



State of New Jersey
DEPARTMENT OF HUMAN SERVICES
PO Box 700
TRENTON NJ 08625-0700

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

ELIZABETH CONNOLLY
Acting Commissioner

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David J. Rosen
Legislative Budget and Finance Officer
Office of Legislative Services
State House Annex
P.O. Box 068
Trenton, New Jersey 08625-0068

Dear Dr. Rosen:

Please see DHS's responses to the follow up questions.

CASS/Medicaid applications/SNAP

Assemblyman Mukherji, Chairman Schaer, and Assemblyman Singleton:

- Please provide to the committee a report on the regularity and timeliness of each county's reporting of its backlog(s) of applications for Medicaid and other public assistance. What incentives or penalties has the department used or considered to encourage better reporting by the counties?

Answer: The County Welfare Agencies were asked to provide the Division of Medical Assistance and Health Services weekly reports of their application backlog every Friday. The backlogs have been reported to the Division for the past 39 weeks. On the following page is a breakdown of how frequently each county responded. Out of the 819 total reportable weeks, 574 have submitted in compliance with the weekly submissions for an overall compliance percentage of 70%.

COUNTY	# Weeks Reported
Atlantic	30
Bergen	35
Burlington	18
Camden	19
Cape May	34
Cumberland	25
Essex	13
Gloucester	28
Hudson	38
Hunterdon	24
Mercer	35
Middlesex	26
Monmouth	24
Morris	36
Ocean	35
Passaic	20
Salem	29
Somerset	24
Sussex	20
Union	29
Warren	32
Total Weeks	39

NOTE: Cumberland, Salem, and Sussex reported a backlog of "0" for most weeks due to low or no backlog.

The CWAs have been advised the Division would evaluate their readiness for returning the online applications as backlogs decrease. Applications that were re-directed to the Health Benefits Coordinator (Xerox) could be directed back to their agency as incentive to complete the backlogged applications.

Chairman Schaer:

- What was the total cost to the State to retain outside counsel in relation to the agreement to terminate the contract with Hewlett-Packard for the development of the Consolidated Assistance Support System?

Answer: \$284,920 has been paid to outside counsel, of which 50% is anticipated to be federally reimbursable.

Assemblyman Brown:

- What is the rate of fraud in the SNAP program, and the costs associated with that fraud? If possible, please indicate these numbers separately for the "traditional" SNAP program and the disaster SNAP program that was operated temporarily following Hurricane Irene and Super Storm Sandy.

Answer: Investigations of New Jersey's SNAP program during federal fiscal year 2014 uncovered improper benefit applications and disbursements equal to .1756% of the \$1.291 billion of benefits issued, as follows: \$99,000 related to benefits trafficking, \$278,000 related to denied applications, and \$1.89 million of fraudulent claims referred for recoupment, benefit disqualification and criminal prosecution.

The Disaster SNAP program (D-SNAP) is a short term limited resource that operates only during presidentially declared disasters and with the goal of providing access to food in emergent situations for eligible applicants. New Jersey, in collaboration with county welfare agencies, operated D-SNAP programs in the aftermath of Hurricane Irene and Superstorm Sandy issuing these one-time federally funded benefits. Based upon its experiences with Irene, the State changed some of its procedural requirements for the implementation of the Sandy-related D-SNAP to reduce potential fraudulent activity. The Sandy D-SNAP program received 8,693 total applications; 4,467 were approved and 4,346 were denied.

Return Home New Jersey

Chairman Schaer:

- What is the total financial differential of having the Return Home New Jersey program, versus not having the program?

Answer: The Return Home New Jersey program operates by moving individuals from out-of-state placements to in-state placements in order to improve the quality and coordination of disability services with medical care through enrollment on New Jersey's home and community-based waivers and NJ FamilyCare, as well as enabling the State to properly fulfill its responsibilities for oversight and monitoring of service delivery.

In either location, individuals have costs associated with habilitation and medical services and support coordination.

Federal matching funds claimed on services provided to individuals now living in New Jersey augment the Division's community investment to provide new services to additional individuals. Through FY16, this additional funding is estimated at \$22.8 million based on the 170 individuals transitioned prior to FY16. The amount of additional funding provided by relocating individuals in-state will continue to increase with each year care is provided in-state, which would continue to augment further community investment and enable the State to serve additional individuals.

Assemblyman Singleton:

- Please provide the annual cost for each of the 170 individuals who have been moved to an in- State placement pursuant to the Return Home New Jersey program for the year prior to the individual's move. Please include and specify what proportion of the annual cost can be attributed to support services, residential services, medical services, transportation, and any other category that is essential.

Answer: On average, the annual cost for in-State residential services for individuals that have returned to New Jersey is \$125,000, with an additional \$30,000 allocated for employment, day and other support services. These amounts are bundled, all-inclusive contract reimbursements for Division services. Support coordination costs are the same in-state or out-of-state; providers bill \$200 per member, per month. Medical services are paid separately through participation in NJ FamilyCare using the prevailing fee-for-service or managed care capitation rates. Federal reimbursement is typically 50% of eligible costs, with enhanced rates applicable to certain services and eligibility categories.

Services, supports and individualized budgets are designed using a needs-assessment tool that is independently operated by the Developmental Disabilities Planning Institute. Once complete, multiple provider agencies can use this information to make service proposals, with the individual, guardian and family members choosing which one best addresses their most important support needs. The Division reviews each proposal to ensure that it is in compliance with health and safety standards, as well as other service-specific provider qualifications, but, once that determination is made, will fund the services that individual chooses.

- Please provide the annual cost for each of the 170 individuals who have been moved to an in- State placement pursuant to the Return Home New Jersey program for the first year of the individual's placement in New Jersey. Please specify in the cost a separate line for transition costs, including support coordination and any other ancillary costs for the transition. Please detail the annual cost by support services, residential services, medical services, transportation and any other category that is essential.

Answer: Annual costs in the first year of placement are the same as the figures given above. Reimbursement rates may change if an individual's level of need is reassessed due a change in circumstances.

- How many complaints and/or inquiries has the department received regarding Return Home New Jersey in 2013, 2014, and to date in 2015?

Answer: From 2013 through 2015 to date, the Division has received 62 letters related to Return Home New Jersey. The Division is continuously in contact with all the individuals, families and guardians that are currently living out-of-state, or that have transitioned to in-state services. This allows staff to have ongoing dialog in order to address issues and inform individuals of their options for community support services.

- What is the total cost for support coordination for the 170 individuals who have moved to in-State placements pursuant to the Return Home New Jersey program?

Answer: Support coordination costs are the same in-state or out-of-state; providers bill \$200 per member, per month.

Assemblywoman Vainieri Huttle:

- Will the 382 individuals who are currently receiving DDD funded services in out-of-State facilities continue to receive DDD funding at the conclusion of their current contracts?

Answer: Individuals who are currently receiving DDD funded services in out-of-Sate facilities will continue to receive DDD funding for the placement at the conclusion of their current contract until their transition plan is complete.

- How many individuals who were residing in out-of-State facilities have been terminated from DDD funding as a result of their refusal to move to an in-State facility?

Answer: No individual has been terminated from services as a result of a shift in funding. Please see the following answer for additional detail.

- How many individuals who were receiving DDD funded services in out-of-State facilities have remained in out-of-State facilities, but are no longer funded by DDD? Please detail for the committee, the current funding source for each of these individuals.

Answer: As a result of transition plans developed by the Division, along with individuals, families, guardians and agencies in other states, fourteen individuals living out-of-state have retained their existing services while shifting to another source of funding. This includes five funded by Maryland, two funded by Pennsylvania, one funded by Massachusetts, one funded by New York, one funded by Wisconsin, and four that have elected to private pay.

- Does the department feel it needs legislation to discontinue or terminate the Return Home New Jersey program?

Answer: The Division is committed to improving the quality and coordination of disability services with medical care through enrollment on New Jersey's home and community-based waivers and NJ FamilyCare.

Assemblywoman Pintor Marin:

- What are the number of division staff who are currently dedicated to the Return Home New Jersey program? If a portion of a staff person's time is allocated to the program, please detail this information.

Answer: There are currently ten staff dedicated to Return Home New Jersey, one project director, three supervisors, and six coordinators. The Division anticipates receiving federal matching funds equal to 45% of the cost.

- What are the current costs for individuals who are in-State placements? Please detail by individual. Please provide a breakdown of funding source for each individual, State, federal, or other. What are the current costs for individuals who are in out-of-State placements? Please detail the cost for each individual. Please provide a breakdown of funding source for each individual, State, federal, or other.

Answer: On average, the gross annual cost for in-State residential services for individuals returning to New Jersey is \$125,000, with an additional \$30,000 allocated for employment, day and other support services. These amounts are bundled, all-inclusive contract reimbursements for Division services. Support coordination costs are the same in-state or out-of-state; providers bill \$200 per member, per month. Medical services are paid separately through participation in NJ FamilyCare using the prevailing fee-for-service or managed care capitation rates. Federal reimbursement is typically 50% of eligible costs, with enhanced rates applicable to certain services and eligibility categories.

- How much cost savings can be attributed to the 170 individuals who have been moved from out-of-State placement to in-State placements? Are the individuals who are no longer funded by DDD, but remain in their out-of-State placement, included as part of the 170 individuals and the commensurate cost savings? If so, please detail the cost savings attributed to these individuals who are no longer funded by DDD and those individuals who are still funded by DDD.

Answer: The cumulative federal claim is estimated at \$22.8 million based on individuals transitioned to date.

Division of Developmental Disabilities (Other)

Chairman Schaer:

- Please provide to the committee the number of individuals who were on the Community Care Waiver Waiting List and were moved into residential placements in the previous calendar year. Please provide the length of time each of these individuals had been on the CCW Waiting List prior to placement. Of those who received placements, how many were emergency placements?

Answer: In FY14, there were 436 individuals moved into residential placements, of which 421 were deemed emergencies.

Assemblyman McKeon:

- How many individuals who are currently on the Community Care Waiver Waiting List are ready to move into housing immediately if housing is located for these individuals?

Answer: Although the impression of the waiting list is that individuals are in need of immediate residential placement, in many cases individuals select other services to complement their existing supports. For example, for individuals on the waiting list served from FY10-14, 49% selected in-home services, 22% declined services or did not desire additional services, 20% selected out-of-home services, and the remainder were no longer in need of or eligible for Division services (e.g., moved to another state, enrolled in another waiver program).

- What is the average wait time for an individual on the CCW waiting list to receive a placement, assuming that the individual never requires an emergency placement?

Answer: As noted above, many individuals on the waiting list are not in need of an immediate residential placement and are already receiving some type of service funded of the Department. For individuals residentially placed in FY14, the average time on the list was approximately fourteen-and-a-half years. Of these, 27% of the individuals were placed on the list as children.

Assemblywoman Vainieri Huttle:

- Please provide to the committee information on the current residential placement for each of the former residents of the Woodbridge Developmental Center and the Vineland Developmental Center.

Answer: The Division of Developmental Disabilities closed North Jersey and Woodbridge Developmental Centers. Per the report submitted to JBOC, at North Jersey, 138 individuals chose to transition to community residential placements, and at Woodbridge, 83 chose to transition to community residential placements.

- Please provide the department's estimate on total savings attributed to closing the developmental centers and specify the amounts which were reinvested into community placements.

Answer: From FY15-16, the Division scored salary and non-salary closure related savings in the developmental center budgets of \$107.5 million. During this time period, community growth for all services, including funding for Olmstead placements, emergencies and other new services, totaled \$211.4 million, \$103.9 million in excess of the reinvested savings. Of this growth, 21% was appropriated for Olmstead transitions from the developmental centers to the community, with the remainder funding increased services for initiatives including age outs, waiting list reduction and emergency placements.

Other Questions

Assemblyman Burzichelli:

- Deputy Commissioner Arye testified that some nursing homes have not reliably provided data related to the nursing home early warning system, which they are required to provide as a condition of receipt of Medicaid/NJ FamilyCare funds (pursuant to budget language on page B-99 of the FY 2015 Appropriations Handbook). Have any facilities failed to report data as required by the commissioner and continued to receive payments from Medicaid/NJ FamilyCare?

Answer: All Medicaid certified nursing homes have complied with our request to provide cost report financial data in compliance with the budget language.

Assemblyman McKeon:

- Of the 387 individuals who have participated in the involuntary outpatient treatment program in 2014, how many have failed to successfully complete the program and been involuntarily committed to inpatient treatment?

Answer: The number of participants in the Involuntary Outpatient Commitment (IOC) program is 387, of whom 207 have been discharged. Of those, 40% successfully completed program requirements. Another 40% of all those who were discharged have been committed to inpatient treatment in a psychiatric hospital. However, it should be noted that termination of IOC status due to psychiatric hospitalization may not necessarily be indicative of a treatment failure, as pre-IOC hospital use should also be considered. Also, DMHAS has engaged Rutgers University to conduct an evaluation/outcomes study of the IOC program.

Assemblyman Singleton:

- Please provide the most recent report by the external quality review organization regarding the quality and availability of personal care assistant services in the Medicaid/NJ FamilyCare program.

Answer: DMAHS has contracted with the national organization, Improving Healthcare for the Common Good (IPRO), to serve as its External Quality Review Organization (EQRO). In accordance with the Balanced Budget Act of 1997, IPRO conducts external quality review (EQR) activities for DMAHS to ensure enrollees receive quality and timely healthcare from its contracted MCOs (see attached report).

In addition, the committee would appreciate a written response to the following questions that were not raised during the hearing due to time constraints:

Medicaid/NJ FamilyCare

- What is the status of the Medicaid Accountable Care Organization (ACO) pilot program, authorized by P.L.2011, c.114? Is DHS promoting and supporting the Medicare ACOs in New Jersey? How is DHS helping patients using ACOs?

Answer: The Department is in the final stages of reviewing the ACO applicants and expects to certify applicants who meet the requirements of P.L. 2011, c. 114 in the near future. The Demonstration project will commence immediately following certification notification. DHS has not been actively promoting or supporting Medicare ACOs in NJ. DHS does not receive information on Medicare ACOs in NJ.

- Governor Christie signed P.L.2010, c.74 creating a Medicaid medical home pilot program. But, the November 2012 report to the Legislature regarding the medical home pilot stated: "Since the first PCMH began its operations in July 2011, it is premature to determine whether cost savings and metrics such as rates of health screening, outcomes and hospitalization rates have been impacted." No reports have been submitted since 2012. Please provide an update on the medical home pilot program from the time of the first report.

Answer: The second report will be ready for release in the near future.

- New Jersey Medicaid announced last year that it will cover telemedicine services for psychiatry, an area in which we have a known physician shortage. How is the new telemedicine program working? Has Medicaid access been improved?

Answer: To date, one program has submitted their policy and procedures for approval to DMAHS, and was approved in late 2014. This provider utilizes telemedicine for Early Intervention Services (EIS) and is currently using this tool to provide services. They have billed for these services, and have been reimbursed by DMAHS. While several providers have informally expressed interest in being permitted to provide telepsychiatry services, only this one provider has submitted documentation for approval.

- During the hearing we discussed physician participation. We know payment rates, and in turn, participation needs improvement. How does DHS ensure network adequacy for Medicaid? What percentage of overall Medicaid payments made to providers of health care services are made to primary care physicians/providers?

Answer: DMAHS's Managed Care Contract requires NJ FamilyCare managed care plans to maintain a network that is in full compliance with both state and federal regulations and includes the following additional general requirements:

Provider/Enrollee Ratios

Primary Care Physicians – Each plan must have 1 full time equivalent per 2,000 enrollees and 1 full time equivalent per 1,000 developmentally/intellectually disabled enrollees.

Primary Care Dentist - Each plan must have 1 full time equivalent per 2,000 enrollees.

Certified Nurse Midwife - Each plan must have 1 full time equivalent per 1,000 enrollees and enrollees must have a choice of at least two providers.

Certified Nurse Practitioner/Clinical Nurse Specialist – If a plan includes these providers in their network, each plan must have 1 full time equivalent per 1,000 enrollees and enrollees must have a choice of at least two providers.

Primary Care Providers

Each plan's network must include the following primary care provider types:

- General/family practice physicians
- Internal medicine physicians
- Pediatricians
- Adult and pediatric dentists

In addition, each plan's network can include certified nurse midwives, clinical nurse specialists, and certified nurse practitioners; if a plan's network does not include these provider types, the plan reimburses out of network providers for these services.

Physician Specialists and Non-Physician Providers

Each plan must provide access to physician specialists and sub-specialists (including pediatric specialists) in accordance with state regulations (N.J.A.C. 11:24-6 et seq.). All physician specialists must have admitting privileges in at least one participating hospital in a county where the specialist will see NJ FamilyCare enrollees. Each plan must also provide a detailed description of accessibility for each physician who will serve as both a primary care physician and a specialist or will serve with more than one specialty.

Ancillary Providers

Each plan must provide access to all necessary ancillary/institutional providers to ensure coverage of all health benefits in accordance with state regulations (N.J.A.C. 11:24-6 et seq.) and must maintain written contracts with hospitals for inpatient and outpatient services.

Access Standards

- In urban areas, 90% of enrollees must be within 6 miles of 2 primary care providers and 2 primary care dentists.
- In non-urban areas, 85% of enrollees must be within 15 miles of 2 primary care providers and 2 primary care dentists.

Travel Time Standards

Each plan must ensure that its enrollees do not live more than 30 minutes away from their primary care provider, primary care dentist, or certified nurse practitioner/certified nurse specialist using the following distance guidelines

- 20 miles away using primary roads in normal conditions
- 20 miles away using secondary roads in normal conditions or in rural areas
- 25 miles in flat areas or areas connected by interstate highways
- 30 minutes travel time on public transportation in metropolitan areas (Newark, Camden, Trenton, Paterson, Jersey City, etc.)

Additional and more specific requirements are available in the managed care contract on the DMAHS public website at <http://www.nj.gov/humanservices/dmahs/home/>. Approximately \$524 million of all paid fee for service claims and managed care encounters in state fiscal year 2014 were serviced by primary care providers based on definitions included in the recent federal primary care rate increase.

- On July 1, 2006 the New Jersey Legislature imposed a moratorium on the enrollment of chiropractic providers in Medicaid. Since then, the moratorium has been readopted in the annual budget and the moratorium continues to be effective. However, because the majority of Medicaid payments are now distributed through managed care organizations that decide which providers to include in their networks, is this language necessary to be included in the budget?

Answer: During the evaluation and construction of the SFY2007 budget, both the New Jersey legislature and Governor expressed interest in improving New Jersey's Medicaid fraud, waste, and abuse programs. This focus followed national trends as many states were ramping up efforts to prevent and detect Medicaid fraud, waste, and abuse as an alternative to other cost savings measures such as cutting benefits or restricting eligibility. As part of New Jersey's FY2007 initiative, the Division of Medical Assistance and Health Services implemented fee-for-service provider moratoriums on several services on the supposition that unnecessary supply creates demand. New chiropractic providers have remained under this fee-for-service moratorium since the July 2006 adoption.

Nursing Homes and MLTSS

- The line-item "Payments for Medical Assistance Recipients - Nursing Homes" on Page D-188 shows an increase of almost \$28 million over the FY 2015 appropriation. Yet budget language indicates that nursing home rates are not being increased, and patient days are reported on page D-185 to be about 50,000 less than the revised FY 2015 figure. To what is this line item's increase attributed?

Answer: As noted in footnote "b" on page D-189 of the FY2016 Budget, the fiscal 2015 appropriation will be supplemented with resources from other accounts. Therefore, projected expenditures in FY15 are in line with the FY16 Recommended Budget.

- The line-item for Managed Long Term Services and Supports on page D-188 shows a recommended increase of \$113 million over the FY 2015 appropriation of \$280 million. Why the increase? On what will it be spent?

Answer: Of the \$113 million, 30% is for care management and administration, 65% is for new access to MLTSS services (which includes funding for Qualified Income Trusts), and 5% is for expanded services for existing clients.

- The capitated fees paid to the Medicaid managed care organizations (MCOs) for persons in nursing facilities and assisted living facilities are set amounts per month. If a person leaves a nursing facility or an assisted living facility for a hospital stay and the hospital stay is paid for by Medicare, is the monthly capitated fee paid to the MCO adjusted for time spent in the hospital?

Answer: Capitation rates are not adjusted when a resident has a hospital stay and the associated costs are paid for by Medicare. Medicaid is responsible for the unpaid crossover costs that are not paid up by Medicare, and those are the costs that are built into the capitation rate.

- What options is DHS exploring with Medicaid managed care organizations to assure quality long term services and supports are available to MLTSS participants with intellectual and developmental disabilities?

Answer: Interim guidance was sent on April 20, 2015 to the MCOs by the Division of Medical Assistance and Health Services (DMAHS), in consultation with the Division of Developmental Disabilities (DDD), which lays out processes and procedures for MCO members who are seeking MLTSS with a diagnosis of developmental or intellectual disability and may or may not be known by the DDD. The guidance explains that individuals can only receive services through one Medicaid waiver program: MLTSS, DDD's Community Care Waiver or DDD's Supports Program, with a few exceptions. Specifically, individuals who were receiving Private Duty Nursing (PDN) services and DDD Day Services prior to July 1, 2014 can maintain MLTSS enrollment and receive DDD Day services at the same time. In addition, DMAHS, in consultation with DDD, is attempting to resolve what federal Medicaid waiver authority can be used and what options are available to allow individuals in the Supports Program to access PDN from the MLTSS system. The Department has sent a request to the federal Center for Medicare and Medicaid Services (CMS) laying out potential options to allow individuals in the Supports Program to access PDN services. The Department is waiting for CMS to respond to its request for resolution.

Division of Developmental Disabilities

- What is the percentage of individuals/families who turn down residential placement when they are offered one?

Answer: With respect to the waiting list, only 20% of the individuals on the waiting list served from FY10-14 selected out-of-home services.

- Please provide a list of all existing congregate housing settings, the number of persons served, which programs will be approved as is and with modifications, the modifications, and how they demonstrated compliance based on the individuals' experiences and outcomes.

Answer: The Statewide Transition Plan submitted to CMS on April 17, 2015 included 2,283 congregate settings with 9,310 residents. The Division will be assessing these settings and issue a report on compliance to CMS by August 2015. It is estimated that 99% of the residents will be in settings that comply with CMS's final rule. The remainder will be addressed on a case-by-case basis to ensure minimal impact to individuals.

- Is the Department of Human Services considering a one-time allocation of funds being made available to ID/DD providers to offset the cost of converting to fee-for-service?

Answer: Currently, providers are paid in advance, with one twelfth of their contract ceiling disbursed each month. The Department is working to ensure a smooth transition during fee-for-service implementation. Providers can, however, bill at the frequency they prefer so the Department does not anticipate cash flow delays to be a risk once providers are familiar with the new process.

Other Questions

- In 2012 Governor Christie declared New Jersey as an "Employment First" state for persons with disabilities. However, this past year funding for supported employment services for persons with mental illness was cut and there is now an increased demand for these services. Why is there not an adequate level of funding for this stated commitment? Is DMHAS considering the Medicaid Waiver 1915(i) Home and Community Based Services (HCBS) to fund supported employment?

Answer: Funding for supported employment (SE) services has not been reduced. Previously, DMHAS contracted for this service with funding provided by the Department of Labor and Workforce Development (DOLWD). DOLWD is now contracting for these services directly and has extended an invitation to all of the SE agencies under contract with the DMHAS to become DOLWD vendors, thus enabling these agencies to continue to provide the same level of supported employment services.

- Since 2011, the NJ 211 partnership has been handling the addictions hotline. How will the move to UBHC differ from the offerings of NJ 211's implementation of the addictions hotline for the State of New Jersey?

Answer: The 211 contract with DMHAS will be terminated and the tasks will be assumed by UBHC as the Interim Managing Entity (IME). Currently, 211 takes calls from the public, screens callers and makes targeted, warm handoff referrals to addictions treatment providers. UBHC will perform those call center and referral functions but additional features will be added. UBHC will perform care coordination that will assist individuals to enter care and move seamlessly from one level of care to the next and/or from provider to provider. UBHC will also perform utilization management activities, which include authorizing and monitoring levels and duration of treatment services to assure that clients are in the care that they need, when they need it, for only as long as they need it. UBHC will also assist DMHAS and NJ FamilyCare with consumer eligibility and provider network management activities. It is anticipated that these additional functions will increase client access to care, decrease inappropriate treatment placements and assure more effective and efficient use of resources.

- In the FY 2015 Appropriations Act, the Legislature included a 0.05% increase for direct support professionals, including those who support people with intellectual and developmental disabilities. A language provision (page B-205 of the FY 2015 Appropriations Handbook) directed that these funds support a contract adjustment to be effective January 1, 2015, but they have not yet been received. Why has there been a delay? When can community providers expect to receive the funding that was appropriated?

Answer: As noted in the report to the Joint Budget Oversight Committee, the broadly-written language provision presented several difficulties with respect to defining “community providers” and “direct care workers,” as well as establishing appropriate contract bases for a variety of provider types, contract types and reimbursement mechanisms.

- Proposed budget language on page D-217 would prohibit adult medical day care providers from serving more clients in a single day than their licensed capacity or 200 clients, whichever is less, effectively prohibiting them from serving clients in multiple shifts. This is at odds with N.J.A.C.8:43F-2.6 and supporting regulatory guidance from the Department of Health, which limits facilities to their licensed capacity to a given time or session, not a day. As this issue has not been determined to be a licensure issue by the Department of Health, what is the rationale for the restriction? Will the language limit patient access to services? Will the language limit managed care organizations’ ability to direct their enrollees to the best and most cost-effective provider of care?

Answer: DHS is unaware of any individual who has been unable to receive services because of capacity issues. The managed care organizations (MCOs) will be able to continue to use medical day care for those NJ FamilyCare participants who are eligible and can benefit from this home and community based services (HCBS) option and will increase the level of care provided.

Sincerely,



Elizabeth Connolly
Acting Commissioner

EC:07