Personal Care expenditures were processed under fee-for-service. Upwards of 28,300 persons received nearly 1.9 million units of service. There were nearly 800 providers of services.

In December 2011, fee-for-service expenditures were $7.4 million. Only 4,400 persons received 98,500 units of service. There were approximately 700 providers of services.

Expenditure/utilization data from managed care organizations are not readily available. The total amount expended on Personal Care services, the total number of persons who received services, and the number of units of services provided in December 2011 compared to June 2011 is not known. Further, it is not known how many service providers are in the managed care network at this time compared to June 2011.

**Question:** For December 2011, how many persons received Personal Care services? What were total expenditures for Personal Care services? How many units of service were provided? How many providers of Personal Care services are in the managed care network? Similarly, how many providers are in the managed care networks compared to fee-for-service?

**Answer:** The total number of PCA recipients for December 2011 was approximately 29,000 of which 25,000 are managed care and 4,000 are fee for service. Total Units of service were 1.9 million of which 1.854 million are managed care and 46,000 are fee for service. The total cost was $35.2 million of which $34.5 million is managed care and $700,000 fee for service. The number of providers has remained consistent in both service models at 256. The numbers cited in the preamble include medical day services, which are not applicable.

25. The FY 2013 budget recommends $20.4 million for the Payments for Medical Assistance Recipients - Waiver Initiatives program. Beginning October 2011, Waiver Initiative recipients were transferred to managed care plans. By March/April 2012, most Waiver Initiative recipients

\(^{4}\) The report recommends the State refund $145.4 million to the federal government. The State disagrees with the report’s findings. It will take several years before the matter is resolved.
should be enrolled in a managed care plan. The FY 2013 recommended appropriation should only reflect fee-for-service costs of persons waiting to enroll into a managed care plan.

• **Question:** What costs do the $20.4 million represent as most recipients should be enrolled in a managed care plan?

  **Answer:** The amount represents the cost of waiver services to waiver recipients that have not yet fully transitioned to managed care. Individuals on the waiver presently receive the State Plan Amendment services using a managed care model. Waiver services, extensions of services that are in addition to the state plan authority, are still being delivered in a fee for service model under DDS.
26. The division has estimated that approximately $34.7 million (gross) in Grants-in-Aid funding will be transferred to the Department of Children and Families (DCF) as a result of the reorganization that will shift primary responsibility for children from the DHS to DCF. The number of children affected by this shift will not be known until case files are reviewed. Similarly, the number of personnel that may be transferred to DCF is not known.

**Questions:** How many children will this reorganization affect? Is the $34.7 million estimate still valid? How many staff may be transferred to DCF?

**Answer:** DCF and DHS are working to finalize the transition of services and funding that will support this proposed restructuring, including the specific contracts that will be integrated into the DCF service system.

The Governor’s Budget Recommendation includes a $34.7 million appropriation to DCF related to this plan. This includes $10.0 million for the transition of the Family Support Services (Home Assistance Program) to DCF effective January 1, 2013, and $24.1 million for Out-of-Home Treatment Services to be transitioned to DCF effective July 1, 2012. The balance of $553,000 will support the salaries of eleven staff that will be reassigned to DCF throughout the phase-in of the proposed restructuring plan.

The General Provisions section of the FY 2013 Recommended Budget includes language to allow further transfers that may be necessary to operationalize this proposed restructuring plan.

27. Savings of $17.6 million are anticipated due to lower census at the developmental centers. The budget also provides $7.4 million to staff group homes operated by the Parents and Friends Association. Such staff had previously been included in the Vineland Developmental Center budget.

**Question:** Does the $17.6 million in developmental center savings include Vineland staff? If so, are actual savings $10.2 million?

**Answer:** The net impact on the developmental center budget is $10.2 million because the Parents and Friends Association (PAFA) is included within Vineland’s appropriation. The PAFA amount represents a shifting of resources as Vineland Developmental Center employees move to PAFA positions.

28. The recommended budget provides $5.3 million for additional staff to oversee community programs. It is not clear whether this includes the department’s centralized licensing operations which have fewer staff than it did 10 years ago although the number of facilities to be licensed and inspected has increased.
Questions: Will developmental center employees, if qualified, be given priority for these positions? Will additional staff be assigned to the licensing unit?

Answer: Hiring will follow current State procedures unless modified due to an extraordinary event, such as a developmental center closure. This increase reflects DDD staffing and does not include DHS licensing.

29.a. The FY 2013 recommended budget assumes $11.2 million in additional federal and other revenues for services. The Comprehensive Medicaid Waiver assumed additional federal reimbursement for services that currently do not qualify for federal reimbursement.

Questions: How is the $11.2 million in additional federal revenues different than the additional federal revenues the Comprehensive Medicaid Waiver was to generate?

Answer: The $11.2 million is unrelated to the Comprehensive Waiver. This revenue includes the rebasing of CCW due to the impact of prior year rate adjustments and the anticipated increase to Contributions to Care related to increased community placements.

29.b. The FY 2012 appropriations act assumed $345.6 million in federal ICF-MR reimbursement. Revised estimates indicate that revenues will be about $325.6 million.

Question: Are additional State funds required in FY 2012 to offset the reduction?

Answer: The Governor’s Budget Message reflects a projected supplemental of $19.99 million.

29.c. The FY 2013 recommended budget assumes a $2.2 million reduction in federal ICF-MR revenues, to $323.4 million. The FY 2013 budget indicates State savings of $17.6 million due to lower census at the developmental centers. This should result in a $17.6 million reduction in federal ICF-MR expenditures.

Question: Are federal ICF-MR revenues overstated?

Answer: The FY13 calculation is accurate. Previous revenue projections used FY10 as a base year and assumed staffing up to the Division’s check cut target. Due to higher than expected census declines – in part by reducing admissions – the Division did not use its full check cut, resulting in lower salary and overtime costs than projected. This shift to the community has generated additional CCW revenue in excess of the ICF/MR adjustment.

29.d. The FY 2012 appropriations act assumed $353.4 million in federal Community Care Waiver (CCW) revenues. Based on data for the July – December 2011 period, federal CCW
revenues of $240 million may be realized, unless pending retroactive adjustments will increase the amount. 5

- **Question:** Is the $353.4 million estimate still valid?
  
  **Answer:** Yes, the current projection includes the impact of expected rate adjustments.

29.e. The FY 2013 recommended budget anticipates $384.4 million in federal Community Care Waiver revenues.

- **Question:** How much of the $384.4 million is related to the Comprehensive Medicaid Waiver?
  
  **Answer:** This projection does not include an amount related to the Comprehensive Waiver.

30. During calendar years 2009 – 2011, nearly 250 clients from developmental centers were placed in community programs as follows: 2009 - 80, 2010 – 60 and in 2011 – 105.

- **Questions:** How many clients are still in a community placement? How many clients are now in a nursing home or other type of institutional setting? How many are now deceased?
  
  **Answer:** Of the consumers transitioned to the community in CY09-11, 93.5% remain in the community, 2.5% are in developmental centers, 1.5% are in skilled nursing facilities, 1.5% are deceased, and 1% are in correctional facilities.

31. The FY 2012 appropriations act had assumed approximately 670 persons in Private Institutional Care/Private Residential Facilities. Revised estimates now indicate that about 690 persons will be in this placement type. Also, available data indicates that between June 2011 and December 2011, the number of individuals in this type of placement increased from around 670 to 720.

- **Questions:** Will the 690 person goal be attained? If not, why?
  
  **Answer:** Caseload reports reflect all known DDD-eligible consumers, whereas the evaluation data reflects DDD-funded placements. In order to maximize federal reimbursement, DDD plans on returning consumers to New Jersey whenever possible, unless the out-of-state facility is eligible for federal Medicaid match.

32. In FY 2012 and FY 2013 approximately $17.8 million and $23.2 million, respectively, is to be expended on Emergency Placements. No information has been provided as to the number of emergency placements undertaken or the per capita cost associated with such placements.

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5 This amount references FY 2012 claims that have been processed. The total amount of CCW claims processed during FY 2012 includes claims for prior year expenditures.
• **Question:** How many Emergency Placements will be provided in FY 2012 and FY 2013 and at what per capita cost?

**Answer:** DDD projects approximately 300 emergency placements slots per year, including both residential and day program services. On an annual basis, DDD projects approximately $139,000 per residential slot and $18,000 per day program slot.

33. Information is not available as to the number of persons who receive services under the [Day Program Age Outs](#) program. Similarly, no explanation has been provided regarding the nearly $0.8 million reduction in FY 2013 funding.

• **Questions:** How many persons are expected to receive services in FY 2012 and FY 2013, respectively? What accounts for the $0.8 million reduction in FY 2013 funding?

**Answer:** DDD projects approximately 100 day program age outs entering contracted services each year. The funding difference is based off our most recent projections and will not have an impact on the services delivered. All consumers aging out in need of a day program will be provided with one.

34. Available data indicate that between December 2010 and December 2011 the number of participants in the [Self Determination and Real Life Choices](#) programs has decreased from about 590 to 510. The FY 2013 recommended budget indicates that about 340 persons will participate in the Real Life Choices project.

• **Question:** Are these two programs being phased-out?

**Answer:** These programs both fall within the larger category of Self-Directed Services. Although consumers are no longer being enrolled in programs with these names, DDD continues to expand the number of consumers who are managing individual budgets to purchase services.

35.a. Advocates for the developmentally disabled have expressed concern about the increase in clients in [nursing homes](#). Specifically, in December 2009 there were 900 clients in nursing homes and in December 2011 there were 1,020 clients in nursing homes. However, during the June 2011 – December 2011 period, the number of clients in nursing homes decreased by nearly 50, to 1,020.

• **Question:** What accounts for the 50 person reduction?

**Answer:** This change is not due to a large shift in consumers, but rather reflects the reclassification of a purchase-of-care provider inadvertently categorized as a skilled nursing facility.

35.b. Though the number of persons with a developmental disability in [nursing homes](#) has increased, nursing homes do not provide any special services for patients with a developmental
disability. As the (new) Department of Health has authorized nursing homes to establish special units for patients with head injuries, behavioral management issues, and Huntington’s disease, there may be a need to establish special units for persons with developmental disabilities.

• **Question:** As demographics point to an increase in the number of persons with developmental disabilities in nursing homes, is there a need to develop specialized units to address the issues of persons with developmental disabilities?

**Answer:** The Division does not anticipate a need for specialized nursing home units. Individuals with developmental disabilities exhibit the same diverse set of needs as people without disabilities and there is no reason to segregate them into their own units. Additionally, before an individual with a developmental disability can even be admitted into a nursing home, a “Preadmission Screening and Resident Review” (PASRR) is required to determine whether the individual requires “specialized services.” Consumers that require specialized services cannot be admitted to nursing homes and would instead be referred to the Division for an alternative placement. Thus, DDD consumers in nursing homes have already been screened and have been determined not to be in need of specialized services.
36. The FY 2012 appropriations act adopted a commission recommendation to restructure education services provided to children by eliminating 10-month teaching positions and by providing services through 12-month teachers. The commission claimed that teaching hours available to students would increase and that the average number of teaching hours a student would receive should increase.

- **Question:** With respect to the number of teaching hours provided, how many hours were provided in FY 2011 and how many hours are expected to be provided during FY 2012? On average, how many teaching hours of service did a child receive in FY 2011 and how many teaching hours are expected to be provided to each child in FY 2012?

  **Answer:** 16,588 lesson hours were provided in FY 2011 compared to 18,954 projected in FY 2012. As of 2/29/12, actual lesson hours were 15,959. On average, a child received 8 teaching hours of service in FY 2011 compared to 10 teaching hours projected in FY 2012.

37. Federal Funds available to the commission in FY 2013 decrease by $0.9 million, from $13.4 million to $12.5 million. The reduction affects the Services for the Blind and Visually Impaired and the Administration and Support Services programs.

- **Questions:** What impact will the $900,000 million reduction have on the commission’s operations?

  **Answer:** This reduction will not affect program services. The methodology on how the Commission received its IDEA funding from the Department of Education changed in FY 2012. Instead of a direct appropriation, the Commission receives, through a MOU, approximately $.5 million to cover teacher salaries. The $.4 million reduction in Vocational Rehabilitation funding represents a decrease in excess federal ceiling and will not affect spending authority as the appropriation will not be reduced below the grant level.
38. At the end of December 2011, nearly $1.4 million in FY 2011 Grant-in-Aid funds were encumbered including over $450,000 in Kinship Care Initiative monies and over $630,000 in WFNJ Child Care funds.

- **Question:** How much of the encumbered funds can be lapsed?

  **Answer:** The $450,000 Kinship and $630,000 in WFNJ Child Care encumbrances were deobligated as part of DFD’s child care contract close-out process and have already been scheduled for lapse to the General Fund as part of the Governor’s proposed budget. DFD has implemented a new Electronic Child Care Time, Attendance and Payment system (eCC) that will enable the Division to track expenditures incurred for Child Care programs on a real-time basis and help reduce the amounts that remain obligated after the close of a Fiscal Year starting in FY 2013.

39. The division is developing and implementing a new welfare eligibility system known as CASS which has been in operation since the mid-1980s. Quarterly Quality Assurance reports on Hewlett Packard’s (HP) work on CASS have noted various problems and delays.

- **Questions:** What is the current status of CASS with respect to its completion date and its total cost? Have fines been levied on HP for any of the problems and delays? If so, how much has HP been fined?

  **Answer:** The estimated date for CASS implementation is October 2013 with a total Hewlett Packard (HP) contract cost of $107.5 million. The current contract cost includes Federal and State approved changes and enhancements to CASS including an upgrade to the latest version of Curam, the addition of Child Care and other related modules, a change to the implementation rollout methodology and additional external and professional workspace licenses.

  The project has been rebaselined to the current implementation date with no increased cost due to delays other than the requested and authorized enhancements and Curam version upgrade. Construction and Implementation Planning (Phase 5) proceeded smoothly, and we are preparing to begin Testing and Conversion (Phase 6) with the project currently on budget and on schedule. Since any delays were due to a variety of factors, all of which have been resolved to State and federal satisfaction, no fines have been levied against HP.

40. a. The division recently ended the Supportive Housing Assistance Program (SHAP) as being “unsuccessful” for the TANF population. Also, the program “did not achieve its goals” with respect to the SSI and GA employable population groups.
• **Question:** How many TANF, GA employable and SSI recipients did SHAP serve in FY 2011? How much was expended during FY 2011 in terms of federal and State funds?

**Answer:** During FY 2011 there were 1,065 TANF SHAP cases and a total of 3,359 total cases for General Assistance (GA) SHAP clients. DFD has limited information available to provide a reliable extrapolation of the number of SSI SHAP clients from the larger universe of EA expenditures. Total federal SHAP expenditures for FY 2011 amounted to $5.616 million and the total State SHAP expenditures for FY 2011 totaled $14.464 million.

40. b. SHAP is being replaced by a new pilot project, Housing Assistance Program (HAP).

• **Question:** How many TANF, GA and SSI recipients will HAP assist during FY 2013? What are projected FY 2013 State/federal costs?

**Answer:** The SHAP program is being replaced by the Housing Assistance Program (HAP) and the Housing Hardship Extension (HHE). SHAP provided the housing assistance needed by these vulnerable clients and was therefore successful in its goal and mission. With regard to the delivery of housing assistance to GA and TANF clients, we bifurcated the SHAP program into two programs to separately address the needs of employable and unemployable clients: the Housing Hardship Extension (HHE) provides additional EA to WFNJ/TANF employable clients; and the Housing Assistance Program (HAP) provides additional EA to WFNJ/TANF/GA clients who are unemployable, as well as SSI recipients. In essence, the single SHAP program was bifurcated to more effectively serve the targeted TANF, GA and SSI populations. DFD projects that the same number of clients for both TANF (HHE) and GA (HAP) will be eligible for these two new pilot programs and that the Federal and State costs would remain consistent with FY2011 expenditures.

41. Federal funds for **Breaking the Cycle** projects are increased from $1.1 million to $1.3 million.

• **Question:** What projects will the $1.3 million support?

**Answer:** Breaking the Cycle is a reference to a Memorandum of Understanding (MOU) between DFD and the Department of State (DOS) Office of Faith-Based Initiatives for faith and community-based collaborative support services. This agreement provides DOS with $1.055 million that is allocated to fund twelve (12) faith and community-based organizations with a demonstrated ability to deliver enhanced and effective sanction support services to Temporary Assistance for Needy Families (TANF) recipients in pre-sanction and sanction status. These services include, but are not limited to mail; telephone and home visit outreach to provide information on sanction rules and policies, referrals to the Sanction Hotline and County Welfare Agencies (CWA) and provide motivation to participate in programs and services that minimize sanction penalties and that promote self-sufficiency and employment.
The agreement is currently funded in accordance with a State Fiscal Year (SFY) from July to June, however, the funding source for this agreement is on a Federal Fiscal Year (FFY) that runs from October through September. The purpose for the increase is to align the MOU agreement with the funding source. In order to achieve this, starting in SFY-2013, DFD will provide a one-time increase from $1.055 million to $1.319 million to include sufficient funds for one additional quarter. For FY 2014, the agreement will be reduced back to the original amount of $1.055 million.

42. Various child care savings were adopted during FY 2012: (1) Equalizing child care income eligibility standards and wrap around co-payments would save over $5.0 million and $2.1 million, respectively; (2) Adopting a 25 hour per week work requirement would save about $6.0 million and would affect 1,300 children; and (3) a co-pay requirement would affect about 4,800 children with incomes between 101% - 250% of the federal poverty level.

- **Question:** Are the $5.0 million, $2.1 million, and $6.0 million in savings being realized? Were estimates that 4,800 children and 1,300 children, respectively, would be affected by the FY 2012 changes correct? If not, how many children were actually affected?

  **Answer:** Yes, the Department believes that the efficiencies related to equalizing Abbots and non-Abbots have been achieved and the number of children impacted has exceeded the original estimates.

43. The FY 2013 budget recommends $27.4 million (gross) for the Substance Abuse Initiative program, a $2.4 million reduction based on “trends.”

   Available utilization data indicates that fewer TANF/GA clients are being referred to the program, assessed and referred to treatment. However, the reduction in utilization does not appear to warrant a $2.4 million reduction in recommended appropriations.

- **Question:** As there has been no significant reduction in utilization, what is the basis for the reduction?

  **Answer:** As part of the NJ Childless Adult Demonstration that was approved in April 2011 by the Center for Medicaid and Medicare Services (CMS), the federal match for Substance Abuse costs for General Assistance clients changed from 100% State funded to a 50% State and a 50% Federal funds participation rate. The $2.4 million amount identified in the FY13 budget is the projected savings to the State from the receipt of the additional federal funds.

44. a. Available information is that in FY 2011 and FY 2012, the activities of the General Assistance review teams will save approximately $1.1 million each year. The cost of the review teams is not mentioned.

- **Question:** What is the total cost associated with the review teams?
A General Assistance review team is generally comprised of five (5) State employees with an annual estimated salary and administrative expenses (inclusive of one time purchase of additional vehicles for field staff - $70,000) of $400,000 per year.

44. b. The FY 2013 recommended budget would prohibit the two General Assistance (GA) programs from providing benefits to recipients who are enrolled in college. No information has been provided as to the number of persons affected by this provision or the amount the GA programs would save.

- **Question:** How many GA recipients are affected by this change? How much does the State expect to save as a result of this policy?

**Answer:** The intent of GA is to serve as the benefit of last resort for individuals and not as a supplement to other programs. Emergency Assistance (EA) was never intended to support the housing needs of college students. The change in the FY’13 budget is intended to close a loophole which allows college students to receive GA benefits, along with EA benefits. Some of these students are still being counted as dependents on their parent’s income taxes and should not be receiving public assistance. Other students are using these benefits to replace other forms of income for housing, including student loans and scholarships. The intent of the policy proposal is to reaffirm the intent of the GA program.

DFD estimates approximately $6.9 million in cost avoidance from the elimination of GA eligibility for an estimated 1,900 college students through June 2012.

44. c. General Assistance (GA) caseloads have decreased significantly since June 2011 as indicated in the table below:

<table>
<thead>
<tr>
<th></th>
<th>June 2011</th>
<th>December 2011</th>
<th>Change</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>56,450</td>
<td>45,600</td>
<td>(10,850)</td>
<td>(19.2%)</td>
</tr>
<tr>
<td>Employable</td>
<td>39,930</td>
<td>31,870</td>
<td>(8,060)</td>
<td>(20.2%)</td>
</tr>
<tr>
<td>Unemployable</td>
<td>16,510</td>
<td>13,740</td>
<td>(2,770)</td>
<td>(16.8%)</td>
</tr>
</tbody>
</table>

The GA program has historically been sensitive to overall economic conditions in the State: Caseloads increase when the economy is not good and caseloads decrease when economic conditions are good. While there is a general consensus the economic conditions in the State are improving, economic conditions, in and of themselves, do not explain a 19.2% reduction in the GA caseload between June – December 2011.

- **Questions:** What accounts for the overall reduction in the GA caseload between June – December 2011? Have the number of unemployable GA recipients approved for federal SSI benefits increased significantly during this period?

**Answer:** As part of the FY 2012 Budget, DFD implemented the following changes to the General Assistance program:
1. Eliminate Emergency Assistance (EA) for anyone over 18 and 36 months for Employable and Unemployable clients respectively.
2. Delay reclassification of employable clients transitioning to unemployable clients for 6 months.
4. Implement a 30 day eligibility/employment search for new applicants. (30 day protocol).
5. Implement an additional GA Assessment team.

Based on feedback DFD has received from the County Welfare Director’s, the 30 day protocol appears to be a significant reason that the GA caseload has decreased.

DFD has reviewed statistics received from the Social Security Administration and there has not been a significant increase of GA recipients being approved for SSI benefits.
Division of the Deaf and Hard of Hearing

45. The FY 2013 budget recommends $284,000 for Services to Deaf Clients. In FY 2010 $146,000 was expended. In FY 2011 $178,000 was expended. The amount that may be expended in FY 2012 is not known at this time.

• **Question:** In view of actual expenditures, can the $284,000 recommendation be reduced?

  **Answer:** The Division does not recommend any reduction to this account. During FY12, the Division has worked collaboratively with the DDHH Advisory Council and its stakeholders to identify goals for FY13. These goals include new initiatives that will increase spending up to the appropriated level for FY13 and beyond. The new initiatives currently being worked on by the Division include the following:

  • **Mentoring/Licensure for Sign Language Service Providers** – This will improve the qualifications and performance skills of American Sign Language interpreters who provide services to deaf and hard of hearing consumers in private, public and state government entities. DDHH also plans to propose a model for licensure for interpreters working in NJ.

  • **Equipment Distribution Program** - As a result of increased outreach efforts, there has been an increase in requests from economically disadvantaged families for specially adapted telecommunications and home safety devices for people who are deaf and hard of hearing which is anticipated to have a higher annualized impact on spending in FY13. Further, the Division is also reaching out to traditionally underserved populations such as seniors with hearing loss and people who are deaf-blind.

  • **Community Based Education Programs** - DDHH is working on developing new modules of instruction for community based education programs for service providers and people who are deaf and hard of hearing. Modules in need of development include self-advocacy training, resources for hospitals and healthcare providers in communicating with patients with hearing loss and emergency response preparation for people who are deaf and hard of hearing.

  • **State Wide Resource Center for the Deaf and Hard of Hearing** - Planning is underway to develop electronic resources that can be viewed on-line auditorily, visually and in both American Sign Language and captioning so as to be accessible to the diverse deaf and hard of hearing community served by the Division.
Division of Management and Budget

46. At the end of December 2011, over $150,000 in various FY 2011 Direct State Services funds were still encumbered.

   • Question: How much of the encumbered funds can be lapsed?

   Answer: The amount of the outstanding FY 2011 encumbrances has been reduced to $108,000. We have been working with vendors to obtain their invoices for products/services already delivered. We anticipate that only $20,000 may be lapsed after all the invoices have been paid. This has been accounted for as part of the Department’s overall spending plan that would include lapsed resources.

47. The number of funded positions in the Institutional Security Services (Human Services Police) program will increase by 14, from 104 to 118 positions in FY 2013. No information is available regarding the increase.

   • Question: As the closure of the Hagedorn Psychiatric Hospital and the West Campus of the Vineland Developmental Center should free up Human Services Police personnel, what accounts for the increase in funded positions?

   Answer: The 104 positions reflected for FY12 represent the filled level as of pay period 2. The 118 positions reflected in FY13 represent the funded level. The difference is due to funded vacancies which are needed to be filled.

48. The FY 2013 budget recommends $4.4 million for Unit Dose Contracting Services and $4.3 million for Consulting Pharmacy Services. The amount paid to the contractors is dependent on the census of various State institutions. As there have been significant census reductions at the developmental centers and psychiatric hospitals, contract expenditures and appropriations should decrease.

   • Question: Can the recommended appropriations be reduced?

   Answer: The Department of the Treasury is currently evaluating bid proposals as a result of the re-procurement of the unit dose pharmaceutical services contract that provides services to approximately 5,300 patients located in 15 facilities. The resultant contract will offer greater efficiencies including the establishment of an administrative capitation rate to be applied against the actual patient census. This will result in lower dispensing costs as the census of these facilities continue to decline. The contract will also alter the current distribution of pharmaceuticals from a 30 day bingo card system to a 14 day system, thereby eliminating the wasteful disposal of unused pharmaceuticals.

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6 The contract is currently being re-bid. An award may be announced before the end of FY 2012.
While these accruals will materialize over time as the patient census declines, the proposed capitation rates under the new contract are expected to increase significantly from the current fixed rate structure. The current contract has maintained the same rate structure since the contract originated in October 2002. The proposed capitation rates under the new contract will reflect current economic conditions that may offset any accruals realized from the reduction in patient census. Consequently, the Department does not anticipate any material savings in FY 2013 and will require the full amount proposed in the FY 2013 Governor’s Budget Recommendation.