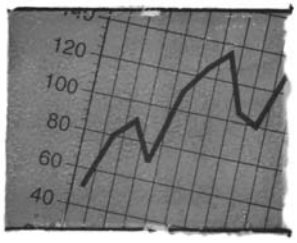

ANALYSIS OF THE NEW JERSEY BUDGET

DEPARTMENT OF HUMAN SERVICES

FISCAL YEAR 2013 - 2014

PREPARED BY OFFICE OF LEGISLATIVE SERVICES
NEW JERSEY LEGISLATURE • APRIL 2013

NEW JERSEY STATE LEGISLATURE

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DEPARTMENT OF HUMAN SERVICES

Budget Pages..... B-3 to B-6, B-8 to B-10, B-11 to B-14; C-5, C-13, C-21, C-25 to C-27; D-161 to D-223; E-1, E-3 to E-5, E-7; F-1, F-3, F-8 to F-10; G-3 to G-4; H-3 to H-5, H-8, H-12, H-15, H-18 to H-20

Fiscal Summary ($000)

	Expended FY 2012	Adjusted Appropriation FY 2013	Recommended FY 2014	Percent Change 2013-14
State Budgeted	6,887,485	6,542,701	6,495,260	(0.7%)
Federal Funds	5,824,414	6,708,299	7,908,608	17.9%
Other	382,248	772,588	786,020	1.7%
Grand Total	$13,094,147	$14,023,588	$15,189,888	8.3%

*Other includes Revolving Funds displayed on page C-27 of the recommended budget

Personnel Summary - Positions By Funding Source

	Actual FY 2012	Revised FY 2013	Funded FY 2014	Percent Change 2013-14
State	9,887	9,496	9,199	(3.1%)
Federal	5,020	4,982	5,029	0.9%
Other	65	65	63	(3.1%)
Total Positions	14,972	14,543	14,291	(1.7%)

FY 2012 (as of December) and revised FY 2013 (as of January) personnel data reflect actual payroll counts. FY 2014 data reflect the number of positions funded.

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

Highlights

BUDGET OVERVIEW

The Governor's FY 2014 Budget recommends a total of $15.19 billion (gross) for the Department of Human Services (DHS) in fiscal year (FY) 2014, an increase of about $1.17 billion from the FY 2013 adjusted appropriation. State funds account for nearly $6.50 billion of the total FY 2014 recommendation, representing a slight decrease from FY 2013 State appropriations of $6.54 billion. Anticipated federal funds account for $7.91 billion of the FY 2014 recommendation, representing a relatively significant increase of $1.20 billion (or 17.9%) over the FY 2013 adjusted appropriation of $6.71 billion.

In part, the increase in anticipated federal funds is related to a key development that will affect DHS in FY 2014: the proposed expansion of the State's Medicaid program in accordance with the federal Affordable Care Act. Another key development, the October 2012 approval of the State's Comprehensive Medicaid Waiver, will begin to have significant programmatic impacts within DHS in FY 2014. Both of these developments are discussed in more detail below.

Medicaid Expansion and the Affordable Care Act

In his budget address, the Governor announced his decision to support New Jersey's participation in the Medicaid expansion under the Affordable Care Act. Effective January 1, 2014, the expansion would allow Medicaid to expand coverage to childless adults without disabilities who earn under 133 percent of the federal poverty level. (The ACA provides for a five percent income disregard, effectively raising the threshold to 138 percent.) Expenditures for these "newly eligible" Medicaid enrollees will be paid entirely by federal funds until calendar year 2017, when the federal matching rate will begin to phase down to 90 percent by 2020.

- Expanding Medicaid will allow the State to achieve an estimated $227.4 million in savings, primarily by shifting certain populations from partially State-funded coverage in the NJ FamilyCare and General Assistance Medical Services programs to Medicaid. Under federal determinations pursuant to the Affordable Care Act, these individuals will be considered "newly eligible" and their coverage will be fully paid with federal funds.

- New costs totaling $42.3 million are expected as a result of the Affordable Care Act, primarily from new enrollees who are currently eligible for Medicaid but are not enrolled. When enrolled, these individuals will receive the State's normal 50 percent federal Medicaid matching rate, as they will not be considered "newly eligible." These enrollees represent the so-called "woodwork effect," whereby some individuals who are currently eligible for, but not enrolled in, Medicaid are expected to enroll due to other Affordable Care Act provisions, such as individual health insurance mandate, new enrollment mechanisms, and subsidies in the health insurance exchange.

Highlights (Cont'd)

Comprehensive Medicaid Waiver

In October 2012, New Jersey received federal approval for its Comprehensive Medicaid Waiver. The State is now authorized to receive federal revenues for new initiatives as well as for certain existing services that were previously supported by State funds. The new initiatives affecting DHS in FY 2014 include:

- The Managed Long Term Care Supports and Services (MLTSS) initiative within the Division of Aging Services and the Division of Disability Services, under which various Medicaid home- and community-based services will transition from fee-for-service delivery to managed care in January 2014. (MLTSS is anticipated to expand to individuals in nursing facilities in FY 2015).

- The Supports Program within the Division of Developmental Disabilities, under which previously State-funded family support services will receive federal financial participation, and additional services centered on independent living will be offered. While the Supports Program is expected to be partially implemented during FY 2014, the department has indicated that federal claims are likely to be minimal and little fiscal impact is anticipated in FY 2014.

- Federal financial participation for the previously State-funded Medication Assisted Treatment Initiative (MATI), which provides medication-assisted treatment and other clinical services to opiate-dependent, low-income adults with mental illness or chronic medical conditions.

Other initiatives under the Comprehensive Waiver, such as the shift of Medicaid coverage for adult behavioral health services to a behavioral health organization (BHO), are not anticipated to be implemented in FY 2014. For a more detailed summary of new initiatives under the Comprehensive Waiver, including those operated by the Department of Children and Families and the Department of Health, please see the *Comprehensive Medicaid Waiver – New Programs* background paper included within this analysis (page 51).

HIGHLIGHTS BY DIVISION

Division of Mental Health and Addiction Services

The Division of Mental Health and Addiction Services (DMHAS) provides a wide array of community-based mental health and substance abuse services. DMHAS also operates the State's four psychiatric hospitals and provides State Aid to support low-income patients in five county-operated psychiatric hospitals.

The Governor's FY 2014 Budget recommends a decrease of $1.0 million in overall funding for the State psychiatric hospitals, to $332.2 million (gross). A $1.0 million reduction in State funding, due to lower psychiatric hospital census, entirely accounts for this decrease, with recommended State appropriations decreasing to $279.2 million in FY 2014. Federal funds are unchanged at $53.0 million.

Overall funding for the rest of the division is recommended to increase by $2.4 million, to $628.0 million (gross). Of this amount, $554.3 million represents State appropriations from

Highlights (Cont'd)

the General Fund and Property Tax Relief Fund. The recommended State appropriations are allocated as follows:

- Direct State Services (other than psychiatric hospitals) funding is recommended to remain virtually unchanged at $17.5 million.

- Grants-in-Aid funding is recommended to increase by $8.9 million, to $406.6 million. The net State increase is primarily attributed to:

    - A total of $12.8 million in additional funding recommended for the Olmstead Support Services and Community Care programs to develop new community-based placements and services in FY 2014 and to support the annualized costs of placements created in FY 2013.

    - $2.4 million in savings associated with Community Care program trends;

    - $2.1 million in savings associated with new federal funding for the Medication Assisted Treatment Initiative (MATI) program under the Comprehensive Medicaid Waiver;

    - a $1.6 million General Fund reduction resulting from the shift of funding for the Community Based Substance Abuse Treatment and Prevention program to other funds; and

    - $2.2 million in funding transferred to DMHAS from the Division of Developmental Disabilities, for services to dually diagnosed clients with "Conditionally Extended Pending Placement" status.

- State Aid funding for the county psychiatric hospitals is recommended to remain unchanged at $130.2 million.

It is also noted that federal funds decrease by $8.1 million, to $60.3 million (excluding psychiatric hospitals), due to the shift of existing federal Substance Abuse Block Grant funds from DMHAS to the Department of Children and Families (DCF). This shift reflects the FY 2013 realignment of adolescent addiction services into DCF. Other funds increase by $1.6 million, due to a shift from General Fund resources to dedicated funds, to $13.4 million.

Division of Medical Assistance and Health Services

The Division of Medical Assistance and Health Services (DMAHS) is the division primarily responsible for the Medicaid, NJ FamilyCare, and General Assistance Medical Services programs, which provide health care coverage to low-income New Jersey residents with a combination of State and federal funds.

The Governor's FY 2014 Budget recommends a net increase of over $1.11 billion in gross funding for the division, to a total of approximately $8.55 billion. The increase is driven by growth in federal funds, which increase by $1.13 billion, primarily as a result of the Medicaid expansion under the Affordable Care Act. State appropriations are approximately $28.0 million less than the FY 2013 adjusted appropriations, primarily as a result of enhanced

Highlights (Cont'd)

federal matching funds. Other funds, in the form of Medicaid drug manufacturer rebates and dedicated fund payments for NJ FamilyCare children, increase by a total of $7.2 million. State appropriations are distributed as follows:

- Direct State Services, representing administrative costs, would remain unchanged at $30.6 million.

- Grants-in-Aid funding for health care benefits to eligible individuals would decrease $28.0 million, to $3.17 billion. Major changes include the following:

    - The budget recommendation includes proposed FY 2013 supplemental appropriations totaling $200.4 million. Available information attributes a portion of this supplemental request to: delays in the approval and implementation of the Comprehensive Medicaid Waiver; a reduction in the federal matching rate for coverage of NJ FamilyCare parents that was not incorporated into the original FY 2013 estimate; and certain higher than expected fee-for-service costs.

    - Cost increases of $157.6 million attributed to health care trends comprised of enrollment and cost increases unrelated to the Affordable Care Act, offset by $20.0 million in anticipated enhanced Medicaid fraud recoveries and $12.0 million in anticipated additional pharmaceutical manufacturer rebates.

    - Additional cost increases of $42.3 million are attributed to the Affordable Care Act, primarily as a result of the "woodwork effect," whereby individuals currently eligible for, but not enrolled in, Medicaid and NJ FamilyCare may enroll as a result of the Affordable Care Act.

    - Savings of $227.4 million are attributed to shifting costs to the federal government as a result of the Affordable Care Act. Most of these savings are associated with transitioning certain adults in NJ Family Care and General Assistance Medical Services programs to Medicaid as "newly eligible" populations under the Affordable Care Act, whose costs will be fully borne by the federal government. The $227.4 million also includes approximately $33 million from a federal Balancing Incentive Payments grant, intended to help the State improve its long-term care services and supports system, and approximately $15 million in savings achieved by transitioning NJ FamilyCare adults who will not be eligible for Medicaid to the health insurance exchange.

Division of Aging Services

The Division of Aging Services (DoAS) administers New Jersey's programs for senior citizens. These include medical services and long-term care, both in nursing homes and community settings, pharmaceutical assistance programs, and several non-health programs intended to improve seniors' quality of life, such as home delivered meals, transportation, and legal assistance. The division also provides State Aid to counties for the operations of the County Offices on Aging and the State share of the Older Americans Act.

Highlights (Cont'd)

The Governor recommends a net decrease of $7.2 million in total funding for the division, for a total budget of $2.33 billion. Federal funds increase by $0.7 million, while Other funds remain unchanged at $180.7 million. State appropriations decrease by $8.0 million, as follows:

- Direct State Services remain unchanged at $11.9 million.

- Grants-in-Aid decrease by $8.0 million, as follows:

    - The FY 2013 baseline includes a requested supplemental appropriation of $17.5 million to pay back to the federal government erroneous Medicaid claims from FY 2010. Excluding the baseline adjustment, the recommended Grants-in-Aid appropriation increases by $9.5 million.

    - Enrollment and utilization trends are expected to drive cost increases of $18.8 million for nursing home care and community-based health care services, while trends in pharmaceutical assistance programs are expected to reduce costs by $9.68 million. The nursing home reimbursement rate formula is unchanged from FY 2013, so facilities' rates will not fall below their FY 2013 levels.

    - Additionally, $1 million in administrative savings attributed to the transition of the division from the Department of Health to the Department of Human Services is used to support a $1 million increase in funding for Adult Protective Services.

- State Aid remains stable at $7.2 million.

Division of Disability Services

The Division of Disability Services (DDS) administers Medicaid personal care assistant services, which provide assistance with aspects of daily living to children and adults with functional limitations. DDS also administers several Medicaid waiver programs providing home- and community-based services and provides information, referral assistance, and other services to adults and children with disabilities.

Overall funding for the division is recommended to increase by $5.3 million, to $111.3 million (gross). Of this amount, $60.5 million represents State appropriations from the General Fund and Casino Revenue Fund. The recommended State appropriations are allocated as follows:

- Direct State Services funding is recommended to increase slightly by $0.1 million, to $1.5 million.

- Grants-in-Aid funding is recommended to increase by $0.5 million, to $59.0 million, primarily due to trends in Medicaid waiver programs.

Federal funds are recommended to increase by $4.7 million, to $47.8 million, reflecting increased Medicaid matching funds, while Other funds remain unchanged at $3.0 million.

Highlights (Cont'd)

Division of Developmental Disabilities

The Division of Developmental Disabilities (DDD) funds a broad range of community-based residential care services, individual and family support services, and day programs for individuals with developmental disabilities. DDD also operates the State's seven developmental centers.

The Governor's FY 2014 Budget recommends overall funding for the State developmental centers to decrease by $0.3 million, to $475.6 million (gross). This recommended net decrease includes a State reduction of $14.0 million and an offsetting increase in federal funds of $13.7 million, driven by increased ICF/MR revenues. Of the $14.0 million State reduction, $12.7 million is attributed to shifts from State funding to the increased federal ICF/MR revenues and $1.3 million is attributed to State savings from a lower developmental center census.

The developmental center census is expected to decrease by 135 residents (net) in FY 2014. Much of the overall decrease is attributed to anticipated reductions at North Jersey Developmental Center and Woodbridge Developmental Center. These reductions reflect the Task Force on the Closure of State Developmental Centers' binding recommendation, issued in August 2012, directing DHS to develop and implement a plan to close North Jersey Developmental Center followed by Woodbridge Developmental Center within the next five years.

It is also noted that, in his FY 2014 Budget address, the Governor announced the settlement of two longstanding lawsuits filed by Disability Rights New Jersey. According to available information, the settlement agreement requires that about 600 persons currently residing at developmental centers be discharged to the community by the end of FY 2017, and that new developmental center admissions be made only if necessary for individuals' health, safety, and welfare and only after the exhaustion of appropriate alternatives. Details are still forthcoming regarding the settlement and its specific operational and fiscal impacts on DDD in FY 2014.

Overall funding for the rest of the division (including community programs and administration and support services) is recommended to increase by $73.1 million, to $1.16 billion (gross). Of this amount, $639.7 million represents State appropriations from the General Fund and Casino Revenue Fund. The recommended State appropriations are allocated as follows:

- Direct State Services (other than developmental centers) funding is recommended to decrease by $0.9 million, to $39.0 million.

- Grants-in-Aid funding is recommended to increase by $23.4 million, to $600.7 million. The net State increase is primarily attributed to:

    - o $34.3 million in additional funding recommended for various Community Programs accounts, to support new FY 2014 community placements and the annualized costs of FY 2013 community placements;

Highlights (Cont'd)

- o $8.7 million in additional funding recommended for FY 2014 community placements for transitioning residents from developmental centers into the community, in accordance with the U.S. Supreme Court's Olmstead decision;

- o $7.4 million in savings associated with a shift of funding for Group Homes to the federal Community Development Block Grant, for the construction of new group homes;

- o $9.7 million in savings associated with anticipated increases in federal Community Care Waiver revenues and clients' contributions to care; and

- o $2.2 million in funding transferred from DDD to DMHAS for services to dually diagnosed clients with "Conditionally Extended Pending Placement" status (as noted in DMHAS highlights above).

Federal funds are recommended to increase by $45.1 million, to $451.2 million, primarily driven by increased Community Care Waiver revenues and Community Development Block Grant funds. Other funds are recommended to increase by $5.4 million, to $59.4 million, due to increased client contributions to care.

Commission for the Blind and Visually Impaired

The New Jersey Commission for the Blind and Visually Impaired (CBVI) provides and promotes services in the areas of education, employment, independence, and eye health for people who are blind or visually impaired, as well as their families and the community at large.

The CBVI's recommended budget is virtually unchanged from FY 2013, including $14.3 million in State funds, $12.5 million in federal funds, and $0.6 million in Other Funds, for a total budget of $27.4 million. Small shifts in anticipated federal funding reduce the commission's recommended budget by $47,000 from FY 2013. State appropriations include $11.0 million for Direct State Services and $3.3 million for Grants-in-Aid.

Division of Family Development

The Division of Family Development (DFD) provides various support services and forms of assistance to financially insecure families and adults without dependents. In cooperation with the county welfare agencies, DFD provides nutrition assistance, child care subsidies, rental and emergency housing assistance, temporary cash assistance, and other support services to these families and individuals.

Overall funding is recommended to decrease by $15.7 million, to $1.49 billion (gross). Of this amount, $557.5 million represents State appropriations from the General Fund. The recommended State appropriations are allocated as follows:

- Direct State Services funding is recommended to increase slightly by $0.3 million, to $36.2 million.

Highlights (Cont'd)

- Grants-in-Aid funding is recommended to decrease by $4.6 million, to $157.5 million. The net State decrease is primarily attributed to:

    - o $2.8 million in savings from federal Medicaid funds available to offset State expenditures under the Substance Abuse Initiative program; and

    - o $2.0 million in reduced funding for Work First New Jersey Child Care, attributed to program efficiencies and a significantly reduced waiting list.

- State Aid funding is recommended to decrease by $24.0 million, to $363.8 million. The net State decrease is primarily attributed to:

    - o $12.1 million in State savings from trends associated with the Temporary Assistance for Needy Families (TANF) program;

    - o $7.0 million in State savings from trends associated with the General Assistance (GA) and GA Emergency Assistance programs;

    - o $2.4 million in State savings from trends associated with State supplemental payments and other assistance to recipients of federal Supplemental Security Income benefits; and

    - o $2.0 million in State savings from federal Medicaid funds offsetting reimbursements to counties for GA administrative costs.

Federal funds increase by $12.6 million, to $885.6 million, due to increased funds from the Temporary Assistance for Needy Families (TANF) Block Grant, while Other funds remain unchanged at $41.9 million.

Division of the Deaf and Hard of Hearing

The Division of the Deaf and Hard of Hearing (DDHH) provides services to New Jersey residents who are deaf, hard of hearing, deaf-blind, or have speech disorders. It also conducts activities that enhance public awareness of hearing loss, and provides communications access referral services to State and other governmental programs.

The Governor's FY 2014 Budget Recommendation provides a Direct State Services appropriation of $1.0 million for DDHH, the same as in FY 2013. This appropriation is spent entirely on the division's operational and administrative costs. The division does not receive any federal or other funds.

Division of Management and Budget

The Division of Management and Budget performs the central administrative functions of the Department of Human Services.

Highlights (Cont'd)

The Governor recommends approximately the same funding as in FY 2013, including $50.0 million in State funds, $22.8 million in federal funds, and $10.2 million in other funds, for a total budget of $83.0 million. State funding is allocated as follows:

- Direct State Services decrease $284,000, to $40.8 million. The decrease is attributed to reduced expenditures in the Additions, Improvements, and Equipment category.

- Grants-in-Aid are unchanged at $9.2 million.

Background Papers

Fiscal and Personnel Summary

AGENCY FUNDING BY SOURCE OF FUNDS ($000)

	Expended FY 2012	Adj. Approp. FY 2013	Recom. FY 2014	Percent Change 2012-14	Percent Change 2013-14
General Fund					
Direct State Services	$706,019	$642,593	$626,810	(11.2%)	(2.5%)
Grants-In-Aid	5,368,580	5,167,092	4,954,716	(7.7%)	(4.1%)
State Aid	351,611	525,103	370,979	5.5%	(29.4%)
Capital Construction	665	0	0	(100.0%)	0.0%
Debt Service	0	0	0	0.0%	0.0%
Sub-Total	$6,426,875	$6,334,788	$5,952,505	(7.4%)	(6.0%)
Property Tax Relief Fund					
Direct State Services	$0	$0	$0	0.0%	0.0%
Grants-In-Aid	0	0	0	0.0%	0.0%
State Aid	160,262	0	130,165	(18.8%)	*
Sub-Total	$160,262	$0	$130,165	(18.8%)	*
Casino Revenue Fund	$300,348	$207,913	$412,590	37.4%	98.4%
Casino Control Fund	$0	$0	$0	0.0%	0.0%
State Total	$6,887,485	$6,542,701	$6,495,260	(5.7%)	(0.7%)
Federal Funds	$5,824,414	$6,708,299	$7,908,608	35.8%	17.9%
Other Funds	$382,248	$772,588	$786,020	105.6%	1.7%
Grand Total	$13,094,147	$14,023,588	$15,189,888	16.0%	8.3%

PERSONNEL SUMMARY - POSITIONS BY FUNDING SOURCE

	Actual FY 2012	Revised FY 2013	Funded FY 2014	Percent Change 2012-14	Percent Change 2013-14
State	9,887	9,496	9,199	(7.0%)	(3.1%)
Federal	5,020	4,982	5,029	0.2%	0.9%
All Other	65	65	63	(3.1%)	(3.1%)
Total Positions	14,972	14,543	14,291	(4.5%)	(1.7%)

FY 2012 (as of December) and revised FY 2013 (as of January) personnel data reflect actual payroll counts. FY 2014 data reflect the number of positions funded.

AFFIRMATIVE ACTION DATA

Total Minority Percent	65.6%	63.4%	63.4%	----	----

Significant Changes/New Programs ($000)

Budget Item	Adj. Approp. FY 2013	Recomm. FY 2014	Dollar Change	Percent Change	Budget Page
DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES (DMHAS)					
DIRECT STATE SERVICES					
Psychiatric Hospitals	$280,176	$279,174	($1,002)	(0.4%)	D-170

Operational costs of the State psychiatric hospitals are expected to decline by $1 million due to reduced census. During FY 2014, the average daily population of the four institutions is expected to decrease by 129, to 1,478. The total number of staff at the State hospitals is expected to remain the same, but the $1.0 million in savings is anticipated in the Materials and Supplies category.

GRANTS-IN-AID					
Olmstead Support Services	$78,953	$88,817	$ 9,864	12.5%	D-175
Community Care	$262,274	$264,975	$ 2,701	1.0%	D-175

The Governor's FY 2014 Budget recommends increases of $9.9 million for Olmstead Support Services and $2.7 million for Community Care, for overall funding of $88.8 million (State) and $265.0 million (State), respectively. These recommendations jointly represent a net increase of $12.6 million, and reflect the following initiatives:

- An increase of $3.4 million to develop 334 new community-based placements, of which 234 will serve patients discharged from the State's psychiatric hospitals and another 100 will serve individuals at risk of institutionalization.

- An increase of $4.4 million, attributed to operational savings from the FY 2012 closure of Hagedorn Psychiatric Hospital, to develop:
  - 133 new units of supportive housing;
  - Rental assistance for 100 individuals utilizing mental health or substance abuse services;
  - Expanded psychiatric services for patients in the community;
  - Expanded supportive employment program capacity; and
  - Implementation of the Behavioral Health Home initiative, integrating physical and behavioral health services for mental health consumers.

- An increase of approximately $5.0 million to support the annualized costs of placements created and services expanded in FY 2013.

- An increase of $2.2 million is attributed to the reallocation of funding for Dually Diagnosed "Conditionally Extended Pending Placement" (CEPP) clients to DMHAS from the Division of Developmental Disabilities. These funds support community placements for individuals with dual diagnoses of a mental illness and a developmental disability who no longer meet the standard for involuntary commitment to a State

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

Budget Item	Adj. Approp. FY 2013	Recomm. FY 2014	Dollar Change	Percent Change	Budget Page

psychiatric hospital or developmental center. The reallocation is intended to better reflect DMHAS' operational role in developing community placements for such individuals.

- An offsetting net decrease of $2.4 million is attributed to Community Care "trend." Available information indicates that this trend is primarily related to underspending recovered from community mental health provider contracts.

Available information indicates that approximately 75 percent of the recommended $12.6 million increase represents the net cost of annualizing new placements and related services initiated in FY 2013, with the remaining 25 percent representing the net cost of new placements to be initiated in FY 2014.

Community Care funds contracts with community mental health agencies to provide an array of mental health services, including: early intervention and support services; screening services; outpatient, partial care, and residential services; supported housing and employment; integrated case management; legal services; and family support services.

Olmstead Support Services provide mental health services that are similar to those supported under Community Care, but with a focus on assisting individuals discharged or diverted from the State's psychiatric hospitals, in accordance with the State's long-term efforts to reduce the number of institutionalized individuals pursuant to the U.S. Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999), which requires that individuals with mental illness receive services in the least restrictive appropriate environment.

As funding for similar community placements and other community-based services may be allocated to both Community Care and Olmstead Support Services, the accounts are presented jointly above. For a more detailed summary of trends involving these accounts, see *Background Paper: Trends in Community Health Services, FY 2010 - FY 2014*, included within this analysis on page 48.

GRANTS-IN-AID					
Community Based Substance Abuse Treatment and Prevention – State Share	$24,265	$22,665	($1,600)	(6.6%)	D-175

The Governor's FY 2014 Budget recommends a $1.6 million decrease in State funding for Community Based Substance Abuse Treatment and Prevention – State Share, which provides grant funding for community-based substance abuse treatment centers and a range of other addiction services. However, this recommended decrease is entirely offset by proposed budget language. The Governor's FY 2014 Budget would direct that $1.6 million be appropriated to this program from the unexpended balances of fees paid into the Alcohol Education, Rehabilitation and Enforcement Fund, established pursuant to P.L.1983, c.531 (C.26:2B--32 et seq.).

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

Budget Item	Adj. Approp. FY 2013	Recomm. FY 2014	Dollar Change	Percent Change	Budget Page

Annual deposits are made to the Alcohol Education, Rehabilitation and Enforcement Fund (the Fund) from alcoholic beverage excise tax collections, pursuant to section 2 of P.L.1990, c.41 (C.54:43-1.1). The Fund's enabling legislation dedicates 75 percent of deposits toward alcohol rehabilitation, 15 percent toward enforcement, and 10 percent toward education. Additionally, fees paid by persons convicted of operating a motor vehicle or watercraft while intoxicated are deposited into the Fund to be used for the screening, evaluation, education, and referral of persons who have been convicted of driving or boating while intoxicated.

GRANTS-IN-AID					
Medication Assisted Treatment Initiative	$11,296	$9,232	($2,064)	(18.3%)	D-175

The Governor's FY 2014 Budget recommends a decrease of $2.1 million (State) for the Medication Assisted Treatment Initiative (MATI), to $9.2 million.

The MATI program delivers an array of medication-assisted treatment and other clinical services to opiate-dependent, low-income adults with mental illness or chronic medical conditions. These services are intended to: reduce drug dependence; reduce the spread of blood-borne diseases resulting from the sharing of syringes; stabilize chronic physical and mental health conditions; and improve housing and employment outcomes.

The recommended $2.1 million decrease is attributed to MATI savings generated by the Comprehensive Medicaid Waiver. The Comprehensive Waiver allows the State to claim federal financial participation for the previously State-funded MATI program.

FEDERAL FUNDS					
Addiction Services	$53,431	$45,295	($8,136)	(15.2%)	D-175

The Governor's FY 2014 Budget recommends a decrease of $8.1 million in Federal Funds associated with DMHAS Addiction Services, to $45.3 million. This decrease is due to the recommended shift of existing federal Substance Abuse Block Grant funds from DMHAS to the Department of Children and Families (DCF), which reflects the FY 2013 realignment of adolescent addiction services into DCF.

OTHER FUNDS					
Addiction Services	$11,394	$12,994	$ 1,600	14.0%	D-176

The Governor's FY 2014 Budget recommends an increase of $1.6 million in Other Funds associated with DMHAS Addiction Services, to $13.0 million. This increase reflects proposed budget language directing that $1.6 million be appropriated to Community Based Substance Abuse Treatment and Prevention – State Share from the unexpended balances of fees paid into the Alcohol Education, Rehabilitation and Enforcement Fund (as described above).

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

Budget Item	Adj. Approp. FY 2013	Recomm. FY 2014	Dollar Change	Percent Change	Budget Page
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES (DMAHS)					
GRANTS-IN-AID					
Payments for Medical Assistance Recipients TOTAL	$2,837,628	$2,965,518	$127,890	4.5%	D-182
Managed Care Initiative	$1,912,731	$2,000,315	$87,584	4.6%	D-182
Inpatient Hospital	$224,141	$231,532	$ 7,391	3.3%	D-182
Prescription Drugs	$271,520	$270,920	($ 600)	(0.2%)	D-182
Outpatient Hospital	$61,920	$76,366	$14,446	23.3%	D-182
Medicare Premiums	$160,966	$168,046	$ 7,080	4.4%	D-182
Clinic Services	$70,175	$82,045	$11,870	16.9%	D-182
Other Services[1]	$136,175	$136,294	$ 119	0.0%	D-182

Total State appropriations for Medicaid managed care and fee-for-service programs (excluding services administered by other divisions or departments) are expected to increase by approximately $127.9 million, to nearly $3.0 billion. The change in recommended appropriations represents the sum of three major factors: enrollment and cost trends, new costs associated with the Affordable Care Act (ACA), and savings associated with the ACA. These three factors are displayed on page B-4 of the Governor's FY 2014 Budget, but are not subdivided by department or division. Additional information is provided below.

Of the $159.8 million in increased expenditures attributed to Medicaid and General Assistance health care trend on page B-4 of the FY 2014 Budget Recommendation, approximately $110 million is attributed to the Medicaid line items in DMAHS (above), and $48 million is attributed to NJ FamilyCare and General Assistance (see below). (The remainder is attributed to growth in the Division of Disability Services and the Division of Aging Services.)

An additional $42.3 million in costs associated with the ACA (page B-4) is also incorporated into the division's budget, but the specific distribution across programs has not been provided. This increase reflects new State costs to cover individuals who are eligible for Medicaid or NJ FamilyCare under current rules, but who newly enroll as a result of the ACA. These individuals may enter the program because they must obtain health coverage to avoid a federal tax penalty, or because they were previously unaware that they were eligible. This increase in enrollment of currently eligible but unenrolled individuals has been described as the "woodwork effect."

[1] Other Medicaid Services include fee-for-service Adult Mental Health Residential, Home Health, Dental Services, ICF-MR, Medical Supplies, Physician Services, Psychiatric Hospital, Transportation Services, PACT, and others.

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

Budget Item	Adj. Approp. FY 2013	Recomm. FY 2014	Dollar Change	Percent Change	Budget Page

These additional Medicaid costs are offset by $227.4 million in savings resulting from the ACA (page B-4). Most of these savings appear in the General Assistance Medical Services and NJ FamilyCare line items, discussed below. Information from the department indicates that approximately $33 million of these savings are attributed to the Balancing Incentive Program, a grant program created under the ACA designed to provide incentive to states to improve their non-institutional long-term care services and supports system. (The Balancing Incentive Program is unrelated to the Medicaid Expansion.)

The FY 2013 adjusted appropriation includes $200.4 million in proposed FY 2013 supplemental appropriations. According to the Executive, the original FY 2013 appropriation will be insufficient to fund FY 2013 obligations because: approval of the Comprehensive Medicaid Waiver came later than anticipated (and, by implication, implementation of waiver programs was delayed); the reduction in the federal matching rate for parents in NJ FamilyCare (specified by federal statute) was not incorporated into the original estimate; and the original estimates for certain fee-for-service costs were low.

GRANTS-IN-AID					
Eligibility Determination Services	$13,048	$13,687	$ 639	4.9%	D-182
Health Benefit Coordination Services	$9,689	$11,502	$ 1,813	18.7%	D-182

Eligibility determination and health benefit coordination services are recommended to increase by a combined $2.5 million, to a total of $25.2 million. No specific information has been provided regarding the growth in these items, but estimated costs in these items is typically driven by applications for and enrollment in Medicaid and NJ FamilyCare, which are both likely to increase due to implementation of the ACA.

GRANTS-IN-AID					
General Assistance Medical Services	$70,622	$31,842	($38,780)	(54.9%)	D-182

Childless adults whose income is less than 25 percent of the Federal Poverty Level and are not otherwise eligible for Medicaid may receive Medicaid-like health care benefits in the General Assistance (GA) Medical Services program. The Executive expects the State costs of this program to decrease by $38.8 million, to $31.8 million.

Growth in program costs due to enrollment and cost trends and the "woodwork effect" (described on the prior page) would be offset by shifting all of the program's costs to the federal government beginning January 1, 2014, saving an estimated $38.9 million. GA recipients will be considered "newly eligible" for Medicaid under the ACA, and the State will begin to receive a 100 percent federal match for these populations when the Medicaid expansion takes effect. This is possible because GA recipients are currently included in Medicaid as an "early expansion" population under the ACA, allowed because of a provision in the law that

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

Budget Item	Adj. Approp. FY 2013	Recomm. FY 2014	Dollar Change	Percent Change	Budget Page
authorizes states to expand Medicaid to "newly eligible" populations prior to January 1, 2014, at the State's standard Medicaid matching rate of 50 percent. Effective January 1, 2014, the State will begin to receive a 100 percent federal match for these populations.					
An additional $0.5 million is saved in the first half of FY 2014 due to the Childless Adults waiver, which allowed the State to receive a 50 percent federal match for the program beginning in April 2011.					
GRANTS-IN-AID					
NJ FamilyCare – Affordable and Accessible Health Coverage Benefits	$271,752	$172,217	($99,535)	(36.6%)	D-182
NJ FamilyCare provides health care coverage to parents earning up to 200 percent of the Federal Poverty Level (though new enrollment is currently frozen, pursuant to budget language on page B-95 of the FY 2013 Appropriations Handbook and page D-187 of the Governor's FY 2014 Budget Recommendation, for parents over 133 percent of the Federal Poverty Level). The recommended appropriation for NJ FamilyCare adults reflects a net reduction of $99.5 million over the FY 2013 adjusted appropriation.					
Similar to the General Assistance program (described above), growth in NJ FamilyCare costs due to enrollment and cost trends and the "woodwork effect" would be offset by transitioning most enrollees into Medicaid as "newly eligible" individuals and shifting costs to the federal government beginning January 1, 2014, saving an estimated $137.5 million. The Executive estimates than an additional $15 million would be saved by transitioning current NJ FamilyCare recipients who will not be eligible for Medicaid to coverage to the health insurance exchange (pursuant to a proposed language provision on page D-187), where they will be eligible to receive federally subsidized health insurance coverage.					
Parents in NJ FamilyCare who earn up to 138 percent of the Federal Poverty Level will be considered "newly eligible" for Medicaid under the ACA, and the State will begin to receive a 100 percent federal match for these populations when the Medicaid expansion takes effect. This is possible because the State's authority to provide coverage to parents through NJ FamilyCare will expire on September 30, 2013, at which time the program will transition to an "early expansion" under the ACA, similar to General Assistance.					
(Children up to 350 percent of the Federal Poverty Level are also covered by NJ FamilyCare, but State funding for children is provided through the off-budget Health Care Subsidy Fund, displayed on page H-17 of the Governor's FY 2014 Budget.)					

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

Budget Item	Adj. Approp. FY 2013	Recomm. FY 2014	Dollar Change	Percent Change	Budget Page
GRANTS-IN-AID					
Enhanced Medicaid Fraud Recoveries	0	(20,000)	($20,000)	—	D-182

The Governor's Budget Recommendation anticipates that Medicaid fraud recoveries will increase by $20 million in FY 2014, offsetting the total recommended State appropriation for the General Medical Services program class. The department has indicated that this is meant to correct a pattern of underestimation in recent years. The Office of Legislative Services cannot independently verify that these increased recoveries are likely to occur.

DIVISION OF AGING SERVICES (DoAS)

GRANTS-IN-AID					
Payments for Medical Assistance Recipients – Nursing Homes	$671,429	$677,857	$ 6,428	1.0%	D-192

Medicaid nursing home services are expected to retain fee-for-service reimbursement during FY 2014 while the department prepares to implement the Managed Long Term Services and Supports program. If nursing home services are transitioned to managed care to any extent during FY 2014, proposed budget language would require that managed care plans reimburse nursing facilities at the same rates as those determined by DoAS for the fee-for-service program in FY 2014.

Proposed budget language retains the same formula for determining reimbursement rates as the FY 2013 Appropriations Act. Proposed language provides that no nursing facility would receive a per-diem rate less than it received in the prior year. Some facilities could see small increases in their rates, but evaluation data on page D-188 do not assume an increase in the average rate. Total patient days are expected to decline slightly (approximately 9,500 patient days) from FY 2013, to 10.2 million. The nursing home provider assessment fee is expected to generate $131 million, the same as in FY 2013.

GRANTS-IN-AID					
Global Budget for Long Term Care					
TOTAL	$122,158	$131,336	$ 9,178	7.5%	D-192
General Fund	$57,748	$41,336	($16,412)	(28.4%)	D-192
Casino Revenue Fund	$64,410	$90,000	$25,590	39.7%	D-192

Costs associated with the Global Options waiver program are expected to increase $9.2 million, to $131.3 million. No specific information has been provided on the anticipated increase; however, evaluation data on page D-189 indicates a 3.8 percent anticipated growth in enrollment in Global Options and the Program of All-Inclusive Care for the Elderly (PACE, see below). (The department has informally indicated that enrollment in PACE is expected to

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

Budget Item	Adj. Approp. FY 2013	Recomm. FY 2014	Dollar Change	Percent Change	Budget Page

increase "significantly," so it is not clear to what extent, if any, the projected enrollment growth is attributable Global Options.) Anticipated growth not related to enrollment may be due to increased utilization or provider reimbursement rates. According to the department, no effects of programmatic changes are assumed in the budget recommendation.

Under the Comprehensive Medicaid Waiver, Global Options will transition into the new Managed Long Term Services and Supports program, in which services will be provided through a managed care organization rather than fee-for-service. Available information indicates that community-based services will begin to transition to managed care in January 2014. The recommended Global Options appropriation represents the annualized FY 2014 fee-for-service cost of these services. Budget language would allow funds appropriated to the program to be transferred to DMAHS during FY 2014 as the services are transitioned to managed care.

Global Options is a Medicaid waiver program designed to allow the State to claim federal financial participation for services provided to individuals living in a community setting who may otherwise live in nursing homes.

GRANTS-IN-AID					
PACE	$18,537	$24,141	$ 5,604	30.2%	D-192

Funding for Programs for All-inclusive Care for the Elderly (PACE) is expected to increase by $5.6 million, to $24.1 million. The department has indicated that enrollment in PACE is expected to grow significantly, primarily as a consequence of the State's efforts to direct clients to the program as a substitute for placement in a nursing home.

Similar to Global Options, PACE is designed to divert, delay, or transition individuals away from institutional care and to community-based care. The State pays a capitated rate for each enrollee, rather than paying for services on a fee-for-service basis, but the program is separate from the State's primary managed care initiative.

GRANTS-IN-AID					
Prior Year Federal Claim Adjustment	$17,511	$0	($17,511)	(100.0%)	D-192

Information from the Executive indicates that the State erroneously claimed federal reimbursement for non-matchable costs in fiscal year 2010 related to nursing facility and community-based long term care services. The prior year claims are expected to be paid in FY 2013 through a proposed supplemental appropriation. No further appropriation is recommended or anticipated for this purpose in FY 2014.

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

Budget Item	Adj. Approp. FY 2013	Recomm. FY 2014	Dollar Change	Percent Change	Budget Page
GRANTS-IN-AID Medical Day Care Services	$3,283	$919	($2,364)	(72.0%)	D-192

This line item represents only the portion of medical day care services that are provided on a fee-for-service basis. Most costs for medical day care services now appear under the Managed Care Initiative line item in the Division of Medical Assistance and Health Services. Fee-for-service costs are still incurred for individuals who are newly enrolled in Medicaid but have not yet chosen a managed care plan, or who are in the middle of changing managed care plans. Evaluation data on page D-188 show a decrease in the number of anticipated patient days compared to FY 2013, explaining the decrease in recommended funding.

GRANTS-IN-AID PAAD and Senior Gold TOTAL	$85,138	$75,455	($9,683)	(11.4%)	D-192
Pharmaceutical Assistance to the Aged – Claims	$2,750	$2,250	($ 500)	(18.2%)	D-192
Pharmaceutical Assistance to the Aged and Disabled – Claims	$24,432	$15,393	($9,039)	(37.0%)	D-192
Pharmaceutical Assistance to the Aged and Disabled – Claims (CRF)	$50,012	$50,000	($ 12)	(0.0%)	D-192
Senior Gold Prescription Discount Program	$7,944	$7,812	($ 132)	(1.7%)	D-192

Recommended funding for pharmaceutical assistance programs is reduced by approximately $9.7 million. The Executive estimates that the PAAD and Senior Gold programs collectively are overfunded by $8.4 million in FY 2013, and will lapse this amount to the General Fund at the end of the year. The Governor's budget recommends incorporating the current lower level of expenditure in proposed FY 2014 appropriations. The Governor recommends a further reduction of approximately $1.3 million, attributed to an anticipated continuation of recent trends of declining enrollment (see evaluation data on page D-189).

PAAD and Senior Gold provide prescription drug coverage for low-income seniors. PAAD and Senior Gold costs have fallen in recent years, as changes in federal law and State rules have resulted in shifting of costs to the federal government, through Medicare Part D. For most

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

Budget Item	Adj. Approp. FY 2013	Recomm. FY 2014	Dollar Change	Percent Change	Budget Page

beneficiaries, these programs now provide secondary coverage, which covers some copayments, and coverage in the Medicare Part D "doughnut hole."

DIVISION OF DISABILITY SERVICES (DDS)

GRANTS-IN-AID					
Payments for Medical Assistance Recipients – Personal Care	$21,969	$19,955	($2,014)	(9.2%)	D-200

The Governor's FY 2014 Budget recommends nearly $20.0 million (State) for Payments for Medical Assistance Recipients – Personal Care. The recommended appropriation represents a $2.0 million decrease from a total adjusted funding level of $22.0 million in FY 2013, which includes a projected supplemental appropriation of $3.8 million.

Personal Care Assistance (PCA) services are primarily provided through managed care. The $20.0 million represents fee-for-service expenditures on behalf of individuals pending their enrollment into a managed care plan.

The net decrease of $2.0 million is factored into an overall net increase of $0.9 million (State) across all Grants-In-aid Accounts within the Division of Disability Services, attributed to "trend." Available information does not indicate specific changes in client caseload or other details regarding this trend.

Medicaid personal care assistance (PCA) services provide assistance with aspects of daily living for Medicaid beneficiaries with a short-term or long-term disability. The services include assistance with: various activities of daily living (e.g., grooming, bathing, dressing, walking, eating); household duties essential to the beneficiary's health and comfort (e.g., cleaning, shopping, preparing meals); and certain health activities (e.g., assistance with exercise or physical therapy procedures, self-administrated medications, use of a wheelchair or other equipment).

GRANTS-IN-AID					
Payments for Medical Assistance Recipients – Waiver Initiatives	$20,412	$23,663	$ 3,251	15.9%	
General Fund	$3,910	$7,161	$ 3,251	83.1%	D-200
Casino Revenue Fund	$16,502	$16,502	$0	0.0%	D-200

The Governor's FY 2014 Budget recommends an increase of $3.3 million (State) for Waiver Initiatives, to $23.7 million.

The net increase of $3.3 million is factored into an overall increase of $0.9 million (State), attributed to "trend," across all Grants-In-Aid accounts within the Division of Disability

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

Budget Item	Adj. Approp. FY 2013	Recomm. FY 2014	Dollar Change	Percent Change	Budget Page

Services. It is noted that evaluation data on page D-199 of the Governor's Budget show that total expenditures on Waiver Initiatives are expected to decrease by about $0.6 million, to $51.3 million (gross). Available information does not explain what accounts for increasing State expenditures in the context of decreasing total expenditures.

Waiver Initiatives funds several Medicaid waiver programs providing home- and community-based services, including Traumatic Brain Injury Program, the AIDS Community Care Alternatives Program, and the Community Resources for People with Disabilities Program. These waiver programs are extensions of services, beyond Medicaid acute/medical services, to applicable subgroups of Medicaid recipients who may otherwise be placed in institutional care.

In January 2014, these waiver services are anticipated to transition into managed care within the new Managed Long Term Services and Supports (MLTSS) program, as approved under the Comprehensive Medicaid Waiver. The recommended Waiver Initiatives appropriation represents the annualized FY 2014 fee-for-service cost of these Medicaid waiver home- and community-based services. Budget language would allow funds appropriated to the program to be transferred to DMAHS during FY 2014 as the services are transitioned to managed care.

DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)

(Note: The Governor's Budget displays the Division of Developmental Disabilities' budget line items in a gross budget format, indicating the aggregated total of State, Federal, and Other Funds. Below, the OLS disaggregates each line item into its various components, as applicable.)

DIRECT STATE SERVICES					
Developmental Centers					
TOTAL	$475,899	$475,577	($ 322)	(0.1%)	D-203
General Fund	$173,010	$158,992	($14,018)	(8.1%)	D-203
Federal	$302,889	$316,585	$13,696	4.5%	D-203

The Governor's FY 2014 Budget recommends overall funding for developmental centers to remain virtually level when compared with the FY 2013 adjusted appropriation, at $475.6 million (gross).

This recommendation includes a State reduction of $14.0 million attributable to:

- $12.7 million (net) in reduced State spending on personal services and materials and supplies, primarily due to an offsetting $13.7 million increase in federal ICF/MR revenues, based on ICF/MR claiming trend projections and adjustments; and

- $1.3 million (net) in State savings on developmental centers' operations due to lower census.

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

Budget Item	Adj. Approp. FY 2013	Recomm. FY 2014	Dollar Change	Percent Change	Budget Page

Evaluation data on page D-202 of the Governor's FY 2014 Budget indicate that the census at the developmental centers is expected to decrease by 135 residents, from 2,284 (FY 2013 revised estimate) to 2,149 (FY 2014 estimate).

The developmental centers with the largest percentage census reductions are North Jersey (reduced by 79 residents, or 24 percent from FY 2013) and Woodbridge (reduced by 71 residents, or 22 percent). All other developmental centers are expected to experience significantly smaller reductions with the exception of Vineland, which is expected to increase by 46 residents (19 percent). According to data reported on page H-18 of the Governor's FY 2014 Budget, the developmental centers' workforce is expected to decrease by 305 positions (with an offsetting increase of 75 new staff elsewhere in DDD, to care for developmentally disabled clients placed in the community).

The budget also anticipates the transfer of 140 clients into community programs in accordance with the State's long-term efforts to reduce the number of institutionalized individuals pursuant to the U.S. Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999), which requires that individuals with disabilities receive services in the least restrictive appropriate environment. Many of these clients account for the net developmental center census reduction.

Pursuant to P.L.2011, c.143, the Task Force on the Closure of State Developmental Centers issued a binding recommendation in August 2012 instructing DHS to develop and implement a plan to close North Jersey Developmental Center followed by Woodbridge Developmental Center within the next five years in accordance with a schedule that takes into account the needs of the residents of the developmental centers to be closed and the operational concerns of the developmental centers and the community services system. Available information indicates that the net shift of residents away from North Jersey and Woodbridge and into Vineland reflects the Task Force's recommendation.

GRANTS-IN-AID					
Community Services Waiting List Placements TOTAL	$2,476	$2,968	$ 492	19.9%	D-208
General Fund	$1,347	$1,491	$ 144	10.7%	
Federal	$1,129	$1,477	$ 348	30.8%	

The Governor's FY 2014 Budget recommends nearly $3.0 million (gross) for Community Services Waiting List Placements, for an increase of $0.5 million over the FY 2013 adjusted appropriation.

This account represents Community Care Waiver (CCW) program services provided to individuals selected from the CCW waiting list. The CCW program provides long-term community-based services and supports for people with developmental disabilities.

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

Budget Item	Adj. Approp. FY 2013	Recomm. FY 2014	Dollar Change	Percent Change	Budget Page

This line item reflects only the total costs associated with new placements, as indicated by footnote (b) on page D-209. Thus, the increase of $0.5 million relative to the FY 2013 adjusted appropriation represents a year-to-year increase in the amount of funding appropriated to new placements only. (In future fiscal years, the ongoing funding for these new placements will be reallocated to the applicable DDD Grants-In-aid Accounts reflecting the actual services received.)

GRANTS-IN-AID Group Homes GRAND TOTAL	$607,377	$644,266	$36,889	6.1%	
Group Homes	$562,023	$419,813	($142,210)	(25.3%)	D-208
General Fund	$232,863	$55,077	($177,786)	(76.3%)	
Federal	$275,163	$305,384	$30,221	11.0%	
Other Funds	$53,997	$59,352	$ 5,355	9.9%	
Group Homes (Casino Review Fund)	$45,354	$224,453	$179,099	394.9%	D-208

The Governor's FY 2014 Budget recommends an increase of $36.9 million for Group Homes, to $644.3 million (gross). The recommended $644.3 million appropriation will support:

- 5,310 group home placements at a per capita cost of nearly $103,600.
- 1,415 supervised apartment placements at a per capita cost of over $77,700.
- 718 supported living placements at a per capita cost of nearly $43,600.

The Group Home appropriation incorporates Supervised Apartments and Supported Living appropriations that had been separate budget accounts in prior fiscal years. Group homes are living arrangements which allow individuals with developmental disabilities to live together in a home, sharing in daily living tasks and in the overall management of the residence. Supervised apartments are occupied by individuals with developmental disabilities who receive supervision, guidance, and training in activities of daily living, as needed, from support staff. Supported living provides a flexible array of services and supports to individuals with developmental disabilities residing in a variety of settings.

The Governor's FY 2014 Budget Recommendation would shift about $177.8 million in funding for Group Homes from the General Fund to the Casino Revenue Fund. The net increase also includes an additional $30.2 million in federal Community Care Waiver funds and an additional $5.4 million from clients' contributions to care (reflected in Other Funds).

The net increase recommended by the Governor's FY 2014 Budget also reflects a decrease of $2.2 million attributed to the reallocation of funding for Dually Diagnosed "Conditionally

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

Budget Item	Adj. Approp. FY 2013	Recomm. FY 2014	Dollar Change	Percent Change	Budget Page
Extended Pending Placement" (CEPP) clients from DDD to the Division of Mental Health and Addiction Services (DMHAS). Additional details are provided above, in the description of DMHAS Significant Changes.					
GRANTS-IN-AID Olmstead Residential Services TOTAL	$18,087	$19,697	$ 1,610	8.9%	D-208
General Fund	$9,749	$8,523	($1,226)	(12.6%)	
Federal	$8,338	$11,174	$ 2,836	34.0%	

The Governor's FY 2014 Budget recommends $19.7 million (gross) for Olmstead Residential Services, for an increase of $1.6 million over the FY 2013 adjusted appropriation. Consistent with the U.S. Supreme Court's Olmstead decision, the Olmstead Residential Services funds support the transitioning of current developmental center residents into community residential settings. The Governor's FY 2014 Budget indicates that the FY 2014 recommended appropriation will enable DDD to transition 140 individuals from developmental centers to community settings.

About $7.4 million of the federal funds allocated to Olmstead Residential Services represents Hurricane Sandy-related disaster recovery funds from the federal Community Development Block Grant. These funds will support the new construction of group homes for community-based placements.

This line item reflects only the total costs associated with new Olmstead placements, as indicated by footnote (b) on page D-209. Thus, the increase of $1.6 million relative to the FY 2013 adjusted appropriation represents a year-to-year increase in the amount of funding appropriated to new Olmstead placements only. (In future fiscal years, the ongoing funding for these new placements will be reallocated to the applicable DDD Grants-In-Aid accounts reflecting the actual services received.)

GRANTS-IN-AID Emergency Placements TOTAL	$23,223	$30,572	$ 7,349	31.6%	D-208
General Fund	$17,567	$23,398	$ 5,831	33.2%	
Federal	$5,656	$7,174	$ 1,518	26.8%	

The Governor's FY 2014 Budget recommends $30.6 million (gross) for Emergency Placements, for an increase of $7.3 million over the FY 2013 adjusted appropriation. Emergency Placements are short-term placements provided to individuals with developmental disabilities who are at risk of homelessness or in imminent peril. Information is not provided as to the number of persons assisted by this program or the average cost of such placements.

This line item reflects only the total costs associated with new placements, as indicated by footnote (b) on page D-209. Thus, the increase of $7.3 million relative to the FY 2013 adjusted

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

Budget Item	Adj. Approp. FY 2013	Recomm. FY 2014	Dollar Change	Percent Change	Budget Page

appropriation represents a year-to-year increase in the amount of funding appropriated to new placements only. (In future fiscal years, the ongoing funding for these new placements will be reallocated to the applicable DDD Grants-In-Aid accounts reflecting the actual services received.)

GRANTS-IN-AID Purchase of Adult Activity Services GRAND TOTAL	$196,580	$211,528	$14,948	7.6%	
Purchase of Adult Activity Services	$189,206	$204,154	$14,948	7.9%	D-209
General Fund	$128,635	$137,666	$ 9,031	7.0%	
Federal	$60,571	$66,488	$ 5,917	9.8%	
Purchase of Adult Activity Services (Casino Review Fund)	$7,374	$7,374	$0	0.0%	D-209

The Governor's FY 2014 Budget recommends an increase of $14.9 million for Adult Activity Services, to $211.5 million (gross).

According to evaluation data on page D-206 of the Governor's FY 2014 Budget, the number of persons receiving services is expected to increase by 220, from 8,338 to 8,558, at a per capita cost of over $25,400.

Adult activity services provide community-based day services to adults with developmental disabilities, supporting the development of each person's personal, social, and work skills.

GRANTS-IN-AID Day Program Age Outs TOTAL	$1,493	$2,359	$ 866	58.0%	D-209
General Fund	$1,414	$2,188	$ 774	54.7%	
Federal	$79	$171	$ 92	116.5%	

The Governor's FY 2014 Budget recommends $2.4 million (gross) for Day Program Age Outs, for an increase of $0.9 million over the FY 2013 adjusted appropriation. These services assist young adults with developmental disabilities with transitioning from special education services in their local school districts to adult day programs.

This line item reflects only the total costs associated with new placements, as indicated by footnote (b) on page D-209. Thus, the increase of $0.9 million relative to the FY 2013 adjusted appropriation represents a year-to-year increase in the amount of funding appropriated to new adult day program placements only. (In future fiscal years, the ongoing funding for these new

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

Budget Item	Adj. Approp. FY 2013	Recomm. FY 2014	Dollar Change	Percent Change	Budget Page

placements will be reallocated to the applicable DDD Grants-In-aid Accounts reflecting the actual services received.)

GRANTS-IN-AID					
Self Directed Services					
TOTAL	$46,052	$57,007	$10,955	23.8%	D-209
General Fund	$22,627	$30,176	$ 7,549	33.4%	
Federal	$23,425	$26,831	$ 3,406	14.5%	

The Governor's FY 2014 Budget recommends an increase of nearly $11.0 million for Self Directed Services, to $57.0 million (gross).

According to evaluation data on page D-206 of the Governor's FY 2014 Budget, the number of persons receiving services is expected to increase by about 130, from 2,157 (FY 2013 revised estimate) to 2,289 (FY 2014 estimate), at a per capita cost of about $26,000.

Self Directed Services provide DDD clients with budgets to obtain community-based day services from providers of their choice. Self-directing clients exercise greater control over the services they receive, how they receive them, and who provides them. Self-directing clients and their families also accept certain additional responsibilities for managing the services.

DIVISION OF FAMILY DEVELOPMENT (DFD)

(Note: The Governor's Budget displays the Division of Family Development's budget line items in a gross budget format, indicating the aggregated total of State, Federal, and Other Funds. Below, the OLS disaggregates each line item into its various components, as applicable.)

GRANTS-IN-AID					
Work First New Jersey Child Care					
TOTAL	$309,684	$307,713	($1,971)	(0.6%)	D-216
General Fund	$88,458	$86,458	($2,000)	(2.3%)	
Federal	$186,226	$186,255	$ 29	0.0%	
Other Funds	$35,000	$35,000	$0	0.0%	

The Governor's FY 2014 Budget recommends a decrease of nearly $2.0 million for Work First New Jersey Child Care, to $307.7 million (gross).

Evaluation data on page D-214 of the Governor's FY 2014 Budget indicate that the overall average number of children per month receiving child care payments is expected to increase by 6 percent, from 50,162 (FY 2013 revised) to 53,078 (FY 2014 estimated). Available information from the department indicates that the recommended appropriations decrease, in the context of an expected enrollment increase, is due to several factors, including:

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

Budget Item	Adj. Approp. FY 2013	Recomm. FY 2014	Dollar Change	Percent Change	Budget Page

- More efficient use of child care funding made possible by the FY 2012 transition of certain child care expenditures away from contracted, center-based slots to child care vouchers provided through the Child Care Assistance Program. According to available information, the department maintains that this transition has generated savings by avoiding payments for underutilized slots and by aligning child care expenditures more closely with actual utilization.

- Implementation of the E-Child Care system, which utilizes a telephone or a swipe card system to provide real time tracking and verification of child care attendance. According to available information, the department suggests that this system has generated savings by more closely aligning child care expenditures with utilization and by reducing improper payments for child care.

It is also noted that the FY 2013 Appropriations Act included an additional $2 million for "Work First New Jersey Child Care" above the Governor's original FY 2013 Budget recommendation, for the purpose of "waiting list reduction." (The Legislature had appropriated an additional $4 million to the Governor's FY 2013 Budget Recommendation, which the Governor's line-item veto reduced to an additional $2 million.)

Although the child care waiting list included 6,993 children as of June 2012, available information suggests that the current waiting list may include fewer than 1,000 children. No information is available regarding the precise number of children currently on the waiting list, or the average number of children likely to be on the waiting list in FY 2014. The OLS cannot determine whether the Governor's FY 2014 Budget Recommendation includes sufficient funding to serve all children on the waiting list in FY 2014.

GRANTS-IN-AID					
Substance Abuse Initiatives					
TOTAL	$26,802	$23,967	($2,835)	(10.6%)	D-216
General Fund	$24,185	$21,350	($2,835)	(11.7%)	
Federal	$ 2,617	$ 2,617	$0	0.0%	

The Governor's FY 2014 Budget recommends a decrease of $2.9 million for Substance Abuse Initiatives, to $24.0 million (gross).

The Substance Abuse Initiative (SAI) provides substance abuse services for eligible Temporary Assistance to Needy Families (TANF) and General Assistance (GA) recipients across the State. SAI addresses substance abuse as a barrier to work activities, providing assessment, case management, and treatment services through a model blending managed care and fee-for-service delivery systems.

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

Budget Item	Adj. Approp. FY 2013	Recomm. FY 2014	Dollar Change	Percent Change	Budget Page
STATE AID Work First New Jersey -- Client Benefits TOTAL	$130,923	$129,993	($ 930)	(0.7%)	D-216
General Fund	$76,593	$64,527	($12,066)	(15.8%)	
Federal	$54,330	$65,466	$11,136	20.5%	

Available information from the department indicates that the decrease is due to additional, offsetting federal Medicaid funds for certain SAI costs related to GA recipients and matchable under the State's current Childless Adults Medicaid waiver program.

The Governor's FY 2014 Budget recommends a decrease of $0.9 million for Work First New Jersey Client Benefits, to $130.0 million (gross).

Included within this decrease are $12.1 million in State savings due to "trends." Offsetting these savings is an additional $11.1 million in Temporary Assistance for Needy Families (TANF) federal block grant funds.

As OLS has noted in previous years, the manner in which federal TANF funds are expended by the State is discretionary so long as the State meets its federal Maintenance of Effort obligation of over $300 million in State expenditures.

Evaluation data on page D-213 of the Governor's FY 2014 Budget indicate that the number of average monthly recipients of individuals receiving WFNJ cash assistance is expected to decrease by 0.6 percent, from 102,325 (FY 2013 revised) to 101,661 (FY 2014 estimated).

STATE AID Work First New Jersey -- Emergency Assistance TOTAL	$109,391	$111,214	$ 1,823	1.7%	D-217
Federal	$104,249	$106,072	$ 1,823	1.7%	
Other Funds	$5,142	$5,142	$0	0.0%	

The Governor's FY 2014 Budget recommends an increase of $1.8 million for Work First New Jersey Emergency Assistance, to $111.2 million (gross). The entire increase of $1.8 million involves federal funding. As noted above, the manner in which federal TANF funds are expended by the State is discretionary so long as the State meets its Maintenance of Effort obligation.

Evaluation data on page D-214 of the Governor's FY 2014 Budget indicate that the number of average monthly recipients of individuals receiving WFNJ emergency assistance is expected to increase by 1.2 percent, from 20,211 (FY 2013 revised) to 20,446 (FY 2014 estimated).

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

Budget Item	Adj. Approp. FY 2013	Recomm. FY 2014	Dollar Change	Percent Change	Budget Page
STATE AID					
General Assistance GRAND TOTAL	$138,854	$131,805	($7,049)	(5.1%)	
Payments for the Cost of General Assistance (General Fund)	$62,741	$65,247	$ 2,506	4.0%	D-217
General Assistance Emergency Assistance Program	$76,113	$66,558	($9,555)	(12.6%)	D-217
General Fund	$74,355	$64,800	($9,555)	(12.9%)	
Other Funds	$1,758	$1,758	$0	0.0%	

The Governor's FY 2014 Budget recommends an increase of $2.5 million for Payments for the Cost of General Assistance, to $65.2 million (gross). However, the Governor's Budget also recommends a decrease of $9.6 million, or 12.6 percent, for General Assistance (GA) Emergency Assistance Program, to $66.6 million (gross).

Evaluation data on page D-213 of the Governor's FY 2014 Budget indicate that the number of average monthly recipients of General Assistance cash assistance is expected to decrease by 6.9 percent, from 41,313 (revised FY 2013) to 38,464 (FY 2014 estimate).

The same evaluation data indicate that the number of average monthly recipients of GA Emergency Assistance is expected to decrease by 7.2 percent, from 6,268 (FY 2013 revised) to 5,848 (FY 2014 estimated). Available information does not explain why the recommended appropriations decrease of 12.6 percent exceeds the expected decrease in GA Emergency Assistance caseload.

STATE AID Payments for Supplemental Security Income (General Fund)	$85,533	$81,783	($3,750)	(4.4%)	D-217

The Governor's FY 2014 Budget recommends a decrease of $3.8 million for Payments for Supplemental Security Income, to $81.8 million (State).

This account funds the State's supplemental payments, burial assistance, and emergency assistance provided to recipients of federal Supplemental Security Income (SSI) benefits. SSI recipients are low-income persons age 65 years and older, or those who are blind or disabled.

Evaluation data on page D-214 of the Governor's FY 2014 Budget indicate that the number of average monthly recipients of SSI benefits are expected to increase by 4.3 percent, from 186,920 (FY 2013 revised) to 194,977 (FY 2014 estimated). Available information does not

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

Budget Item	Adj. Approp. FY 2013	Recomm. FY 2014	Dollar Change	Percent Change	Budget Page
explain the recommended appropriations decrease of $3.8 million (4.4 percent) in the context of an increasing number of SSI benefit recipients.					
STATE AID State Supplemental Security Income Administrative Fee to SSA (General Fund)	$23,464	$24,370	$ 906	3.9%	D-217

The Governor's FY 2014 Budget recommends an increase of $0.9 million for State Supplemental Security Income (SSI) Administrative Fees, to $24.4 million (State). These fees are paid to the federal Social Security Administration (SSA) for costs associated with administering the program. (States have the option of contracting with SSA to administer their SSI state supplemental payments).

Although available information does not explain the reason for this recommended increase, additional funds are generally required to reimburse the SSA for administrative costs as the number of individuals receiving SSI benefits increases. It is noted that evaluation data on page D-214 of the Governor's FY 2014 Budget indicate an expected increase of 4.3 percent in the number of average monthly recipients of SSI benefits, from 186,920 (FY 2013 revised) to 194,977 (FY 2014 estimated).

STATE AID General Assistance County Administration TOTAL	$44,678	$42,678	($2,000)	(4.5%)	D-217
General Fund	$29,678	$27,678	($2,000)	(6.7%)	
Federal	$15,000	$15,000	$0	0.0%	

The Governor's FY 2014 Budget recommends a decrease of $2.0 million for General Assistance County Administration, to $42.7 million (gross).

This appropriation reimburses counties for the costs of administering the General Assistance (GA) program. Available information from the department attributes the decrease to additional, offsetting federal Medicaid funds for certain administrative costs related to GA recipients and matchable under the State's current Childless Adults Medicaid waiver program. The OLS notes that the FY 2013 adjusted appropriation for this line item incorporates an additional $15.0 million in federal Medicaid funds above the total funding assumed in the FY 2013 Appropriations Act ($29.7 million).

Significant Language Changes

DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES

Appropriation to Community Based Substance Abuse Treatment and Prevention

Addition

2013 Handbook: n/a
2014 Budget: p. D-177

Notwithstanding the provisions of any law or regulation to the contrary, in addition to the amount hereinabove appropriated for Community Based Substance Abuse Treatment and Prevention - State Share, an amount not to exceed $1,600,000 is appropriated from the unexpended balances of fees paid into the "Alcohol Education, Rehabilitation and Enforcement Fund," subject to the approval of the Director of the Division of Budget and Accounting.

Explanation

This language provision would appropriate $1.6 million to Community Based Substance Abuse Treatment and Prevention – State Share from the unexpended balances of fees paid into the Alcohol Education, Rehabilitation and Enforcement Fund, established pursuant to P.L.1983, c.531 (C.26:2B-32 et seq.). This appropriation would offset a $1.6 million decrease in the General Fund appropriation for Community Based Substance Abuse Treatment and Prevention – State Share, which provides grant funding for community-based substance abuse treatment centers and a range of other addiction services.

Annual deposits are made to the Alcohol Education, Rehabilitation and Enforcement Fund (the fund) from alcoholic beverage excise tax collections, pursuant to section 2 of P.L.1990, c.41 (C.54:43-1.1). The fund's enabling legislation dedicates 75 percent of deposits toward alcohol rehabilitation, 15 percent toward enforcement, and 10 percent toward education. Additionally, fees paid by persons convicted of operating a motor vehicle or watercraft while intoxicated are deposited into the fund to be used for the screening, evaluation, education, and referral of persons who have been convicted of driving or boating while intoxicated.

The Governor's FY 2014 Budget estimates that the fund will receive $18.2 million in revenues in FY 2014, and will distribute $15.3 million in expenditures and transfers to other funds, including the $1.6 million transfer specified in this language provision. (See page 21 of the "Other Governmental Funds and Proprietary Funds" section of the Governor's Budget, available online only.)

Appropriation to Involuntary Outpatient Commitment Program

Addition

2013 Handbook: n/a
2014 Budget: p. D-177

The unexpended balance at the end of the preceding fiscal year in the Community Care account, not to exceed $2,400,000, is appropriated for the Involuntary Outpatient

EXPLANATION: FY 2013 language not recommended for FY 2014 denoted by strikethrough.
Recommended FY 2014 language that did not appear in FY 2013 denoted by underlining.

Significant Language Changes (Cont'd)

Commitment Program.

Explanation

This language provision would appropriate the unexpended FY 2013 balance of the Community Care account, not to exceed $2.4 million, to the Involuntary Outpatient Commitment (IOC) Program. The IOC Program was established pursuant to P.L.2009, c.112, which amended the State's civil commitment laws to allow for the involuntary commitment to outpatient treatment of an individual. The statutory revision requires IOC sites in all 21 counties by August 2013.

Available information indicates that, within the $265.0 million recommended appropriation for Community Care (page D-175), the Governor's FY 2014 Budget provides $2.0 million for the IOC program sites currently operational in six counties. The $2.4 million appropriated through this language provision would represent additional funds beyond the $2.0 million.

No information is provided regarding how many additional county-based IOC programs the $2.4 million would support in FY 2014, or in which counties those programs would be located.

Elimination of State House Commission Role in Rate Setting

Revision

2013 Handbook: p. B-85
2014 Budget: p. D-177

Notwithstanding the provisions of R.S.30:4-78, or any law or regulation to the contrary, the State share of payments from the Support of Patients in County Psychiatric Hospitals account to the several county psychiatric facilities on behalf of the reasonable cost of maintenance of patients deemed to be county indigents shall be at the rate of 125% of the rate established ~~State House Commission rate~~ by the Commissioner of Human Services for the period July 1~~, 2012~~ to December 31~~, 2012~~ and at the rate of 45% of the rate established by the Commissioner of Human Services for the period January 1~~, 2013~~ to June 30~~, 2013~~ such that the total amount to be paid by the State on behalf of county indigent patients for ~~fiscal~~ the calendar year ~~2013~~ shall not exceed 85% of the total reasonable per capita cost; and further provided that the rate at which the State will reimburse the county psychiatric hospitals shall not exceed 100% of the per capita rate at which each county pays to the State for the reasonable cost of maintenance and clothing of each patient residing in a State psychiatric facility, excluding the depreciation, interest and carry-forward adjustment components of this rate, and including the depreciation, interest, and carry-forward adjustment components of each individual county psychiatric hospital's rate established ~~for the period July 1, 2012 to December 31, 2012 by the State House Commission and~~ for the period January 1~~, 2013~~ to ~~June 30, 2013~~ December 31 by the Commissioner of Human Services. The initial determination of whether a county hospital rate exceeds the per capita rate that counties pay

EXPLANATION: FY 2013 language not recommended for FY 2014 denoted by strikethrough.
Recommended FY 2014 language that did not appear in FY 2013 denoted by underlining.

Significant Language Changes (Cont'd)

to the State on behalf of applicable patients residing in a State psychiatric facility will be based on a comparison of estimated cost used to set reimbursement rates for the upcoming calendar year. A second comparison of the actual per diem costs of the county psychiatric hospital and State psychiatric hospitals will be completed after actual cost reports for the period are available including an inflationary adjustment for the six-month difference in fiscal reporting periods between State and county hospitals. The county hospital carry-forward adjustment to be included in rates paid by the State will exclude costs found to exceed 100% of the actual cost rate of the State psychiatric facilities.

Explanation

Historically, the State House Commission has met each December to approve the Department of Human Services (DHS) recommendation as to the rates counties pay for patients at State or county psychiatric hospitals. A new language provision included in the FY 2013 Appropriations Act eliminated the requirement that the State House Commission approve the rates, beginning with the rates for calendar year 2013. The proposed revision to this language provision would delete references to the State House Commission, as its role in the rate setting process has been eliminated.

The proposed language revision also specifies the methodology by which certain payment rates are calculated when determining the ceiling for State reimbursement of county hospitals (where the ceiling for county hospital reimbursement is 100 percent of the per capita rate that each county pays to the State on behalf of applicable patients residing in a State psychiatric facility). Available information indicates that this revision is intended to clarify the current process and does not represent a change to the existing methodology.

Transfer Language – Closure of County Psychiatric Hospitals

Revision

2013 Handbook: p. B-86
2014 Budget: p. D-178

In the event that the Division of Mental Health and Addiction Services is notified that a county psychiatric hospital will cease operations for the current fiscal year, or any portion thereof, in order to assure continuity of care for patients who otherwise would have been served by the county hospital, as well as to preserve patient and public safety, the Division shall have the authority to transfer funds from the Support of Patients in County Psychiatric Hospitals account to Direct State Services and Grants-In-Aid accounts in the Division of Mental Health and Addiction Services, ~~in amounts not to exceed $33,200,000~~ for the fiscal year, subject to a plan approved by the Director of the Division of Budget and Accounting.

EXPLANATION: FY 2013 language not recommended for FY 2014 denoted by strikethrough.
Recommended FY 2014 language that did not appear in FY 2013 denoted by underlining.

Significant Language Changes (Cont'd)

Explanation

Burlington County sold its county psychiatric hospital (Buttonwood Hospital) to a private operator in FY 2013. This language provision had allowed up to $33.2 million in funds paid to Burlington County for patients served by the county hospital to be transferred to other accounts, upon the hospital's sale, to continue providing services to those patients. As the sale of Buttonwood was finalized in August 2012, the deleted language authorizing the transfer of specific amounts previously allocated to Buttonwood is no longer necessary in FY 2014.

The revised language would provide ongoing authorization to the division to transfer funds, subject to approval by the Director of the Division of Budget and Accounting, from the Support of Patients in County Psychiatric Hospitals account to other accounts in the event that the division is notified that a county psychiatric hospital will cease operations.

Transfer Language – Community Support Services

Addition

2013 Handbook: n/a
2014 Budget: p. D-178

An amount not to exceed $7,900,000 may be transferred from the Community Care Grant-in-Aid account within the Division of Mental Health and Addiction Services to the General Assistance Medical Services account within the Division of Medical Assistance and Health Services to reimburse the State share expended for Community Support Services, subject to the approval of the Director of the Division of Budget and Accounting.

Explanation

This language provision would allow up to $7.9 million to be transferred from the Community Care account to the Medicaid division. According to the department, funds transferred pursuant to this provision would represent payments for mental health and addiction services provided to individuals who are also recipients of General Assistance Medical Services benefits. This transfer would allow the State to claim federal matching funds under the Childless Adults waiver (which was approved October 2012) for services that had previously been provided entirely at State expense.

EXPLANATION: FY 2013 language not recommended for FY 2014 denoted by strikethrough.
Recommended FY 2014 language that did not appear in FY 2013 denoted by underlining.

Significant Language Changes (Cont'd)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Premiums for NJ FamilyCare Children Under 200% FPL

Deletion

2013 Handbook: p. B-92
2014 Budget: n/a

~~Notwithstanding the provisions of any law or regulation to the contrary, commencing at the beginning of the fiscal year, of the amounts hereinabove appropriated to NJ FamilyCare -- Affordable and Accessible Health Coverage Benefits, premiums will no longer be required for children from families with incomes at or below 200% of the federal poverty level.~~

Explanation

The Governor recommends deleting this language, as it is obviated by current regulations. Pursuant to N.J.A.C.10:49-9.2, NJ FamilyCare does not require families to pay premiums for children if the family's income is less than 200 percent of the federal poverty level.

Scheduling of EPSDT/PDN Hours

Deletion

2013 Handbook: p. B-93
2014 Budget: n/a

~~The amount hereinabove appropriated to Payments for Medical Assistance Recipients -- Clinic Services shall be conditioned upon the following: notwithstanding the provisions of subsection (b) of N.J.A.C.10:60--5.3 and subsection (a) of N.J.A.C.10:60--5.4 to the contrary, a person receiving the maximum number of Early and Periodic Screening, Diagnosis and Treatment/Private Duty Nursing (EPSDT/PDN) services, that is, 16 hours in any 24--hour period, may be authorized to receive additional PDN hours if private health insurance is available to cover the cost of the additional hours and appropriate medical documentation is provided that indicates that additional PDN hours are required and that the primary caregiver is not qualified to provide the additional PDN hours.~~

Explanation

According to information provided by the department, current regulations obviate the need for this language provision, which allowed individuals eligible to receive private duty nursing services through Medicaid's Early and Periodic Screening, Diagnosis, and Treatment program to exceed the regulatory cap of 16 hours of service per day, if any hours beyond the cap were paid by private insurance. However, independent analysis by the Office of Legislative Services has concluded otherwise. Discussions between the department and the OLS are ongoing.

Specifically, the OLS is concerned that N.J.A.C.10:60-5.9 provides that "Private duty nursing services shall be limited to a maximum of 16 hours, including services provided or paid for by

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Recommended FY 2014 language that did not appear in FY 2013 denoted by underlining.

Significant Language Changes (Cont'd)

other sources, in a 24-hour period." It appears that elimination of this language provision would generally prohibit Medicaid from covering private duty nursing services for a person receiving more than 16 hours of services in a 24 hour period, even if hours in excess of the 16 hour limit are paid for by private insurance.

Transition of Services to Managed Care

Revision

2013 Handbook: p. B-94
2014 Budget: p. D-187

Notwithstanding the provisions of any ~~other~~ law or regulation to the contrary, ~~and subject to any federal approval that may be necessary,~~ the amounts hereinabove appropriated in the Managed Care Initiative account are subject to the following condition: Effective July 1, 2011, ~~assuming receipt of any applicable federal approval,~~ the following services, which were previously covered by Medicaid fee-for-service, shall be covered and provided instead through a managed care delivery system for all clients served by and/or enrolled in that system: 1) home health agency services; 2) medical day care, including both adult day health services and pediatric medical day care; 3) prescription drugs; and 4) rehabilitation services, including occupational, physical, and speech therapies. The above condition shall be effective for personal care assistant services.

Explanation

This language requires that several specified Medicaid services be covered through a managed care organization, instead of being paid on a fee-for-service basis. The budget recommendation eliminates the condition of federal approval, as the Comprehensive Medicaid Waiver grants federal approval to transition most Medicaid services from fee-for-service to managed care where federal approval had not previously been granted.

Populations Exempt from Mandatory Enrollment in Managed Care

Revision

2013 Handbook: p. D-95
2014 Budget: p. D-187

Notwithstanding the provisions of any ~~other~~ law or regulation to the contrary, ~~and subject to any federal approval that may be necessary,~~ the amounts hereinabove appropriated in the Managed Care Initiative account are subject to the following condition: only the following individuals shall be excluded from mandatory enrollment in the Medicaid/NJ FamilyCare managed care program: (1) individuals who are institutionalized in an inpatient psychiatric institution, or an inpatient psychiatric program for children under the age of 21 or in a residential facility including facilities characterized by the federal government as ICFs/MR,

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Recommended FY 2014 language that did not appear in FY 2013 denoted by underlining.

Significant Language Changes (Cont'd)

except that individuals who are eligible through the Division of Child Placement and Permanency (DCP&P) and are placed in a DCP&P non-Joint Committee on Accreditation of Healthcare Organizations (JCAHO) accredited children's residential care facility and individuals in a mental health or substance abuse residential treatment facility shall not be excluded from enrollment pursuant to this paragraph; (2) individuals in out-of-State placements; (3) special low-income Medicare beneficiaries (SLMBs); and (4) individuals in the Program of All-Inclusive Care for the Elderly (PACE) program.

Explanation

This language specifies the populations in the Medicaid program who are exempt from mandatory enrollment in managed care. The budget recommendation eliminates the condition of federal approval, as the Comprehensive Medicaid Waiver grants federal approval to require the enrollment of certain Medicaid populations in managed care or to exempt certain Medicaid populations from mandatory managed care enrollment, where federal approval had not previously been granted.

Hospital Inflation Factor

Deletion

2013 Handbook: p. B-95
2014 Budget: n/a

~~Notwithstanding the provisions of any law or regulation to the contrary, of the amounts hereinabove appropriated to Payments for Medical Assistance Recipients – Inpatient Hospital, effective January 1, 2013, the Medicaid inpatient fee-for-service payment rates will not be adjusted to incorporate the annual excluded hospital inflation factor, also referred to as the economic factor recognized under the Centers for Medicare and Medicaid Services Tax Equity and Fiscal Responsibility Act, Pub.L. 97-248 (TEFRA) target limitations.~~

Explanation

Elimination of this language provision would allow the Medicaid reimbursement rate to hospitals to grow according to the annual excluded hospital inflation factor. This is expected to increase State costs by approximately $1 million in FY 2014. The increased cost is incorporated into the recommended appropriation for Payments for Medical Assistance Recipients – Outpatient Hospital (page D-182).

EXPLANATION: FY 2013 language not recommended for FY 2014 denoted by strikethrough.
Recommended FY 2014 language that did not appear in FY 2013 denoted by underlining.

Significant Language Changes (Cont'd)

Managed Care Organization Provider Contracts

Addition

2013 Handbook: n/a
2014 Budget: p. D-187

Notwithstanding the provisions of any law or regulation to the contrary, in order to facilitate and maximize participant enrollment and to prevent plan inefficiencies, the amounts hereinabove appropriated for the Managed Care Initiative are subject to the following condition: no new provider agreements with managed care organizations (MCOs), including specialty MCOs that serve a particular eligibility group or that principally provide a limited set of benefits, or with primary care case managers to participate in the Medicaid/NJ FamilyCare program shall be approved or entered into unless the Director of the Division of Medical Assistance and Health Services determines that such agreement is necessary to provide access to services for enrollees and promotes the stability and success of the managed care program.

Explanation

The proposed language would prohibit Medicaid managed care organizations (MCOs) and primary care case managers from entering into new agreements with Medicaid service providers unless the Medicaid director approves the agreement. The director's approval is to be based upon a determination that "the agreement is necessary to provide access to services for enrollees and promotes the stability and success of the managed care program." This language gives the director broad discretion in deciding whether to approve a particular contract. It is noted that some new provider contracts will likely have to be approved in order to allow managed care organization to establish provider networks for services that are currently delivered on a fee-for-services basis. Specifically, available information indicates that community-based long-term services and supports are intended to be transitioned into managed care during FY 2014.

Transition of Certain NJ FamilyCare Populations to Health Care Exchange

Addition

2013 Handbook: n/a
2014 Budget: p. D-187

Notwithstanding the provisions of any law or regulation to the contrary, the amounts hereinabove appropriated to NJ FamilyCare – Affordable and Accessible Health Coverage Benefits and Managed Care Initiative are subject to the following conditions: as of January 1, 2014 or on such date established by the federal government for the Health Insurance Exchange pursuant to the Affordable Care Act, the following groups of current enrollees shall be transitioned to the federal Health Care Exchange for continued health care coverage: a) adults or couples without dependent children who were enrolled in the New Jersey Health ACCESS program on October 31, 2001; b) all parents or caretakers who: (i) have gross family income that does not exceed 200% of the poverty level; (ii) have no health insurance, as

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Recommended FY 2014 language that did not appear in FY 2013 denoted by underlining.

Significant Language Changes (Cont'd)

determined by the Commissioner of Human Services; (iii) are ineligible for Medicaid, or (iv) are adult aliens lawfully admitted for permanent residence, but who have lived in the United States for less than five full years after such lawful admittance, and are enrolled in NJ FamilyCare; and c) Essential Persons (Spouses) whose coverage is funded solely by the State.

Explanation

This proposed language would effectively terminate State-funded health care coverage for certain adults in the NJ FamilyCare program, and transition these individuals to health coverage in the federally operated health insurance exchange when it becomes active. Under the Affordable Care Act, all of the specified populations are potentially eligible for federal subsidies to purchase health insurance in the exchange. Information provided by the department indicates that this provision is expected to save approximately $15 million.

Medicaid Reimbursement Rates for Outpatient Psychiatric Care

Revision

2013 Handbook: p. B-91
2014 Budget: p. D-187

Notwithstanding the provisions of any law or regulation to the contrary, ~~effective January 1, 2009, payments for the~~ amounts appropriated to Payments for Medical Assistance Recipients -- Outpatient Hospital ~~account~~ for outpatient hospital reimbursement for all billable psychiatric services provided as an outpatient hospital service to all eligible individuals regardless of age, shall be paid at the lower of charges or the prospective hourly rates as defined in N.J.A.C.10:52, with the following exceptions and conditions which are effective for dates of service on or after July 1, 2013: (1) individual outpatient hospital psychiatric therapy for individuals age 21 and older, excluding partial hospitalization, shall be billed on a unit basis of 30 minutes, with a daily billing limit of two units per recipient per day and a 30 minute unit rate of $50.00; (2) outpatient hospital initial evaluative psychiatric testing for individuals age 21 and older, excluding partial hospitalization, shall be billed on a unit basis of 30 minutes with a daily billing limit of four units per recipient per day and a 30 minute unit rate of $62.50; (3) outpatient hospital psychiatric medication monitoring and medication management for individuals age 21 and older, excluding partial hospitalization, shall be billed on a unit basis of 15 minutes with a daily billing limit of two units per recipient per day and a 15 minute unit rate of $42.00. In addition, a one-time prospective payment shall be made by the Division of Medical Assistance and Health Services to hospitals for billable psychiatric services provided as an outpatient hospital service. This one-time prospective payment amount shall be defined as the unit volume for services (1) through (3) above for individuals age 21 and older that were provided from January 1, 2009 through June 30, 2013, and paid through July 1, 2013, multiplied by the following amounts per unit: individual outpatient hospital psychiatric therapy for individuals age 21 and older, excluding partial hospitalization, $10.00; outpatient hospital initial evaluative psychiatric testing for individuals age 21 and older, excluding partial hospitalization, $12.50; and outpatient

EXPLANATION: FY 2013 language not recommended for FY 2014 denoted by strikethrough.
Recommended FY 2014 language that did not appear in FY 2013 denoted by underlining.

Significant Language Changes (Cont'd)

hospital psychiatric medication monitoring and medication management for individuals age 21 and older, excluding partial hospitalization, $8.00. Costs related to ~~such~~ outpatient hospital psychiatric services shall be excluded from outpatient hospital cost settlements. ~~Hospitals may provide continued services to all eligible individuals in partial hospitalization programs in need of additional care beyond the 24 month limit and shall bill for these extended services at the community partial care rate.~~

Explanation

The revised language would increase Medicaid fee-for-service payment rates to hospitals for certain outpatient psychiatric services provided to adults over the rates provided under N.J.A.C.10:52-4.3. It would also make a one-time payment to hospitals that effectively provides retroactive payment as though the rate change had been in effect on January 1, 2009. The proposed revision also reinstates the authority of regulations which limit partial hospitalization to 24 months pursuant to N.J.A.C. 10:52A-4.4.

The cost in FY 2014, including the retroactive payment, is expected to be approximately $2 million. This amount is included in the recommended appropriation for Payments for Medical Assistance Recipients – Outpatient Hospital (page D-182).

DIVISION OF AGING SERVICES

Nursing Home Reimbursement Rate Formula

Revision

2013 Handbook: p. B-98
2014 Budget: p. D-194

Notwithstanding the provisions of N.J.A.C.8:85 or any law or other regulation to the contrary, the amounts hereinabove appropriated for Payments for Medical Assistance Recipients -- Nursing Homes and Global Budget for Long Term Care shall be conditioned upon the following: (1) the per diem rate for each nursing home shall not be less than the per diem rate last received by that facility for Fiscal Year ~~2012~~ 2013 and (2) monies designated pursuant to subsection c. of section 6 of P.L.2003, c.105 (C.26:2H-97) for distribution to nursing homes less the portion of those funds to be paid as pass-through payments in accordance with paragraph 1 of subsection d. of section 6 of P.L.2003, c.105 (C.26:2H-97) shall be combined with amounts hereinabove appropriated for Payments for Medical Assistance Recipients -- Nursing Homes and Global Budget for Long Term Care for the purpose of Medicaid reimbursement to nursing facilities according to the rate setting methodology established in N.J.A.C.8:85. For the purposes of this paragraph, a nursing facility's per diem reimbursement rate shall not include, if the nursing facility is eligible for reimbursement, the difference between the full calculated provider tax add-on and the quality of care portion of the provider tax add-on.

EXPLANATION: FY 2013 language not recommended for FY 2014 denoted by strikethrough.
Recommended FY 2014 language that did not appear in FY 2013 denoted by underlining.

Significant Language Changes (Cont'd)

Nursing Home Reimbursement by Managed Care Organizations

Revision

2013 Handbook: p. B-101
2014 Budget: p. D-196

Notwithstanding the provisions of any law or regulation to the contrary, the amount hereinabove appropriated for Payments for Medical Assistance Recipients – Nursing Homes and Global Budget for Long Term Care is subject to the following condition: if nursing facility reimbursement is shifted to managed long term care during fiscal year ~~2013~~ 2014 under the Medicaid Comprehensive Waiver, the managed care organizations for the State shall maintain the reimbursement rates last calculated pursuant to N.J.A.C. 8:85, effective in fiscal year ~~2013~~ 2014, through the end of fiscal year ~~2013~~ 2014.

Explanation

The Governor's FY 2014 Budget retains the same formula for determining reimbursement rates as the FY 2013 Appropriations Act. The language provides that no nursing facility would receive a per-diem rate less than it received in the prior year. Some facilities could see small increases in their rates, but evaluation data on page D-188 do not assume an increase in the average rate.

A related language provision carried forward from the FY 2013 Appropriations Act, with updated references to FY 2014, would ensure that nursing homes receive the reimbursement rate calculated by the State through the end of FY 2014, even if nursing home services are transitioned to managed care. Available information indicates that nursing homes are not expected to transition to managed care until FY 2015.

PAAD and Senior Gold Prescription Drug Refills

Revision

2013 Handbook: p. B-100
2014 Budget: p. D-195

Notwithstanding the provisions of any law or regulation to the contrary, the amount hereinabove appropriated for the Pharmaceutical Assistance to the Aged and Pharmaceutical Assistance to the Aged and Disabled (PAAD) programs, and Senior Gold Prescription Discount Program shall be conditioned upon the following provision: no funds shall be appropriated for the refilling of a prescription drug when paid by PAAD or the Senior Gold Prescription Discount Program as the primary payer until such time as the original prescription is 85% finished.

EXPLANATION: FY 2013 language not recommended for FY 2014 denoted by strikethrough.
Recommended FY 2014 language that did not appear in FY 2013 denoted by underlining.

Significant Language Changes (Cont'd)

PAAD Prescription Drug Refills (CRF)

Revision

2013 Handbook: p. B-102
2014 Budget: p. D-197

Notwithstanding the provisions of any law or regulation to the contrary, the amount hereinabove appropriated for the Pharmaceutical Assistance to the Aged and Disabled (PAAD) program shall be conditioned upon the following provision: no funds shall be appropriated for the refilling of a prescription drug paid by PAAD as a primary payer until such time as the original prescription is 85% finished.

Explanation

The above two language revisions clarify that the limitation on prescription refills in PAAD and Senior Gold (which requires a prescription to be 85% finished prior to refilling) applies only when PAAD or Senior Gold is the primary payer. In nearly all cases PAAD and Senior Gold are secondary payers, as program rules generally require that beneficiaries enroll in Medicare Part D, which serves as the primary payer. No significant impact on the budget is anticipated.

Transfer Language (CRF)

Deletion

2013 Handbook: p. B-101
2014 Budget: p. n/a

~~In order to permit flexibility in the handling of appropriations and ensure the timely payment of claims to providers of medical services, amounts may be transferred to and from the various items of appropriation within the Medical Services for the Aged program classification, subject to the approval of the Director of the Division of Budget and Accounting. Notice thereof shall be provided to the Legislative Budget and Finance Officer on the effective date of the approved transfer.~~

Explanation

This language provided authority to transfer funds between the various line items in the Medical Services for the Aged program class. Language in the General Provisions section of the recommended budget (page F-1) provides broad authority for the transfer of funds among Medicaid appropriations, including the authority provided by this language. Deletion of this provision will not impact the Executive's ability to transfer funds.

EXPLANATION: FY 2013 language not recommended for FY 2014 denoted by strikethrough.
Recommended FY 2014 language that did not appear in FY 2013 denoted by underlining.

Significant Language Changes (Cont'd)

Elimination of Drug Utilization Review Council (CRF)

Deletion

2013 Handbook: p. B-102
2014 Budget: n/a

~~Notwithstanding the provisions of any law or regulation to the contrary, no State funds are appropriated for the Drug Utilization Review Council in the Department of Health and Senior Services, and therefore, the functions of the Council shall cease.~~

Explanation

The Drug Utilization Review Council has been inoperative since 2003, and it was formally abolished by P.L.2010, c.87. Budget language providing for its elimination is deleted as unnecessary.

Charge to Casino Simulcasting Fund (CRF)

Revision

2013 Handbook: p. B-103
2014 Budget: p. D-198

Notwithstanding the provisions of any law or regulation to the contrary, of the amount hereinabove appropriated for the Community Based Senior Programs (CRF) account, ~~$400,000~~ $350,000 shall be charged to the Casino Simulcasting Fund.

Explanation

This language revision decreases the amount of Casino Revenue Funds appropriated for Community Based Senior Programs that may be charged to the Casino Simulcasting Fund. This change aligns the amount to be appropriated with the amount expected to be available in the Casino Simulcasting Fund in FY 2014.

DIVISION OF DISABILITY SERVICES

Transfer Language – Rate Increase for Private Duty Nursing Services

Deletion

2013 Handbook: p. B-104
2014 Budget: p. D-201

Notwithstanding the provisions of subsection (a) of N.J.A.C.10:60-5.10 and subsection (c) of N.J.A.C. 10:60-11.2 to the contrary, the amount hereinabove appropriated for Payments for Medical Assistance Recipients - Waiver Initiatives is conditioned upon the Commissioner of

EXPLANATION: FY 2013 language not recommended for FY 2014 denoted by strikethrough.
Recommended FY 2014 language that did not appear in FY 2013 denoted by underlining.

Significant Language Changes (Cont'd)

Human Services increasing the hourly nursing rates for AIDS Community Care Alternatives Program (ACCAP) and Community Resources for People With Disabilities (CRPD) Private Duty Nursing (PDN) services by $10 per hour above the fiscal year 2008 rate. The rate for ACCAP and CRPD PDN services shall be equal to the rate for the Early and Periodic Screening, Diagnostic and Treatment PDN services of similar magnitude. ~~Of the amounts appropriated hereinabove for Payments for Medical Assistance Recipients - Waiver Initiatives the Commissioner shall transfer $2,174,000 to appropriate accounts to effectuate this provision.~~

Explanation

Within the FY 2013 Appropriations Act, the Legislature had included this language provision requiring that the reimbursement rates for private duty nursing services provided through the AIDS Community Care Alternatives (ACCAP) program and the Community Resources for People With Disabilities (CRPD) program be increased by $10 per hour above the FY 2008 rate. Within the FY 2013 Appropriations Act, the Legislature had also added $2.2 million to the appropriation for Payments for Medical Assistance Recipients - Waiver Initiatives to support the rate increase.

The Governor's line-item veto retained the new language provision but removed the additional $2.2 million appropriation. The Governor's veto message stated that "At the originally recommended level, this appropriation should be sufficient to fund the related budget language providing for a rate increase for certain nursing services."

The Governor's FY 2014 Budget retains the language provision providing for the rate increase, but deletes language directing the Commissioner of Human Services to transfer $2.2 million to effectuate the provision. As the additional $2.2 million appropriation was not required to support the rate increase in FY 2013, the transfer language no longer appears necessary.

ACCAP and CRPD are Medicaid waiver programs providing various home- and community-based services to individuals who require a nursing facility level of care and who have received an AIDS diagnosis (for ACCAP) or who meet Social Security Administration disability criteria (for CRPD).

DIVISION OF DEVELOPMENTAL DISABILITIES

Federal Community Care Waiver Revenues	
Revision	2013 Handbook: p. B-106 2014 Budget: p. D-209

Notwithstanding the provisions of any law or regulation to the contrary, ~~$384,370,000~~ $422,076,000 of federal Community Care Waiver funds is appropriated for community-

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Recommended FY 2014 language that did not appear in FY 2013 denoted by underlining.

Significant Language Changes (Cont'd)

based programs in the Division of Developmental Disabilities. The appropriation of federal Community Care Waiver funds above this amount is conditional upon the approval of a plan submitted by the Department of Human Services that must be approved by the Director of the Division of Budget and Accounting.

Explanation

The division anticipates that the amount of federal Community Care Waiver revenues that the State will realize for community programs for persons with developmental disabilities will increase by $37.7 million in FY 2014, to $422.1 million.

Cost Recoveries in DDD Programs

Revision

2013 Handbook: p. B-107
2014 Budget: p. D-209

Cost recoveries from consumers with developmental disabilities collected during the current fiscal year, not to exceed ~~$53,997,000~~ $59,352,000, are appropriated for the continued operation of the Division of Developmental Disabilities community-based residential programs, subject to the approval of the Director of the Division of Budget and Accounting.

Explanation

Contributions to care from persons who receive services under Division of Developmental Disabilities community-based residential programs are anticipated to increase by about $5.4 million in FY 2014, to $59.4 million. These funds are used to support the overall $644.3 million (gross) appropriation for Group Homes.

Federal ICF/MR Revenues

Revision

2013 Handbook: p. B-110
2014 Budget: p. D-204

The State appropriation for the State's developmental centers is based on ICF/MR revenues of ~~$323,432,000~~ $337,326,000 provided that if the ICF/MR revenues exceed ~~$323,432,000~~ $337,326,000, an amount equal to the excess ICF/MR revenues may be deducted from the State appropriation for the developmental centers, subject to the approval of the Director of the Division of Budget and Accounting.

EXPLANATION: FY 2013 language not recommended for FY 2014 denoted by strikethrough.
Recommended FY 2014 language that did not appear in FY 2013 denoted by underlining.

Significant Language Changes (Cont'd)

Explanation

The division anticipates that the amount of federal ICF/MR revenues that the State expects to realize for services provided to clients at State developmental centers will increase by $13.9 million in FY 2014, to $337.3 million.

Evaluation data on page D-202 of the Governor's FY 2014 Budget indicate that the census at the developmental centers is expected to decrease by 135 residents, from 2,284 in FY 2013 to 2,149 in FY 2014. A reduction in the number of clients at the various developmental centers would typically correspond to a reduction in federal ICF/MR revenues. Available information suggests that the discrepancy between increasing ICF/MR revenues and a decreasing developmental center census may be partially attributed to revenue adjustments resulting from prior year underprojections.

EXPLANATION: FY 2013 language not recommended for FY 2014 denoted by strikethrough.
Recommended FY 2014 language that did not appear in FY 2013 denoted by underlining.

Background Paper: Trends in Community Mental Health and Addiction Services, FY 2010 - FY 2014

Budget Pages.... D-175 to D-177

State Funding ($000)	Expended FY 2012	Adj. Approp. FY 2013	Recomm. FY 2014
Olmstead Support Services	$60,282	$78,953	$88,817
Community Care	256,023	262,274	264,975
TOTAL	316,305	341,227	353,792

This background paper provides expenditure and utilization data for State-funded community mental health and addiction services for adults for the period FY 2010 – FY 2014. The service providers receive Grants-in-Aid funding through contracts with the Division of Mental Health and Addiction Services, and also receive additional funds from third party insurance programs such as Medicare or Medicaid, fees charged to clients, and other public and private grants. Although the data presented here do not include services provided through the Medicaid program, the State receives limited federal Medicaid funds for certain programs.

Beginning in January 2014, when Medicaid eligibility levels will be increased to 138 percent of the Federal Poverty Level, it is likely that much of the expenditure in these programs will shift to Medicaid. Expenditures for individuals who are newly eligible for Medicaid under the Affordable Care Act would be fully supported by federal funds through calendar year 2016, with the matching rate phasing down to 90 percent by 2020. The FY 2014 Budget Recommendation does not appear to assume any savings from increased Medicaid enrollment. Any savings that are realized may be used to offset increased need in other areas or lapsed to the General Fund at the end of the fiscal year.

Table 1 (below) presents the Governor's recommendation for changes in funding for specific community mental health services in FY 2014, drawn from evaluation data on pages D-172 and D-173. The FY 2014 Budget Recommendation anticipates modest growth from FY 2013 in each program category, but expects particularly significant growth in Early Intervention and Support Services (a new program in FY 2012 intended to divert individuals in short-term psychiatric distress from hospital emergency departments) and Supported Housing (which provides stable housing and serves as an alternative to institutionalization). It is noted that the total revised FY 2013 expenditures of $331.2 million is less than the $341.2 million appropriation, suggesting an expected lapse of $10.0 million.

Background Paper: Trends in Community Mental Health and Addiction Services, FY 2010 - FY 2014 (Cont'd)

Table 1. Expenditures for Community Mental Health Services, FY 2013 to FY 2014 ($000)

Service	Revised FY 2013	Estimate FY 2014	Change ($000)	Change (%)
Early Intervention and Support Services	$5,463	$7,733	$2,270	41.6%
Screening Services	44,335	44,643	308	0.7%
Outpatient Services	60,561	62,689	2,128	3.5%
Partial Care	18,597	18,726	129	0.7%
Residential	54,600	56,209	1,609	2.9%
Supported Housing	67,464	82,338	14,874	22.0%
Integrated Case Management Services	20,223	20,364	141	0.7%
Program for Assertive Community Treatment (PACT)	15,095	15,200	105	0.7%
Other	44,894	45,892	998	2.2%
Total	331,232	353,794	22,562	6.8%

Trends, FY 2010 – FY 2014

Table 2 (below) presents changes in funding for specific community mental health services for the FY 2010 – FY 2014 period. Between FY 2010 and FY 2014, total State expenditures for community-based mental health services for adults increased 16.2 percent, from $304.4 million (FY 2010) to $353.8 million (FY 2014 recommended). Supported housing has accounted for more than half of the total spending growth over this period, while there has also been significant growth in early intervention and support services, outpatient services, and residential services. Spending has decreased modestly for screening services, integrated case management services, and programs for assertive community treatment.

Table 2. Expenditures for Community Mental Health Services, FY 2010 to FY 2014 ($000)

Service	Actual FY 2010	Estimate FY 2014	Change ($000)	Change (%)
Early Intervention and Support Services[2]	$0	$7,733	$7,733	n/a
Screening Services	45,834	44,643	(1,191)	-2.6%
Outpatient Services	55,874	62,689	6,815	12.2%
Partial Care	18,488	18,726	238	1.3%
Residential	50,162	56,209	6,047	12.1%
Supported Housing	52,982	82,338	29,356	55.4%
Integrated Case Management Services	21,171	20,364	(807)	-3.8%
Program for Assertive Community Treatment (PACT)	15,586	15,200	(386)	-2.5%
Other	44,346	45,892	1,546	3.5%
Total	304,443	353,794	49,351	16.2%

[2] Early Intervention and Support Services was a new program in FY 2012.

Background Paper: Trends in Community Mental Health and Addiction Services, FY 2010 - FY 2014 (Cont'd)

Table 3 (below) provides data on utilization of selected services, while Table 4 (below) provides information on spending per client for each of the selected services. This information illuminates the factors driving expenditure trends. The increased spending for supported housing, residential services, and outpatient services are all primarily driven by growth in utilization, which in turn is related to the State's efforts to provide services in less restrictive settings than institutions or traditional group homes. Where total spending has declined, decreased cost per client has generally been more significant than decreased utilization.

It is noted that it may not be appropriate to sum the clients receiving each service, as an individual may receive more than one type of service during a year.

Table 3. Clients Utilizing Selected Services, FY 2010 to FY 2014

Service	Actual FY 2010	Estimate FY 2014	Change (number)	Change (%)
Early Intervention and Support Services	0	9,661	9,661	n/a
Screening Services	96,364	98,217	1,853	1.9%
Outpatient Services	122,069	136,704	14,635	12.0%
Partial Care	12,541	12,127	(414)	-3.3%
Residential	3,018	3,499	481	15.9%
Supported Housing	4,108	5,858	1,750	42.6%
Integrated Case Management Services	10,927	10,725	(202)	-1.8%
Program for Assertive Community Treatment (PACT)	2,306	2,443	137	5.9%

Table 4. Spending per Client Served for Selected Services, FY 2010 to FY 2014 (dollars)

Service	Actual FY 2010	Recomm. FY 2014	Change ($)	Change (%)
Early Intervention and Support Services	n/a	$800	n/a	n/a
Screening Services	476	455	(21)	-4.4%
Outpatient Services	458	459	1	0.2%
Partial Care	1,474	1,544	70	4.7%
Residential	16,621	16,064	(557)	-3.3%
Supported Housing	12,897	14,056	1,158	9.0%
Integrated Case Management Services	1,937	1,899	(39)	-2.0%
Program for Assertive Community Treatment (PACT)	6,759	6,222	(537)	-7.9%

Background Paper: Comprehensive Medicaid Waiver – New Programs

This background paper provides a brief summary of significant new initiatives authorized under the Comprehensive Medicaid Waiver, which was approved October 2, 2012 by the federal Centers for Medicare & Medicaid Services (CMS). The paper also relays available information regarding the expected timeframe for full implementation of these initiatives and their expected fiscal impacts in FY 2014, if any. However, the implementation schedule for each initiative may be subject to change. The waiver also includes many technical changes to current Medicaid programs, which are not discussed in this paper.

The waiver authorizes the State to require most Medicaid participants to enroll with a managed care organization to provide and coordinate most Medicaid services. Exceptions are allowed for certain populations (primarily certain disabled Medicare beneficiaries whose income is too high to qualify for full Medicaid benefits), certain categories of care, and benefits provided under certain demonstration programs. Many of the new demonstration programs are designed to build upon the managed care model to promote greater coordination of care, with the expectation that this will improve patient outcomes and reduce costs.

The Comprehensive Medicaid Waiver was originally submitted for federal approval on September 9, 2011, but the final approved waiver differs significantly from the original proposal. The programs summarized below are those included in the final, approved waiver.[3] This paper does not provide specific estimates for participation or savings, except where these have been specifically provided by the Executive. Participation levels and fiscal impacts of each program will depend on the manner and timing of implementation of each program, which in most cases are tentative.

Managed Long Term Care Supports and Services (MLTSS)

The waiver consolidates most of the State's current home- and community-based services Medicaid waiver programs under single waiver authority, and transitions them into the new MLTSS program. Institutional (i.e., nursing facility) long-term care services will also be transitioned into managed care under the MLTSS program, where they will be coordinated and reimbursed by the State's Medicaid managed care organizations. Thus, managed care organizations would be able to shift MLTSS enrollees between nursing facility services and waiver-supported community placements, depending on the most cost-effective approach to meeting enrollees' needs.

Available information indicates that the Department of Human Services is planning to begin transitioning individuals who are currently receiving services through home- and community-based services waiver programs to MLTSS in January 2014. The current schedule of implementation does not anticipate expanding MLTSS to individuals in nursing facilities until FY 2015. Recommended budget language (page D-196) provides that, if nursing facility reimbursement is shifted to managed care during FY 2014, the managed care organizations would be required to "hold harmless" the facilities' fee-for-service reimbursement rates at no lower than their FY 2013 rates through the end of the fiscal year. The FY 2014 budget

[3] The original Comprehensive Waiver proposal included several programmatic changes that did not require federal approval, or received approval separately, and which were implemented prior to October 2012. This paper focuses on the major new initiatives and reforms requiring federal approval prior to implementation.

Background Paper: Comprehensive Medicaid Waiver – New Programs (Cont'd)

recommendation does not appear to assume any savings from partial implementation of MLTSS.

Supports Program

Medicaid-eligible adults (age 21 or older) with developmental disabilities who are living in an unlicensed setting (e.g., living with family members or in their own homes) may be eligible for the Supports Program. In addition to receiving Medicaid State Plan benefits provided through a managed care organization, enrollees are eligible for a package of home- and community-based services subject to an annual expenditure cap determined by the individual's plan of care. Services available in the Supports Program include coordination services; behavioral management; physical, occupational, and speech therapy; employment-related services; transportation; environmental and vehicle modifications; and participant-specific services that would decrease the need for other Medicaid services or promote inclusion in the community. In effect, the Supports Program will allow the State to receive a 50 percent federal match for New Jersey's current State-funded Family Support Program and will provide additional services centered on independent living, such as employment and day services.

Informal information from the Department of Human Services indicates that the Supports Program is expected to be partially implemented during FY 2014, but that federal claims are likely to be minimal. The program will not expand to its full level of implementation until FY 2015.

Pervasive Developmental Disorders (PDD) Pilot Program

Children who are younger than 13 years of age, eligible for Medicaid or NJ FamilyCare, and diagnosed with a pervasive developmental disorder may be eligible for a limited package of additional home- and community-based services, including: behavior consultative supports; individual behavior supports; and occupational, physical, and speech therapy. The value of services eligible for coverage is capped at $9,000, $18,000, or $27,000, based on an individual's assessed level of need.

The PDD program will be primarily operated by the Department of Children and Families (DCF). Available information indicates that no fiscal impacts relating to PDD are assumed in the Governor's FY 2014 Budget. However, no information has been provided about the anticipated schedule for PDD implementation and whether the program might commence in FY 2014.

Intellectual Disabilities/Development Disabilities with Co-Occurring Mental Health Diagnoses (ID-DD/MI) Pilot

Medicaid-eligible children between five and 21 years who have developmental disabilities and co-occurring mental illnesses may be eligible for the ID-DD/MI pilot program. The program provides a range of home- and community-based services, including case

Background Paper: Comprehensive Medicaid Waiver – New Programs (Cont'd)

management, behavioral supports, intensive in-home and out-of-home services, and transportation.

The ID-DD/MI program will be primarily operated by DCF, through the Division of Children's System of Care. The program is expected to be operational in FY 2014, generating anticipated State savings of about $3.6 million.

Intellectual Developmental Disability Program for Out of State (IDD/OOS) New Jersey Residents

Under this program, a 50 percent federal match can be claimed for individuals who receive out-of-State home- and community-based services coordinated by the Division of Developmental Disabilities (DDD). Previously, services associated with out-of-State placements were generally paid with State-only funds. The only individuals eligible for the program are DDD clients who are currently placed out-of-State, and any future clients who receive an out-of-State placement pursuant to a court order.

No information has been provided about the anticipated schedule for implementation of IDD/OOS, or if any savings are anticipated in FY 2014.

Program for Children diagnosed with Serious Emotional Disturbance (SED)

Children between five and 21 years of age, and certain children under five, who show evidence of severe behavioral or emotional symptoms, who are at risk of being placed outside their homes, and whose families earn 150 percent of the federal poverty level (FPL) or less are eligible for coverage in the SED program, and children with particularly intense treatment needs may be eligible regardless of family income. The program provides a special set of services intended to maintain children at home, provide less restrictive and more appropriate medical treatment than would be received in a hospital setting, and promote life skills. SED program recipients are exempt from mandatory managed care organization enrollment, and their services will be reimbursed under a fee-for-service system and coordinated by an Administrative Services Organization.

The SED program will be primarily operated by DCF, through the Division of Children's System of Care, and will make a 50 percent federal match available for previously State-funded child behavioral health services. The program is expected to be operational in FY 2014, generating anticipated State savings of about $15.8 million, which are incorporated within the Governor's FY 2014 DCF Budget Recommendation.

Medication Assisted Treatment Initiative (MATI)

The waiver allows the State to claim federal financial participation for the previously State-funded Medication Assisted Treatment Initiative program. Adults over 18 years of age who earn under 150 percent FPL but are not otherwise eligible for Medicaid, are dependent on opiates, and have a mental illness or chronic medical condition, have been homeless for over a year, or have lacked stable employment for over two years are eligible for a special category of

Background Paper: Comprehensive Medicaid Waiver – New Programs (Cont'd)

home- and community-based services. These services are intended to: reduce the spread of blood-borne diseases resulting from the sharing of syringes; reduce drug dependence; stabilize chronic physical and mental health conditions; and improve housing and employment outcomes.

The Department of Human Services expects to begin claiming federal funds for the Medication Assisted Treatment Initiative in FY 2014, saving over $2 million. The recommended appropriation for the Medication Assisted Treatment Initiative (page D-175) is reduced from $11.3 million to $9.2 million to reflect this shift to federal funds.

Behavioral Health Organization

Under the waiver, most behavioral health services will be excluded from coverage furnished through primary managed care organizations, but instead will be covered through a behavioral health organization, which will contract with the State as an administrative services organization. Services will continue to be paid by the State on a fee-for-service basis, while the behavioral health organization will be responsible for coordinating services.

Behavioral health care services for children were managed by a behavioral health organization prior to approval of the Comprehensive Waiver. The contract is currently held by PerformCare. No Request for Proposals has been issued for an adult behavioral health organization, and available information suggests that a contract for an adult behavioral health organization is unlikely to be effective during FY 2014.

Delivery System Reform Incentive Payments (DSRIP) Program

The Comprehensive Waiver transitions the Hospital Relief Subsidy Fund into a new Delivery System Reform Incentive Payments (DSRIP) program. The new program requires each participating hospital to develop an individual hospital plan, which describes how the hospital will carry out a project that is designed to improve the quality of care provided, the efficiency with which care is provided, or population health. The plan must choose a focus area from the list provided in the Comprehensive Waiver (or another focus area approved by the State and the federal government), and program activities must be drawn from a predetermined menu provided in the Waiver. According to approval documents for the waiver, only half of each hospital's FY 2014 payments will be based on its performance on metrics included in its individual plan. In FY 2015 and beyond, hospitals' entire subsidies will be dependent on demonstrated improvement according to each hospital's DSRIP plan.

The Delivery System Reform Incentive Payments program will be operated by the Department of Health. The Governor's FY 2014 Budget Recommendation incorporates the transition to the Delivery System Reform Incentive Payments program (see appropriations changes on page D-156 and language on page D-158). Under the waiver, gross funding will be held steady for the full five-year demonstration at $166.6 million, the same as the amount appropriated for the Hospital Relief Subsidy Fund in FY 2012. More information on the Hospital Relief Subsidy Fund and the Delivery System Reform Incentive Payments program is provided in the analysis of the Department of Health's recommended budget.

Background Paper: Comprehensive Medicaid Waiver – New Programs (Cont'd)

Additional information

The CMS approval documents and other information regarding the Comprehensive Waiver are currently available through the Department of Human Services: http://www.state.nj.us/humanservices/dmahs/home/waiver.html

Background Paper: Trends in Child Care Services FY 2009 - FY 2014

Budget Pages.... D-214; D-216

Funding ($000)	Expended FY 2012	Adj. Approp. FY 2013	Recomm. FY 2014
Work First New Jersey Child Care	$278,391	$309,684	$307,713

BACKGROUND

This background paper provides expenditure and utilization data for New Jersey's child care assistance services for the FY 2009 – FY 2014 period. These services are funded through the Work First New Jersey Child Care appropriation.

New Jersey provides subsidized child care benefits to: low-income parents receiving Temporary Assistance for Needy Families (TANF) welfare benefits; low-income parents transitioning away from TANF participation; and low-income parents "at risk" for TANF participation who need child care services in order to accept or remain in full-time employment or to be enrolled in a full-time educational or training program. In addition, child care assistance is provided for certain children receiving protective services through the Department of Children and Families (DCF). In order to receive child care benefits, parents must currently meet the following criteria:

- Income requirements: Families must generally have annual gross incomes at or below 200 percent of the Federal Poverty Level (FPL) when initially applying for child care benefits.[4] Family incomes must remain at or below 250 percent of the FPL upon annual redetermination. For a three-person family, this equates to annual gross income not exceeding $39,060 when first applying and not exceeding $48,825 upon redetermination.

- Work requirements: Generally, all adult family members must be engaged in employment or educational or training programs for at least 25-30 hours per week, but this varies according to a family's eligibility category and other circumstances.

- Co-payments: Families above 100 percent of the FPL must contribute a co-payment toward the cost of child care. The co-payment amount varies according to the family's annual gross income, family size, hours of care needed, and number of children in care. TANF families and caregivers for children in protective services are generally exempt from co-payments.

- Age of children: Child care services are largely limited to families with children under age 13, with exceptions for children with special needs.

Child care assistance is administered by the Division of Family Development in the Department of Human Services (DHS). Historically, DHS has reported child care assistance expenditure and utilization data for the following categories of families and services:

[4] In general, TANF families automatically qualify for child care assistance (TANF income eligibility requirements are approximately 25-40 percent of the FPL, depending on family size). Child care assistance income requirements do not apply for children under the protective supervision of DCF.

Background Paper: Trends in Child Care Services FY 2009 - FY 2014 (Cont'd)

Table 1. Categories of child care assistance services for which data are reported[2]

Category	Description
Active TANF participants involved in work activities	Families receiving TANF welfare benefits
Transitional (former TANF) child care services	Families who stopped receiving TANF within the last 24 months
Post-transitional (former TANF) child care	Families who stopped receiving TANF more than 24 months ago
Low income families in the Child Care Assistance Program[3]	Non-TANF working families with gross incomes below 200-250 percent of the FPL
Abbott preschool-related child care services	Before-school, after-school, and summer "wrap around" child care for working families with incomes under 200-250 percent of the FPL and with children ages 3-4 receiving Abbott preschool services
Children placed through protective services	Children under DCF supervision

[2] The State provides two additional types of child care assistance for which disaggregated expenditure and utilization data have not been routinely reported:

Kinship child care provides child care assistance for certain kinship legal guardian caregivers. Eligibility depends on the caregiver's age, family size, and income.

Post-adoption child care provides child care assistance for certain families adopting DCF-involved children.

[3] Prior to the Governor's FY 2014 Budget, this category had been disaggregated to show data for low-income families provided with slots in State-contracted child care centers and low income families provided with child care vouchers. In FY 2012, the State began converting contracted slots into vouchers. In FY 2014, all services in this category will be provided through vouchers.

EXPENDITURES, FY 2009 – FY 2014

As previously noted, child care assistance services are funded through the Work First New Jersey Child Care appropriation. Excluding certain administrative, operational, and other costs from this appropriation, historical expenditure trends for specific categories of child care assistance services can be derived from evaluation data contained in the FY 2014 Governor's Budget (page D-214), and from prior year budget documents. Chart 1 (below) provides information on DHS' total child care assistance expenditures for the categories shown in Table 1 (above). The data indicate that, during the FY 2009 – FY 2014 period, DHS' annual child care assistance expenditures across all categories decreased by 26 percent, from $315.9 million (FY 2009) to $233.6 million (recommended for FY 2014).

Background Paper: Trends in Child Care Services FY 2009 - FY 2014 (Cont'd)

Chart 1. Total Annual Expenditures on Child Care Services, FY2009-FY2014 ($000)

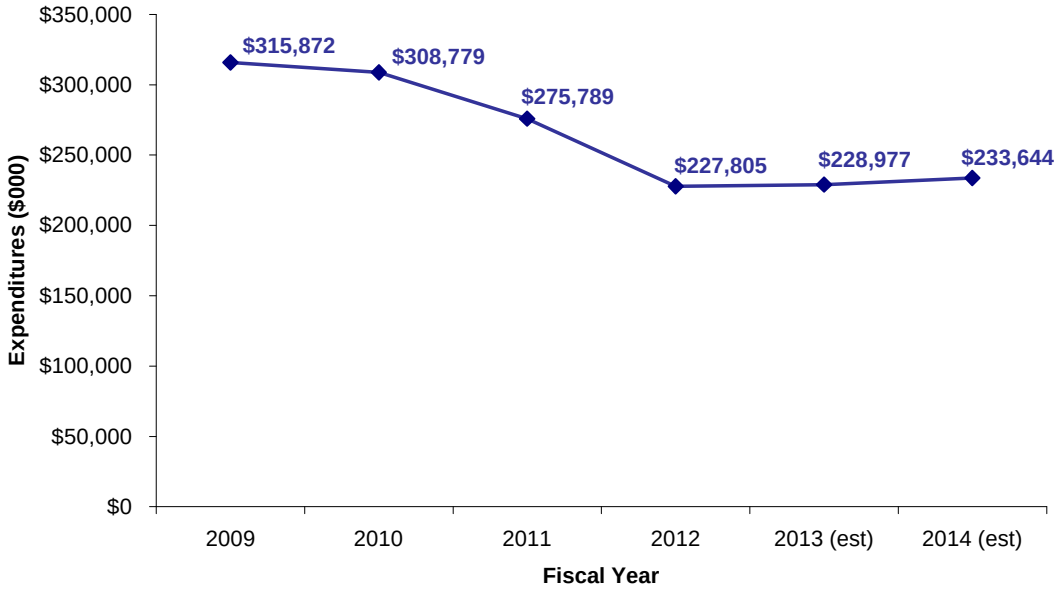

Table 2 (below) presents service-specific child care assistance expenditures for the FY 2009 – FY 2014 period. The data indicate that:

- Expenditures on services provided through the Child Care Assistance Program (i.e., slots in State-contracted child care centers and vouchers provided to low-income, non-TANF working families) increased during this period; and

- Expenditures on all other child care assistance services decreased during this period.

Table 2. Child Care Payments for Eligible Families, FY 2009 – FY 2014. ($000)

SERVICE	FY 2009 EXPENDED	FY 2014 RECOMMENDED	% CHANGE
Active TANF recipients in work activity	$44,048	$43,705	(0.8%)
Transitional (former TANF) child care services	36,988	33,276	(10.0%)
Post-transitional (former TANF) child care services	3,952	2,502	(36.7%)
Low-income families in Child Care Assistance Program	109,942	113,716	3.4%
Abbott-related Child Care Services (wraparound)	102,094	21,961	(78.5%)
Children receiving DCF protective services	18,848	18,484	(1.9%)
TOTAL EXPENDITURES	$315,872	$233,644	(26.0%)

Background Paper: Trends in Child Care Services FY 2009 - FY 2014 (Cont'd)

The largest expenditure decrease occurred for Abbot-related child care services, which saw expenditures decrease by 78.5 percent during the FY 2009 – FY 2014 period. See below for a more complete discussion regarding policy changes contributing to this decrease.

UTILIZATION, FY 2009 – FY 2014

Chart 2 provides information on the average number of children per month receiving DHS' child care assistance services across all of the categories shown in Table 1. The data indicate that, during the FY 2009 – FY 2014 period, the average number of children per month receiving services across all categories decreased by 18 percent, from about 64,900 children per month (FY 2009) to about 53,100 children per month (estimated for FY 2014).

Available information indicates that the FY 2012 "dip" in utilization reflects a transitional period where fewer children were temporarily served through contracted, center-based child care slots, as the contracted slots were converted into Child Care Assistance Program vouchers.

Chart 2. Overall Average Monthly Children Served by Child Care Services, FY2009-FY2014 ($000)

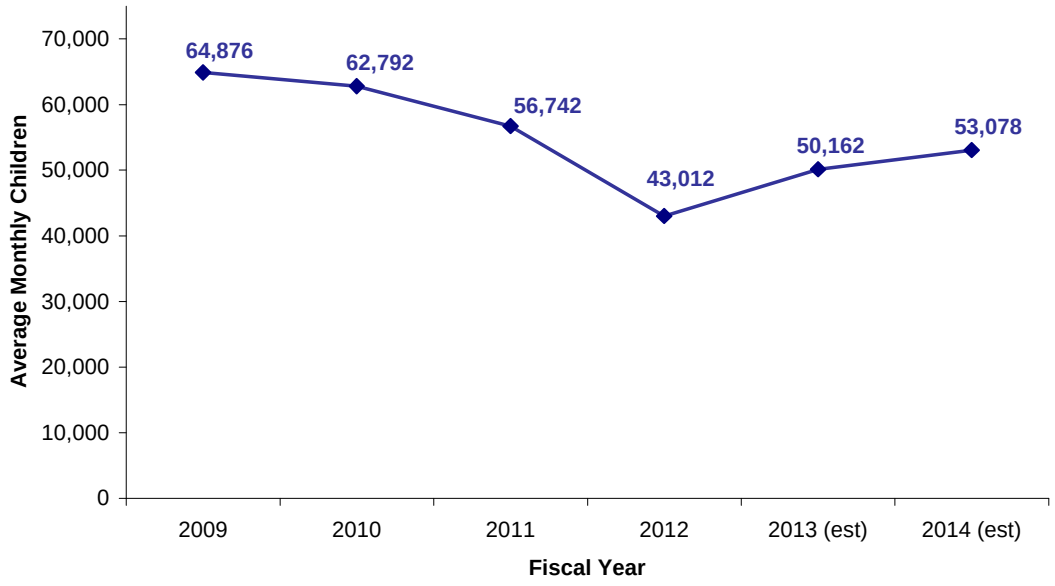

Table 3 (below) presents utilization data, by service, for the average number of children per month receiving child care assistance for the FY 2009 – FY 2014 period. The data indicate that:

- Utilization for active TANF families, "transitional" (former TANF) families, low-income families served by the Child Care Assistance Program, and children receiving DCF protective services increased during this period;

- Utilization for "post-transitional" (former TANF) families decreased, but the decrease was relatively small in absolute numbers (205 children); and

Background Paper: Trends in Child Care Services FY 2009 - FY 2014 (Cont'd)

- Consistent with expenditure trends, Abbot-related child care services experienced the largest utilization decrease in terms of percentage and absolute numbers. The average number of children per month receiving Abbot-related child care services decreased by 14,600 children, or 65.5 percent, during the FY 2009 – FY 2014 period.

Table 3. Average Number of Children Per Month Receiving Subsidized Child Care, FY 2009 – FY 2014.

SERVICE	FY 2009 ACTUAL	FY 2014 ESTIMATED	% CHANGE
Active TANF recipients in work activity	7,440	8,147	9.5%
Transitional (former TANF) child care services	6,640	7,120	7.2%
Post-transitional (former TANF) child care services	765	560	(26.8%)
Low-income families in Child Care Assistance Program	25,205	26,182	3.9%
Abbott-related Child Care Services (wraparound)	22,351	7,711	(65.5%)
Children receiving DCF protective services	2,475	3,358	35.7%
TOTAL CHILDREN (MONTHLY AVERAGE)	64,876	53,078	(18.2%)

ABBOTT-RELATED CHILD CARE SERVICES ("WRAP AROUND")

The overall decrease in expenditures and utilization between FY 2009 and FY 2014 appears partially attributable to policy changes affecting Abbott-related child care services during the period.

DHS' Abbott-related child care services provide four hours of daily before-school and after-school "wrap around" child care to three- and four-year-olds in certain low-income communities (the 31 former Abbott school districts). These children are also eligible to receive six hours of daily preschool services funded through the New Jersey Department of Education (DOE), resulting in a 10-hour, full-day education program from September through June. The DHS "wrap around" child care program also provides these children with 10 hours of daily summer child care during July and August.

Prior to FY 2008, families residing in Abbott school districts received free "wrap around" child care for three- and four-year-olds enrolled in DOE-funded preschool programs, regardless of the parents' income or work status. Beginning in FY 2008, the following eligibility requirements for "wrap around" child care assistance were added:

FY 2008:

- Abbott families' annual gross incomes could not exceed 300 percent of the FPL

Background Paper: Trends in Child Care Services FY 2009 - FY 2014 (Cont'd)

FY 2009:

- Abbott families' annual gross incomes could not exceed 250 percent of the FPL

FY 2011:

- Newly-enrolled Abbott families' gross incomes could not exceed 200 percent of the FPL at initial determination
- Newly-enrolled families were required to fulfill work requirements (employment or training of at least 25 hours per week)
- All enrolled families above 100 percent of the FPL would be subject to co-payments

According to DHS, these reforms were intended to improve equity, so that Abbott and non-Abbott families would have to meet the same requirements when seeking subsidized child care services. Previously, Abbott families did not have to fulfill income, work, and co-payment requirements that non-Abbott families were required to fulfill in order to receive child care assistance.

DHS has also stated that these reforms allow for a seamless transition from one program to another. Previously, families who received Abbott-related child care services for three- and four-year-olds were not assured of qualifying for other, non-Abbott child care services as their children aged because those families may not have met the income or work requirements for non-Abbott child care services.

CHILD CARE SERVICES WAITING LIST

DHS' child care expenditure and utilization trends have also occurred in the context of a waiting list. In recent years, the number of families eligible for child care assistance has exceeded the number of children that could be served with available funding, resulting in some families being placed on a waiting list for services (there is no waiting list for TANF-eligible families or for families involved with DCF child protective services).

Although DHS does not routinely publish information regarding the number of children on the child care waiting list, the following data are available:

DATE	CHILD CARE WAITING LIST	SOURCE
October 2011	8,000 children (approx.)	NJ Office of the State Comptroller[5]
February 2012	10,472 children	National Women's Law Center, 50-state survey[6]
June 2012	6,993 children	DHS
August 2012	3,633 children	National Women's Law Center, 50-state survey

[5] New Jersey Office of the State Comptroller, *Oversight of the New Jersey Child Care Assistance Program* (January 2012).

[6] 50-state survey of state child care administrators conducted by National Women's Law Center, as reported in *Downward Slide: State Child Care Assistance Policies 2012* (October 2012).

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