

Department of Human Services (General)

Comprehensive Medicaid Waiver

1. October 2015 will mark the start of the fourth year of the Comprehensive Medicaid Waiver, a five-year demonstration project approved by the federal government under section 1115 of the Social Security Act to reform many aspects of the Medicaid program in New Jersey. The department indicated that several of these reforms would lead to significant State cost savings. Total savings of \$300 million were anticipated in FY 2012, based on the waiver proposal that was originally submitted for federal approval.¹ However, the federal government's denial of certain State reimbursement claims, as well as the delayed implementation of some programs authorized by the waiver, caused the actual savings to be much lower in that year.

Under a section 1115 waiver, the State is required to ensure that federal spending will not increase from what it would have been in the absence of the waiver. The budget neutrality calculations in the State's original application anticipate a total savings of approximately \$919 million over 5 years (\$461 million federal and \$458 million State).² These estimates are likely no longer valid, because: (1) the final waiver that was approved differs in some ways from the original application; (2) some programs included in the waiver have been significantly delayed or implemented differently from the original expectation; and (3) some underlying assumptions based on information available in 2011 may need to be updated with more current information. In response to FY 2015 OLS discussion point #28a, the department indicated that the State was updating the Comprehensive Waiver budget neutrality analysis to reflect some changes.

- **Questions:** Please provide an update of the estimated State savings attributable to the Comprehensive Medicaid Waiver for each year of the demonstration project. Please provide the most recent budget neutrality analysis available that has been or is intended to be submitted to the federal government.

Answer: Below is the most recent budget neutrality analysis that was sent to CMS, which indicates that the State will spend significantly less in State funds as a result of the implementation of the Comprehensive Medicaid Waiver. This analysis was based on the trend rates reflected in "Special Term and Condition #128" of the Comprehensive Waiver.

¹ The department provided a breakdown of the original estimate to the Assembly Budget Committee in 2011: http://www.njleg.state.nj.us/legislativepub/budget_2012/DHS_follow_up_responses_medicaid_AB_U_05242011.pdf.

² In this case, the same calculations show an anticipated State savings as well as federal savings. The calculations are included in the document at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nj/Comprehensive-Waiver/nj-1115-request-demo-comprehensive-waiver-09092011-2.pdf>

Budget Neutrality "Without Waiver" Caps as Established in STC #128						
TOTAL COMPUTABLE						
	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
NO WAIVER						
Title XIX	1,888,003,055	2,722,442,509	3,157,084,805	3,428,507,095	3,723,385,278	14,919,422,742
ABD	2,358,149,481	3,404,758,934	3,567,018,136	3,763,055,711	3,969,915,079	17,062,897,341
LTC	1,983,020,213	2,721,202,620	2,703,781,937	2,860,757,867	3,026,849,098	13,295,611,734
HCBS state plan	30,677,444	44,456,350	50,476,671	86,694,073	91,538,141	303,842,678
	\$ 6,259,850,193	\$ 8,892,860,413	\$ 9,478,361,549	\$ 10,139,014,745	\$ 10,811,687,596	\$ 45,581,774,496
	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
WITH WAIVER						
Title XIX	1,654,962,556	2,319,967,237	2,609,573,154	2,759,357,872	2,917,739,958	12,261,600,778
ABD/LTC	3,956,021,601	5,316,504,981	5,758,799,496	6,040,442,889	6,335,860,508	27,407,629,475
HCBS state plan	42,909,624	64,079,589	63,927,565	108,868,669	114,193,068	393,978,515
Hospital Subsidies	192,443,637	266,607,552	266,000,000	266,000,000	266,000,000	1,257,051,189
CNOMS	28,436,196	26,544,406	15,000,000	15,000,000	15,000,000	99,980,602
	\$ 5,874,773,614	\$ 7,993,703,765	\$ 8,713,300,215	\$ 9,189,669,431	\$ 9,648,793,534	\$ 41,420,240,558
Difference	385,076,579	899,156,648	765,061,334	949,345,314	1,162,894,063	4,161,533,938
Notes:						
1. Federal share is calculated using Composite Federal Share Ratios (source data is CMS 64 Schedule C as reported in QE Sept 2014 with a run date of Jan 30, 2015).						
2. "With Waiver" expenditures from CMS 64 Schedule C as reported in QE Sept 2014 with a run date of Jan 30, 2014						
3. Member-months are reported from MMS with last actual reported as of December 2014.						
4. "With Waiver" pmpm's calculated using Sch C expenditures and MMS eligibility actual member-months reported through September 2014 as reported in December 2014.						
5. CNOMS (costs not otherwise matchable) include Severe Emotionally Disturbed children (SED at risk) and MATI population						
FEDERAL SHARE						
	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
NO WAIVER						
Title XIX	947,810,913	1,511,489,729	1,654,838,290	1,807,258,019	1,962,696,216	7,884,093,166
ABD	1,182,578,863	1,712,826,354	1,793,756,464	1,890,844,053	1,994,785,859	8,574,791,593
LTC	994,456,801	1,368,950,828	1,359,658,443	1,437,461,312	1,520,918,120	6,681,445,504
HCBS state plan	15,580,580	22,929,269	25,926,499	44,424,574	46,906,816	155,767,738
	\$ 3,140,427,156	\$ 4,616,196,179	\$ 4,834,179,697	\$ 5,179,987,958	\$ 5,525,307,011	\$ 23,296,098,001
	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
WITH WAIVER						
Title XIX	830,820,462	1,288,036,988	1,367,850,990	1,454,531,521	1,538,018,966	6,479,258,927
ABD/LTC	1,983,889,302	2,674,565,224	2,895,943,734	3,035,175,770	3,183,615,945	13,773,189,975
HCBS state plan	21,793,107	33,050,355	32,835,326	55,787,485	58,515,862	201,982,135
Hospital Subsidies	96,221,820	133,303,778	133,000,000	133,000,000	133,000,000	628,525,598
CNOMS	14,725,860	13,803,090	7,799,999	7,574,999	7,500,000	51,403,949
	\$ 2,947,450,551	\$ 4,142,759,435	\$ 4,437,430,049	\$ 4,686,069,776	\$ 4,920,650,773	\$ 21,134,360,584
Difference	192,976,605	473,436,744	396,749,647	493,918,182	604,656,238	2,161,737,417

Superstorm Sandy Federal Funding

2. New Jersey received temporary supplemental funding under the federal Social Services Block Grant (SSBG) in order to provide enhanced social services to those affected by Superstorm Sandy. This funding expires by September 30, 2015, which will result in the reduction or termination of some contracts that were supported with this funding. In response to a discussion point, the department provided the following table displaying the allocation of the portion of this funding to be administered by DHS:

<u>Program Area</u>	<u>Original Allocation</u>	<u>Current Allocation</u>	<u>Current Expenditures</u>
Housing Assistance	\$112,434,000	\$103,608,000	\$17,035,543
Behavioral Health Services	\$ 8,100,000	\$ 18,000,000	\$ 1,954,152
Child Care	\$ 2,750,000	\$ 2,750,000	\$ 15,572
Services for Older Adults and People with Disabilities	\$ 549,692	\$ 417,692	\$ 117,692
Legal Assistance for Storm Impacted Residents	\$ 6,500,000	\$ 6,500,000	\$ 132,698
Administration	\$ 5,542,764	\$ 12,323,948	\$ 206,500

- **Question:** Please provide an updated table showing expenditures to date and expected final allocations and expenditures. What areas, if any, will the State continue to provide State-funded support when the federal supplemental funding is no longer available?

Answer: The updated table is below. The State will continue to provide funding to the Supportive Housing program as it has prior to Superstorm Sandy.

<u>Program Area</u>	<u>Original Allocation</u>	<u>Current Allocation</u>	<u>Current Expenditures (as of 2/28/15)</u>
Housing Assistance	112,434,000	154,659,444	117,198,688
Behavioral Health Services	8,100,000	15,000,000	7,833,160
Child Care	2,750,000	750,000	609,617
Services for Older Adults and People with Disabilities	549,692	417,692	154,762
Legal Assistance for Storm Impacted Residents	6,500,000	2,000,000	1,594,967
Administration	5,542,764	7,113,877	3,430,138

Contract Oversight

3. A study released by Rutgers University, Department of Labor Studies and Employment Relations in March 2014 entitled *Overlooking Oversight*³ reported several problems with the State's procedures for contracting with private vendors. The report's major general findings are the following:

- Oversight costs are typically not incorporated into contracts or the decision to contract, resulting in insufficient allocation of resources to oversight and, in some cases, the contracting out of services that could be more efficiently provided in-house. (The report notes that DHS contracts include the \$30,000 to \$80,000 cost of a CPA audit, though this addresses only the financial integrity of the vendors, not the specific contracts, nor vendors' performance under them.)
- Contracts do not contain adequate performance requirements and standards, resulting in poor quality service provided to consumers. (The report cites the Division of Mental Health Services as a notable exception to this general finding, in that it had "clear, outcome-based performance measures in contracts combined with a comprehensive system of oversight.")
- A decline in the number of experienced contract managers and inadequate training and qualification of remaining contract managers, along with insufficient on-the-ground oversight capacity, generally as a result of attrition of experienced employees over time, results in an inability to effectively monitor vendors. (The report specifically notes declines in staff at the Office of Information Systems, from 82 in 2003 to 54 in 2012; and the Office of Auditing, from 60 staff 12 years ago to 30 staff currently.)
- **Questions:** Is the report accurate in its claim that the department requires all (or nearly all) private contractors to undergo a CPA audit, funded directly or indirectly by the State? What is the effect of the dramatic reduction in staff at the Office of Information Systems and the Office of Auditing? Please describe any other fiscal and performance oversight processes that are employed for all DHS contracts. Please also describe other fiscal and performance oversight processes employed by the contracting offices of each major division of DHS.

Answer: The Department has taken a variety of steps over the past several years to enhance contract oversight. During the contract period, the Department's Contract Reimbursement Manual and Contract Policy and Information Manual both stipulate multiple controls and oversight processes for each contract, including quarterly expenditures reports, service utilization review, and compliance with all other service qualifications that are monitored by other State or Departmental units, such as licensing. The contracting manuals also detail oversight through internal controls, as well as requirements for disbursements and for payroll.

With respect to audits, all third-party providers that receive at least \$100,000 in funding are required to have an organization wide financial audit conducted by an independent auditor in accordance with federal and State OMB circulars. These audits are subject to a detailed desk review by the Office of Auditing to ensure compliance with federal, State and professional accounting standards, as well as including a thorough financial assessment of the agency's ability to continue doing business with the Department. The cost of these audits is an allowable contract expense.

³ Available online at <http://smlr.rutgers.edu/news-events/new-study-review-of-njs-oversight-of-third-party-contractors>

In addition to these mandated organization wide audits, Divisions have the ability to request auditing services through the Department's audit plan process to provide additional oversight and monitoring of contracts. Audit plan requests are further prioritized through the use of an internally-developed risk assessment model, in conjunction with the Risk Indicator Report used by the Office of Program Integrity and Accountability to report performance data on contracts administered by the Division of Developmental Disabilities, including data on licensing, auditing, investigations and critical incident reporting. In 2015, the Office of Auditing has allocated approximately 50% of total audit plan hours to support DHS in monitoring and oversight of third-party contracts. Additionally, the State has a Treasury-administered contract that is used to secure specific audit and contract monitoring services as required.

Division of Mental Health and Addiction Services (DMHAS)

Utilization of Services

4. Budget evaluation data on page D-169 of the Governor’s FY 2016 Budget Recommendation indicate that DMHAS provides community mental health services to approximately 325,000 clients per year. However, this appears to be a simple sum of the number of clients served by each category of community service listed on pages D-169 to D-170, and thus appears to exclude individuals receiving services funded in the Addiction Services program class, and may double-count individuals who receive multiple types of mental health service. Budget evaluation data on page D-171 do not report the unduplicated number of clients receiving services in the Addiction Services program class, or the unduplicated number of clients receiving services funded by DMHAS (including both the Community Services and Addiction Services program classes).

- **Questions:** How many unique clients receive services funded by DMHAS? Of these, how many receive (1) exclusively mental health services, (2) exclusively addiction services, or (3) both mental health and addiction services simultaneously? (If possible, please provide FY 2014 actual, FY 2015 revised, and FY 2016 estimated values.)

Answer: During SFY14, the number of clients served was as follows:

- 1) 347,245 exclusive mental health clients (*inclusive of clients served in State/county hospitals and other inpatient settings not included in our Evaluation Data*).
- 2) 83,709 addiction clients of which 12.6% of these clients also received mental health services while in treatment

The projected amounts for FY15 and FY16 (*similarly including counts for State and county hospitals, and other inpatient settings*) are as follows:

Client Need	FY15	FY16 (projected)
Mental Health	351,467	354,879
Addictions	84,090	84,563

5. Budget evaluation data on page D-171 of the Governor’s FY 2016 Budget Recommendation indicate a declining trend in the number of admissions in nearly every category of substance use disorder treatment. The only admissions categories showing an increase from FY 2014 to FY 2016 are *adult outpatient admissions* and *juvenile residential detoxification admissions*. The OLS notes that the decline from FY 2013 to FY 2014 may partly be attributable to the shift of services for children from DHS to the Department of Children and Families.

- **Questions:** What explains the ongoing downward trend in the number of admissions to addiction treatment from FY 2014 to FY 2016? To what extent might the system be operating below its capacity?

Answer: The published Evaluation Data only included admissions for “Drug treatment - primary alcohol” and “Drug treatment – primary other drugs.” there is no line for “Total Substance Abuse Admissions.” In gathering the data for the Governor’s Budget Book, we therefore *excluded* admissions where the drug referenced was either “unknown” or “missing.”

Since there has been an increase in the number of admissions in these categories (which will be addressed with providers and additional controls in our IT system), this led to the perceived drop in reported admissions in Evaluation Data. However, if we include these categories, which were

added to the “other drugs” line, *total* admissions for alcohol and primary drugs, including all the “unknown” and “missing” admissions would be:

	FY 15 (projected)	FY 16 (projected)
FY 14	66,904	67,438
	67,438	68,101

Shift of Services to Medicaid/NJ FamilyCare

6. The expansion of eligibility for Medicaid/NJ FamilyCare under the Affordable Care Act (ACA), which became effective on January 1, 2014, allows childless adults earning up to 138 percent of the federal poverty level to enroll in Medicaid/NJ FamilyCare, which would provide covered services instead of DMHAS. For those individuals who would otherwise be receiving State-funded services through DMHAS, the State can shift expenses for their care entirely to the federal government (until 2017, when the federal matching rate begins to phase down), reducing State expenditures or freeing State funds to provide services to other individuals.

The FY 2015 Appropriations Act reflected a shift of \$6.9 million to Medicaid/NJ FamilyCare for *mental health services* relative to FY 2014 in the Community Care line item. The Governor’s FY 2016 Budget Recommendation assumes an additional \$17.148 million in savings for *mental health services* in FY 2016 (attributed by the Executive to a combination of a shift to federal funds and unspecified “trend”). However, no comparable savings for *addiction services* resulting from the ACA are included in the Governor’s FY 2016 Budget Recommendation.

- **Questions:** To date, how have the overall size and characteristics of the DMHAS client base changed as a result of the Medicaid/NJ FamilyCare expansion under the Affordable Care Act? How much has DMHAS saved (or reinvested in other clients) in FY 2014, FY 2015, and FY 2016 as a result of the Medicaid/NJ FamilyCare expansion? Of this, what portion is federally funded, and what portion remains a State expense that has shifted to the Division of Medical Assistance and Health Services? Why have savings manifested only in relation to mental health services, and not addiction services?

Answer: Medicaid Expansion has had an impact on the entire DMHAS client base: Mental Health – Data for 3rd and 4th quarter of CY14 are still being collected; however, DMHAS was able to compare the first six months of CY 13 against the first six months of CY14. During that time period the Division experienced a 6% increase in clients where Medicaid was the reimbursement source (35.4% to 41.8%). It’s important to note that since this data is from the initial six months of expansion, in which enrollment was just ramping up, we expect this number to continue to rise and then stabilize as the Medicaid Expansion matures.

Addictions – Based on data for CY 14 by income level, there were approximately 45,000 addictions clients who fall equal to or below 133% of the Federal Poverty Level of which 13,000 were enrolled so it appears that an additional 32,000 are eligible yet not enrolled (although it is probably overstated due to some being undocumented).

Savings in behavioral health services for FY14 have not been quantified given that expansion only began in the latter half of that year and savings were difficult to realize due to the limited time available to notify providers of reductions in their contracts. In FY15, a budget reduction of \$6.9 million was taken in DMHAS, reflecting expected reduced State costs due to clients shifting to Medicaid coverage. This was partially offset in DMAHS by increased State share of costs related to “Woodwork” clients previously eligible of about \$1.2 million. DMHAS expects to

achieve these savings through contractual reductions in FY15. Based on a review of Alternative Benefit Plan claims in early FY15, it was determined that an additional reduction to State appropriations of \$6.5 million could be expected in FY16.

Although the appropriation reductions have been effected in the Mental Health Community Care account, savings in actuality are realizable in addictions services as well. DHS expects that with additional data received during the maturation of Medicaid Expansion and further experience in analyzing the impact in FY15/16, as well as an expected increase in Medicaid rates for addiction services (that will drive more clients to Medicaid), we will be able to more clearly identify savings in the individual service lines. We would then make adjustments to appropriation line items accordingly.

Please note that \$11.5 million of the total \$17 million reduction is related to anticipated federal match on psychiatric emergency services as a result of the recent State Plan Amendment (SPA) approval. This is appropriately recorded as a reduction to the mental health Community Care appropriation.

7. New Jersey provides a slightly different package of benefits, called the Alternative Benefit Plan, to individuals who are newly eligible for Medicaid/NJ FamilyCare under the ACA. Most notably, the Alternative Benefit Package provides coverage for certain mental health and addiction treatment services that the standard Medicaid/NJ FamilyCare benefit package does not include, but which must be covered for recipients who are newly eligible under the ACA.

A language provision newly added to the FY 2015 Appropriations Act and also recommended for FY 2016 (page D-180) would authorize the Commissioner of Human Services to expand services in the Alternative Benefit Plan to other Medicaid/NJ FamilyCare populations. This may allow some services previously provided through DMHAS at entirely State expense to be provided through Medicaid/NJ FamilyCare, and thereby become eligible for a 50 percent federal match. As of March 2015, the OLS is not aware of any Alternative Benefit Plan services being made newly available to the general Medicaid/NJ FamilyCare population.

- **Questions:** Is the department still contemplating expanding any Alternative Benefit Plan services to other Medicaid/NJ FamilyCare populations? If all current Alternative Benefit Plan services were made available to all Medicaid/NJ FamilyCare recipients, what would be the total fiscal impact to the State?

Answer: Yes, the department is still considering expanding the Alternative Benefit Plan (ABP) services to other Medicaid/NJ FamilyCare populations. The fiscal impact is being analyzed by DHS and consists of two factors:

- 1) State savings realized by permitting some services previously paid for with 100% state funding to receive a 50% federal match, and
- 2) Costs associated with the ABP “true-up” by creating an additional Medicaid entitlement would likely result in a “woodwork” effect as more individuals would receive these services. We are proceeding to increase certain Medicaid addiction rates that fall under the ABP as part of the Rutgers University Behavioral Health Care initiative (see next question). However, we will not proceed with the full “true-up” until the analysis of the two factors above is completed.

Addiction Services

8. The Governor’s FY 2016 Budget Recommendation includes approximately \$4 million (\$2.3 million from the State General Fund and \$1.7 million in federal Medicaid funds) for a program to be

operated by Rutgers University Behavioral Health Care to coordinate and administer certain aspects of the State's addiction treatment system. This program will also operate a new phone line that would provide a "no wrong door" resource for individuals who have a substance use disorder or their families, connecting them to the various federal, State, and local government programs and partners, and providing better coordination of addiction services Statewide. At least one media report⁴ indicates that the program will have an automated, real-time system showing what treatment beds are available and where, which could dramatically simplify the notoriously difficult process of finding available treatment.

- **Questions:** Please describe the functions that Rutgers University Behavioral Health Care will perform under the contract. Will it play an active role in managing patients, or will its role be limited to directing callers to available resources? Has the State developed a system for identifying available treatment beds on a real-time basis?

Answer: UBHC, as the Interim Managing Entity (IME), will be responsible for maintaining a call center for individual and provider inquiries related to government assistance in accessing treatment. The IME will play an active role in managing consumers by screening for client financial and clinical eligibility for services, provide utilization management based on clinical need, and care coordination to improve client access to care. Using information supplied by DMHAS and NJ FamilyCare, UBHC will develop, implement and maintain a bed management system specific to addiction services. The system will be used to track treatment capacity and allow UBHC to make targeted referrals.

9. It is widely believed that the State lacks sufficient treatment capacity for substance use disorders to provide treatment to all those in the State seeking it, particularly beds in residential treatment facilities. The last time the DHS conducted a formal assessment of met and unmet demand (in 2010, when the current opioid epidemic was in its infancy), the department estimated that 37 percent of people seeking treatment did not receive it.⁵ Governor Christie has publicly acknowledged this problem, but has resisted a significant increase in State funding for new facilities. The Governor has emphasized that the mandate for treatment from the State's expanded drug court program, as well as better insurance coverage through Medicaid/NJ FamilyCare and private health insurance, will help to attract private capital to expand these services.⁶

- **Questions:** Please provide a history of the licensed capacity for (1) residential and (2) outpatient substance use disorder treatment slots in the State since 2010. How efficiently has this capacity been used – i.e., what proportion of State-funded beds are unfilled at any given time? Does the department consider the shortage of inpatient treatment capacity to be more critical than the shortage of outpatient treatment capacity? To what extent, if any, has there been an increase in private capital investment in addiction treatment facilities in the past several years?

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http://www.nj.com/healthfit/index.ssf/2015/03/substance_abuse_hotline_proposed_by_christie_to_launch_july_1.html

⁵ http://nj.gov/humanservices/dmhas/publications/need/Tx_Demand_2010.pdf

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http://www.nj.com/politics/index.ssf/2014/12/christie_government_private_sector_need_to_step_up_fight_against_heroin_in_nj.html

Answer: The chart below represents data for FY10-14 for contracted DMHAS slots and how efficiently those slots are being used.

SERVICE	FY10		FY11		FY12		FY 13		FY 14	
	Slots	Annualized Utilization								
Outpatient Psycho-Social	1751	100%	1725	97%	1725	93%	1449	85%	1457	106%
Intensive Outpatient	655	86%	699	107%	699	108%	659	98%	532	105%
Halfway House	106	97%	104	100%	106	99%	101	99%	99	103%
Residential Short-Term	50	94%	50	93%	50	93%	50	100%	41	106%
Residential Long-Term	895	86%	847	91%	876	83%	823	78%	542	100%
Methadone Maintenance	4121	103%	4121	102%	4165	100%	3955	102%	3954	103%
Methadone Intensive Outpatient	195	101%	195	98%	195	103%	190	102%	190	110%
Methadone Residential	20	98%	20	98%	20	93%	18	95%	18	100%

Outpatient and residential treatment are equally important. DMHAS will be launching an Interim Managing Entity (IME), operated by Rutgers University Behavioral Health Care (UBHC), to manage all the services above on 7/1/15. The management will be launched in phases but the goal is to better utilize our current resources by ensuring consumers are in the appropriate level of care and for their clinical need and for the appropriate duration.

DMHAS has been working with providers to stand up additional outpatient and residential programs. These ventures will include both public and provider funding sources. For example, one provider in Pittsgrove, NJ is building a facility for outpatient and residential programs that is close to completion. Both the provider and DMHAS have contributed funding. In addition, AOC has invested in residential capacity to support Drug Court expansion. See the response to the question below regarding Drug Court for more information.

Please note that the reduction in slots in certain line items above reflects a combination of factors: A) Contracts were moved over to DCF and b) Federal sequestration in the Substance Abuse Block Grant resulted in decreased resources and, consequently, a reduction in capacity. With respect to the former, as an example, DMHAS lost approximately 275 Residential slots to DCF due to the contract transfer. With respect to the latter, the reduction in capacity did not have any adverse effects on utilization/access to needed services.

10. Because of the difficulty that many individuals have in accessing treatment for a substance use disorder, it is sometimes suggested that the best way to ensure access to treatment is for the person to commit a crime and hope that they will be admitted to State-funded treatment through a drug court. Although the Governor's FY 2016 Budget Recommendation includes \$38.858 million in funding for Drug Court Treatment/Aftercare through the Judiciary (page D-442), this funding would be transferred to DMHAS, which contracts with providers for treatment services. These contracts differentiate drug court

beds from other public beds, but it is not clear how much flexibility the providers have to admit patients to different types of bed when a bed is not filled.

- **Questions:** Please describe the system by which DHS directs substance use disorder treatment providers to prioritize the admission of new patients. Of all DMHAS-funded substance use disorder treatment beds, how many are reserved for drug court participants? If drug court beds are not filled, are providers permitted to admit other public patients to those beds? Are providers that are filled to capacity required to accommodate drug court participants at the expense of other publicly funded patients, either by discharging other patients or allowing the drug court participant to skip to the head of a waiting list? When drug court participants graduate from their treatment, do they receive any ongoing State-subsidized treatment?

Answer: Referral of Drug Court (DC) participants are done directly by the local Drug Court staff to the approved provider. DMHAS is not actively involved in facilitating referrals.

There are a total of 570 licensed short term residential beds of which 26 or 5% are dedicated, exclusively for DC.

There are 1,105 long term residential beds at present, 280 of which are dedicated for DC; either contracted or exclusively held for fee for service beds. This represents 25% of the present bed capacity. There are currently 45 LTR beds being developed with DC funds and will be exclusive to DC. These beds are not yet licensed and consequently are not included in the aforementioned count of 1,105.

There are 721 currently licensed halfway house (HWH) beds of which 102 or 14% are dedicated to DC. There are presently 107 HWH beds currently being developed with DC funding and will be exclusive to DC. The 107 beds are not yet licensed; consequently, they are not included in the aforementioned count of 721.

In instances where a vacant bed dedicated exclusively for DC is not filled, the provider cannot accept a non-DC referral unless they have permission from the DMHAS to do so. However, this has not been an issue in the recent past because utilization of these beds, with only a couple of exceptions, is maintained at a 95-100% occupancy rate.

DC does use other available fee for service (FFS) beds on a first come first serve basis; that is they compete for those beds with other funding sources. The providers of the beds are not required to accommodate DC, hold beds vacant for a DC referral or jump an existing waiting list. However, DC assertively seeks access to non-dedicated FFS vacant beds for their participants. This leads to their ability to capture additional open FFS beds in the STR, LTR and HWH levels of service. Although the actual number of FFS beds filled with DC participants varies at any given time, when dedicated and free FFS beds are combined, DC has approximately 7% of the STR, 36% of the LTR and 51% of the HWH beds.

When DC participants graduate from DC, they have completed all of their treatment. It is possible that after graduation a former participant might relapse and require additional treatment using other state funding sources.

11. In addition to funding programs that provide treatment to individuals with *current* addictions, DMHAS also supports *primary prevention* programs intended to prevent substance use disorders before they begin. The Governor's FY 2016 Budget Recommendation does not distinguish between these two different functions. These programs are primarily funded through federal Substance Abuse Block Grant funds, General Fund appropriations, and the Alcohol Education, Rehabilitation and Enforcement Fund. (Except for certain diversions from the fund authorized through appropriations language in prior fiscal

years, spending from the Alcohol Education, Rehabilitation and Enforcement Fund does not appear in the Governor's FY 2016 Budget Recommendation⁷ or appropriations acts.)

- **Questions:** Please provide a breakdown of the division's total budget in FY 2014, FY 2015, and FY 2016 for the Addiction Services program class, separating primary prevention programs from treatment programs. Please also provide a breakdown of these totals by funding source (i.e. State, federal, and other funds).

Answer: The breakdown of prevention and treatment programs by funding source for FY14, FY15, and FY16 is as follows:

FY 2014 (000's)				
	State	Federal	Other	Total
Total Appropriations	\$34.861	\$42.361	\$12.994	\$90.216
Prevention	\$0.650	\$13.765	\$0.270	\$14.685
% Prevention	1.86%	32.50%	2.08%	16.28%

FY 2015 (000's)				
	State	Federal	Other	Total
Total Appropriations	\$32.912	\$47.954	\$13.750	\$94.616
Prevention	\$0.650	\$12.343	\$1.320	\$14.313
% Prevention	1.97%	25.74%	9.60%	15.13%

FY 2016 (000's)				
	State	Federal	Other	Total
Total Appropriations	\$36.826	\$55.856	\$12.149	\$104.831
Prevention	\$0.650	\$12.343	\$1.320	\$14.313
% Prevention	1.77%	22.10%	10.86%	13.65%

Please note that the amounts above exclude treatment and prevention dollars that were appropriated outside of the Division of Mental Health and Addiction Services, e.g., Drug Court appropriations in Judiciary and Mutual Agreement Parolee (MAP) appropriations in the Department of Corrections/State Parole Board. Also, please note that the overall percentage of prevention dollars shows a decline in FY16 due mainly to the return of \$7.9 million of federal Substance Abuse Block Grant (SABG) funds to DMHAS from the Department of Children and Families.

Community Mental Health Services

12. The Governor's FY 2016 Budget Recommendation includes \$6.7 million for the involuntary outpatient commitment program, embedded within the Community Care line item on page D-172. This

⁷ A summary of the Alcohol Education, Rehabilitation and Enforcement Fund is available online at http://www.nj.gov/treasury/omb/publications/16budget/pdf/Supplementary_Information.pdf.

represents an increase of nearly \$1 million over the total available funds in FY 2015 (\$3.35 million embedded in the line item, plus a \$2.4 million appropriated from the prior fiscal year pursuant to appropriations language). The involuntary outpatient commitment program, established pursuant to P.L.2009, c.112, provides for mandatory mental health care services (such as day treatment services, counseling, psychotherapy, and medication treatment) provided on an outpatient basis to individuals who may otherwise be committed to inpatient treatment in a psychiatric hospital. The program expanded during FY 2015 to include an additional 15 counties, so that the program is now operational in all 21 counties. In response to FY 2015 OLS discussion point #8b, the original six counties' programs served the following numbers of individuals between July and December 2013:

<u>County</u>	<u>Individuals Served</u>
Burlington	22
Essex	43
Hudson	38
Ocean	17
Union	73
Warren	16

- Questions:** On what dates did the involuntary outpatient commitment programs become operational in the remaining 15 counties? How many individuals have been served in each county in FY 2015? How many treatment slots are reserved for involuntarily committed patients in each county, and at what cost, in FY 2016? If beds are not filled, are providers permitted to admit other public patients to those beds?

Answer: Currently, 17 of the 21 counties have Involuntary Outpatient Commitment (IOC) programs. The four counties that do not have IOC (Sussex, Monmouth, Morris, and Middlesex) are being RFP'd and will be operational during FY 2016. The chart below represents each of the counties that do have IOC programs, the number of individuals served, and the number of slots reserved for each county:

Involuntary Outpatient Commitment program development (e.g. building up a caseload) has been delayed by recruitment of psychiatrist staff, with multiple agencies having difficulty in this area, and by low referral numbers from key referring entities (e.g. Designated Screening Services, Short Term Care Facility). Similar trends were observed in previous rounds of IOC development.

The IOC "slots" are reserved for persons who meet the legal and clinical criteria and cannot be offered to other public customers.

County	PROVIDER AGENCY	Operational Date	FY15 YTD (7/1/14 - 3/31/15) *	Annualized Contract Ceiling	Capacity Caseload Target
Atlantic	Legacy Treatment Services	December, 2014	5	\$300,000	40
Bergen	Care Plus NJ	October, 2014	4	\$300,000	25
Burlington	Legacy Treatment Services	August, 2012	37	\$287,607	40

Camden	Twin Oaks Community Services	October, 2014	9	\$300,000	25
Cape May	Cape Counseling	October, 2014	3	\$287,362	30
Cumberland	New Point Behavioral Health (One Program Serving 3 Counties)	March, 2015	N/A	See Gloucester entry	Subsumed in Gloucester Figure
Essex	Mental Health Association of Essex County, Inc.	August, 2012	60	\$465,055	65
Gloucester	New Point Behavioral Health (One Program Serving 3 Counties)	March, 2015	N/A	\$900,000	72
Hudson	Jersey City Medical Center	August, 2012	68	\$270,288	75
Hunterdon	Hunterdon Medical Center Behavioral Health	October, 2014	2	\$300,000	25
Mercer	Greater Trenton Behavioral Healthcare	October, 2014	16	\$300,000	50
Ocean	Ocean Mental Health Service	February, 2013	67	\$351,270	75
Passaic	Mental Health Association of Passaic County	December, 2014	6	\$300,000	30
Salem	New Point Behavioral Health (One Program Serving 3 Counties)	March, 2015	N/A	See Gloucester entry	Subsumed in Gloucester Figure
Somerset	Richard Hall Community Mental Health Center of Somerset County	December, 2014	12	\$300,000	30
Union	Trinitas Hospital	August, 2012	87	\$534,992	100
Warren	Family Guidance Center of Warren County	August, 2012	28	\$293,935	35
TOTALS			404		717

** Please note that programs in Cumberland, Gloucester and Salem counties just started in March and are expected to begin ramping up client levels in fourth quarter of SFY15. Middlesex, Monmouth, Morris and Sussex will begin in SFY16.*

13. Individuals with a dual diagnosis of a developmental disability and mental illness present distinctive challenges for their caregivers and the health care system. Currently, the department contracts with only one general hospital in the State (Trinitas Hospital in Elizabeth) to provide acute specialized beds specifically for individuals with a dual diagnosis. Anecdotal reports suggest that other general hospitals are ill-equipped to treat patients with a dual diagnosis who are in crisis. Recent media reports⁸ have highlighted cases in which individuals have been admitted to Ancora Psychiatric Hospital, a long-term care facility owned and operated by the State, because no other facility in South Jersey is equipped to handle patients with a dual diagnosis.

- **Questions:** How does the DHS view the needs and adequacy of health care and behavioral health resources for individuals with a dual diagnosis? What differentiates Trinitas from other general hospitals with psychiatric screening centers? Is there a need for such services in other geographical areas of the State?

⁸ E.g., <http://www.courierpostonline.com/story/news/local/south-jersey/2015/02/13/despite-calls-change-little-done-mental-health/23367043/>

Answer: The ten (10) bed DD/MI closed acute care inpatient unit at Trinitas was specifically created to treat the DD/MI consumers in the community that needed inpatient care. However, it is important to note that the department does not contract with Trinitas for these beds. They are licensed by DoH and funding is provided by Medicaid and/or private insurance. The staff on this unit are trained to evaluate and treat the consumers' developmental disability needs and their mental health needs. The number of admissions in CY' 14 was two hundred and seventy-nine (279) consumers. This is the only such unit in the State that is treating DD/MI consumers in a DD/MI inpatient setting in a community hospital. This DD/MI unit provides the same clinical level of care as a Short Term Care Facility (STCF), however, it is not a designated STCF and does not receive the additional per bed annual funding provided to STCF's.

Trinitas currently has contracts with both DDD and DMHAS for the Statewide Clinical Consultation and Training (SCCAT) program. This program has staff available 24/7 to consult with DMHAS contracted Psychiatric Screening Programs, emergency rooms, providers of services to the DD population and other constituents regarding the behavioral and support needs of individuals with developmental disabilities who may be in crisis. The goal of this service is to address and resolve crises in an effort to reduce the risk of hospitalization. During recent fiscal years, DMHAS has partnered with DDD to develop specialized supportive housing to serve the DD/MI population, specifically individuals who are transitioning from a state psychiatric hospital. As an integral part of the Olmstead initiative, DMHAS and DDD have also worked closely to streamline and monitor processes to make sure that discharged clients receive appropriate services. Where funding permits, the addition of specialized supportive housing for the DD/MI population would improve the Department's ability to assertively transition individuals from state psychiatric hospitals when this level of care is no longer needed and concomitantly reducing the reliance on costly inpatient admissions with the supports and services availed to this cohort in the stated housing programs.

14. The 16-bed psychiatric unit at St. Luke's Warren Hospital, the only inpatient psychiatric unit in Warren County, stopped admitting patients on December 1, 2014. Shortly thereafter, DMHAS released an RFP advertising \$400,000 in grants for outpatient mental health care services in Warren County.

- **Questions:** Was the \$400,000 in grant funds originally intended for Warren County, or was it diverted from another project in response to the closure of the psychiatric unit at St. Luke's? How will the closure of the psychiatric unit at St. Luke's and the State-funded expansion of outpatient services affect overall availability of acute psychiatric care in Warren County?

Answer: An RFP for Outpatient Services, in Warren County, was issued to both assist the County with wait times for outpatient services as well as the loss of the voluntary beds operated by St. Luke's. DMHAS worked very closely with the Department of Health (DoH) in approving the Certificate of Need (CN) to close the beds. The utilization for those beds was low, which, ultimately, was a major factor in the decision to approve the CN and the request to close the beds. In approving this CN, there were a number of conditions that were placed on it in order to ensure a smooth transition to close the beds. DMHAS was very involved in developing and approving them.

The \$400,000 for expanded outpatient services was funded by DMHAS within existing resources. The RFP was awarded to Family Guidance Center of Warren County and the funding allowed the agency to cut its waiting list in half. The DMHAS's rationale for issuing this RFP was that if clients have access to outpatient services including medication and therapy, it could potentially reduce, even further, the number of people seeking a voluntary bed.

The DMHAS continues to work with Warren County to address their behavioral health challenges.

15. Press reports⁹ indicate that the department has threatened to withhold funding to several community mental health agencies that have contracted with the State to develop 430 community placements for individuals being discharged from State psychiatric hospitals, because it appeared that these agencies would not meet a March 16 deadline for the placements to be available (though the department offered extensions to May 1 if agencies could show good cause). Historically, the State has generally not taken a punitive approach to community mental health agencies' struggles to meet deadlines.

- **Questions:** Of the 430 planned placements, how many are expected to be incomplete by the May 1 extended deadline? How much money is being withheld from the agencies for failure to meet the deadline? Will the department make funds available when the placements become available?

Answer: The quote from the press did not accurately reflect the content of DMHAS correspondence to housing providers dated 2/9/15. The 430 number reflects the approximate number of individuals on Conditional Extension Pending Placement (CEPP) status at the time the letter was issued. This number was provided to the press by DHS at the time in response to its inquiry regarding the number of CEPP designees at the state hospitals. The 2/9/15 letter specifically referenced individuals at the state psychiatric hospitals who were deemed ready for discharge, either by CEPP designation or by clinical determination of the treatment teams, and who were referred to and accepted by a housing provider for services. On 2/9/15 this represented 211 individuals. As of 3/31/15, 115 of this cohort were discharged to the care of the respective housing provider. Another 32 individuals had their referrals pulled by the treatment teams due to a change in the individuals' clinical condition or a determination that another level of care was required. The remaining 64 individuals continue to work on their discharge plan with their treatment teams and assigned housing providers. The 2/9/15 correspondence to the housing providers concluded by stating if the individuals referred to the program vacancies were not admitted by 5/1/15, DMHAS may take one-time contract reductions, annualized reductions in the contract or a rebidding of the service depending on the volume of the unused service slots. The amount withheld from a particular contract would, as indicated, be contingent upon the volume of the unused service slots. If funds were removed during the current fiscal year, DMHAS could elect to restore the contract to its original funding level as the provider meets its contract obligations. Note that any contract reductions would only occur after discussions, negotiations and agency corrective action planning did not result in remediation of a specific agency's contract deficiencies.

Psychiatric Hospitals

16. At the end of State FY 2014, Camden County sold the Camden County Health Services Center to Ocean Healthcare, generating approximately \$37 million for the county and saving the future costs of operating the facility. Camden County had originally intended to lease back the 150-bed psychiatric unit and continue to operate it. However, the leaseback arrangement was terminated,¹⁰ and the beds are no longer operated as public beds for individuals involuntarily committed for inpatient psychiatric treatment.

⁹

http://www.nj.com/politics/index.ssf/2015/03/njs_deadline_for_releasing_psych_patients_draws_controversy.html#i_ncart_river

¹⁰ <http://www.newsworks.org/index.php/local/item/64393-camden-county-plan-to-lease-psychiatric-unit-dissolves-worrying-advocates-for-mentally-ill>

Consequently, the State's contribution of \$24.3 million to the hospital has been eliminated (reflected as a decrease in the FY 2015 adjusted appropriation for Support of Patients in County Psychiatric Hospitals on page D-173, compared to the original FY 2015 appropriation of \$129.8 million). Subsequently, the department transferred this \$24.3 million to the Community Care line item, and awarded 125 involuntary inpatient beds to replace the beds at Camden County Health Services Center (105 beds at Elmwood Hills Healthcare Center and 20 beds at Carrier Clinic).¹¹

- **Questions:** How has the termination of the county-operated psychiatric services at Camden County Health Sciences Center affected the general availability of psychiatric services in Camden and surrounding counties? Does the department plan to replace any of the remaining 25 beds that have not yet been replaced, or expand outpatient services as an alternative?

Answer: The termination of the county-operated psychiatric services in Camden County has had a minimal effect on the availability of psychiatric services in Camden County and the surrounding counties. As noted, 105 beds are provided by Elmwood Hills Healthcare Center, and these are located at the same site where Camden County Health Services Center operated. Additionally, Carrier Clinic was awarded 20 beds. The admissions and discharges for these facilities since their start of operations are as follows:

Elmwood Hills Healthcare Center (aka Northbrook) (105 beds) 5/2014 – 2/2015

562 admissions

620 discharges

Carrier (20 beds) 5/2014- 2/2015

294 admissions

279 discharges

Currently there is no plan to replace the remaining 25 beds that have not been replaced. In March of 2014, DMHAS was able to expand outpatient services in Camden County. By repurposing a surplus in the existing budget of the contract that DMHAS has with South Jersey Behavioral Health Services, they are able to serve additional individuals in need of outpatient services. As a result, an additional 1,204 individuals will be able to receive medication monitoring outpatient services on an annualized basis. DMHAS also funds involuntary Outpatient Commitment Services, Intensive Outpatient Treatment and Support Services, and Early Intervention and Support Services in Camden County. These services are offered to individuals to assist them in their mental health treatment and recovery.

17. In 2014, Union County finalized the sale of Runnells Specialized Hospital to Center Management Group for \$26 million.¹² The county estimated that the sale would save \$50 million over the following five years. Union County now leases the hospital's 44-bed Cornerstone Psychiatric Unit, at a cost of approximately \$4 million per year.¹³ According to press reports, most of the hospital's staff were guaranteed job offers from the new operator, and the psychiatric unit's 80 employees remain county

¹¹ http://www.state.nj.us/humanservices/dmhs/info/notices/RFP%20awards/Alternative_IP_beds_Apr16_2014.pdf

¹²

http://www.nj.com/union/index.ssf/2014/05/union_county_sells_runnells_hospital_to_private_contractor_for_26_million.html

¹³

http://www.nj.com/union/index.ssf/2014/11/union_county_continues_operating_psychiatric_hospital_officials_say_costs_expected_to_remain_stable.html

employees. The county estimated that the total cost to operate the psychiatric unit is \$14 million annually,¹³ and it continues to anticipate \$13.3 million in reimbursements from the State.

- **Question:** Does the Governor's FY 2016 Budget Recommendation include any change in State funding for Union County psychiatric patients as a result of the sale of Runnells Hospital?

Answer: Union County did sell the hospital; however, the County will be leasing back the space, continuing to operate the beds, retaining the license issued by the Department of Health, and still be entitled to State Aid. As such, the Governor's FY16 Budget Recommendation continues to assume that Runnells Specialized Hospital will be paid under the State Aid program, i.e., no impact as a result of the sale.

18. A language provision included in the budget since FY 2013 (page D-176) eliminates the statutory role of the State House Commission in determining per capita cost rates to be paid by the State to the counties for the cost of maintenance of State and county patients in county psychiatric facilities, and instead gives the Commissioner of Human Services authority to determine a rate-setting methodology without specific Legislative approval.

- **Question:** Please provide a full description of the current methodology by which per capita cost rates for patients in county psychiatric hospitals are determined.

Answer: The current methodology is no different than the methodology that was in place prior to removing it from the State House Commission. The description of the methodology in the development of State Aid County Psychiatric Rates is as follows:

- 1) Development of the rates begins with an analysis of the most recent total cost report figures for each county psychiatric facility. Per Budget language, DHS has to develop the rates by October 1 of the calendar year before the rate is to be effective. This change allowed the counties to review and ask questions about their rates two months in advance in comparison to going through the State House Commission process. The counties had requested advanced notice of the proposed rates, which would allow them to identify the budget impact of the rate in their calendar year budgets. The "base" year is 2 years prior to the year for which the new rate will be effective. For example, the calendar year 2015 rate was to be developed and approved by October 1, 2014. Therefore, the calculations would have been based on the calendar year 2013 audited cost reports
- 2) Any non-reimbursable costs would be deducted along with depreciation and interest expenditures.
- 3) An inflation factor is applied to estimate what those costs would be using a weighted average of the changes in CPI and average hourly earnings statistics.
 - a. Note: there are known changes to the cost structure of the hospital beyond what applying the inflation factor would indicate, a base year cost adjustment will be included in the total adjusted cost.
- 4) Depreciation and Interest are now added back. (They are backed out above because it would be incorrect to apply inflation factors to them.)
- 5) A true-up adjustment is then applied. This true-up adjustment is based on a comparison of the true costs from the base year to the amount that was paid by applying the per diem rate that was in effect at the time to the total resident days. So, for example, in the development of the Calendar Year 2015 rate, DHS examined the county's 2013 costs. This was compared to what we actually reimbursed them during 2013 (net of any carryforward, or true-up adjustment that was made in 2013). The development of any year's rate tries to "true up" to the State share of actual costs incurred.

- 6) The total costs, with the true-up adjustment, are then divided by the estimated resident days to arrive at the per diem rate.
- 7) Note – As per Budget language (see D-175 in GBM), the rate for any county hospital is capped at 100% of the average State psychiatric hospital rate for the upcoming year, but allowing for each county’s *actual* depreciation, interest and true-up adjustments. In other words, the State allows each county its actual depreciation, Interest and true-up adjustments and doesn’t look to the analogous State figures as a “cap.”

19. A November 2014 federal Inspector General report¹⁴ found that New Jersey claimed approximately \$11.9 million in federal Medicaid Disproportionate Share Hospital payments in excess of the hospital-specific limits for five county psychiatric hospitals in calendar years 2010 and 2011. The report indicates that the excessive claims resulted from the State’s lack of procedures for reconciling and adjusting facilities’ expenditures. In response to the report, the department indicated that it does not concur with the finding of financial disallowance, and indicated that it has established procedures for reconciling and adjusting expenditures.

- **Questions:** What is the current status of the disputed claims? How do the State’s current procedures for tracking and adjusting facilities’ expenditures compare to those used in CY 2010 and 2011, to reduce the future risk of such claim disputes?

Answer: There is no change in the status of the disputed claims and CMS has not acted on the OIG’s recommendation. The Department does not believe it received federal matching funds on the cited DSH claims since they exceed statutory Disproportionate Share Hospital (DSH) limit. Therefore, a refund to the federal government is not appropriate. However, if these claims were disallowed, DHS would still have additional submitted claims that would offset the loss revenue from these claims. Historically, DHS’ claims volume eligible for Psych DSH far exceeds the federal allowable DSH cap for psych services. The state utilizes the following information to better project the cost-based claims: 1) Results of independent DSH audits to determine if facilities are receiving excess DSH payments; 2) Better monitoring of charity care claims volume and “payments” that are submitted by the hospitals to the Department and 3) Closer monitoring of new reimbursement received by the hospitals for the services rendered to newly-eligible childless adults (Medicaid expansion) that used to be uninsured.

DMHAS General

20. Under the Comprehensive Medicaid Waiver, the State obtained federal authorization to contract with a managed behavioral health organization to coordinate adult behavioral health services (including both mental health and addiction services) for most Medicaid/NJ FamilyCare recipients. The organization would operate as an administrative services organization, meaning that it would not determine payment rates, but it would be responsible for administrative functions similar to those performed by managed care organizations, such as prior authorizations, network management, utilization management, and quality management. This management has the potential to significantly improve the efficiency of the State’s mental health and addiction treatment system and improve patient outcomes by ensuring that the most appropriate services are available to those who would most benefit from them.

In response to an FY 2014 OLS Discussion Point, DMHAS indicated that the RFP for the administrative services organization would be issued in late spring 2013, and that it was anticipated to “go live” sometime after July 2014. As of March 2015, no RFP has been issued. It is noted that the contract with Rutgers University Behavioral Health Care described in discussion point #8 above seems to serve some similar functions, but it is more limited in scope, particularly in that it does not include mental health services.

¹⁴ <http://oig.hhs.gov/oas/reports/region2/21301035.asp>

- **Questions:** What has caused the delays in issuing the RFP for an adult behavioral health administrative services organization? What is the currently anticipated timeframe for issuing the RFP and awarding the contract?

Answer: Several issues have impacted the RFP timeline. Factors such as the cost analysis, provider rate setting, and Medicaid Expansion have prompted DHS to reexamine the plan for an ASO. DHS has been analyzing the service implications and the costs of the current RFP to assure that the state is procuring the most cost effective and client centered management system. DHS is weighing the benefits of several different models, including an MBHO or carving the behavioral health services into the Medicaid Managed Care companies.

As previously mentioned, as a first step in our transition to managed care, DMHAS is moving forward with UBHC as the Interim Managing Entity for addictions services.

21. The State has contracted with Myers and Stauffer, L.C. to conduct a rate setting study to assist in establishing a standard fee-for-service schedule for services administered by DMHAS to provide “like rates for like services,” eventually to replace the current system of contracts that pay different providers in sometimes dramatically different ways, and to be implemented along with the introduction of the administrative services organization (discussed above). According to the department’s website, the study was originally anticipated to be completed by September 2013. As of March 2015, no findings have been made public, and the contract has been extended to July 2015.¹⁵

- **Questions:** What is the status of the DMHAS rate setting study? Will the study’s findings be made public? What is the anticipated schedule for implementation of a system-wide fee-for-service payment mechanism?

Answer: DMHAS has received the fee for service rates calculated by Myers and Stauffer for Mental Health and Addictions services. Staff have been thoroughly reviewing the underlying calculations and assumptions that built the rates to determine if any changes need to be made. In addition, staff continue to analyze the estimated State and federal budget impacts of the proposed rates, considering projected Medicaid and non-Medicaid utilization. A timetable for a system-wide implementation has not yet been finalized by DHS. This will be determined, in large part, by the results of our planning for a managing entity to oversee the majority of our services. However, DMHAS does intend to finalize the rates and release them to providers in early FY’16. This will allow providers ample time to adjust/change their business model in anticipation of the full system reform.

¹⁵ DPP contract index # G-2009

Division of Medical Assistance and Health Services (Medicaid/NJ FamilyCare)

Medicaid/NJ FamilyCare Recipients' Access to Care

22. A federal Inspector General report¹⁶ based on a survey of 32 states found that half of registered Medicaid providers could not offer appointments to enrollees in Medicaid managed care plans, either because they were not accepting Medicaid patients (8 percent of all providers) or because they could not be found at their last known address (43 percent of all providers). Of those who offered appointments, half had a wait time over two weeks. A companion report¹⁷ found that states vary widely in the standards they impose on Medicaid managed care plans to ensure the adequacy of the provider networks, and that many states have relatively weak methods to ensure plans are compliant with access standards. Specifically, the report recommends that states be required to conduct direct tests (such as “secret shopper” calls to providers) to validate data provided by the plans. New federal regulations applicable to Medicare Advantage plans require them to contact providers every three months and update their provider directories in “real-time”; similar rules for plans sold through healthcare.gov require directories to be updated monthly. In both cases, failure to comply may result in financial penalties.

- ***Questions:*** Please describe the techniques used to ensure Medicaid/NJ FamilyCare managed care organizations are compliant with regulatory and contractual standards for provider network adequacy. How does the State ensure that plans' provider directories are accurate and regularly updated?

Answer: The Department of Human Services' Division of Medical Assistance and Health Services (DMAHS) administers the Medicaid/NJ FamilyCare program through an organized delivery system by contracting with full-risk, capitation managed care plans (MCOs/HMOs). The MCO contract has a solid set of requirements governing network adequacy including requirements that mirror Medicare. These requirements include acceptable panel sizes, appointment availability and 24/7 access requirements. In addition, the plans must submit quarterly updates on their network adequacy. DMAHS also has a dedicated network monitoring unit which requires plans to do network spot checks and to certify the results monthly. Provider directories are monitored quarterly with secret shopper calling, resources permitting. DMAHS monitors and addresses complaints, grievances and appeals for access issues from members, and providers, and engaged advocates and stakeholders. The managed care contract also provides sanction remedies for DMAHS when a provider's network adequacy is out of compliance. The remedies include corrective action plans to monetary penalties.

23. As required by the ACA, the State temporarily increased Medicaid/NJ FamilyCare reimbursement rates for primary care physician services to the rates paid by Medicare in calendar years 2013 and 2014. An article published in the *New England Journal of Medicine*¹⁸ found that, during this period, New Jersey had one of the largest increases in the percentage of practices that were available to Medicaid recipients (from 70.6 percent to 81.5 percent) of all states. Under the ACA, the federal government paid 100 percent of the difference between the pre-ACA rates and the required enhanced rate, but this additional federal funding expired after 2014. In response to FY 2015 OLS discussion point #15, DHS estimated that the State cost to reinstate the same rate increase would be approximately \$100 million (plus an estimated \$120 million in federal funds).

¹⁶ <http://oig.hhs.gov/oei/reports/oei-02-13-00670.asp>

¹⁷ <http://oig.hhs.gov/oei/reports/oei-02-11-00320.asp>

¹⁸ http://www.nejm.org/doi/full/10.1056/NEJMsa1413299?query=featured_home&

The Governor's FY 2016 Budget Recommendation includes an additional \$45 million (\$15 million State plus \$30 million federal) to increase Medicaid physician reimbursement rates, embedded within several line items on page D-179. According to informal information provided by the department, this does not mirror the ACA primary care rate increase. Instead, it will be targeted to the areas of weakness identified in the State's and managed care organizations' provider networks, including certain physician specialties.

- **Questions:** According to the department's analysis, has the participation rate of primary care physicians in Medicaid/NJ FamilyCare, or the frequency of claims against the applicable billing codes, increased as a result of the increased reimbursement rate in 2013 and 2014? Have these rates decreased since its termination?

Answer: The Department's analysis of the ACA primary care provider increase focuses on the frequency of claims against the billing codes included in the increase. In addition to the limitation on billing codes, the ACA increase was only available to certain general provider types (family medicine, general internal medicine, and pediatric medicine) and certain sub-specialties and board certified providers within these provider types. In addition, only claims for beneficiaries eligible for NJ FamilyCare under Title XIX of the federal Social Security Act were eligible for the increase. Finally, the Department typically allows six months for all claims to be received before using claim information for analytical purposes, meaning nearly complete data is only available through September 2014 and therefore the Division cannot comment on trends since the expiration of the increase in December 2014. The table below shows the number of ACA Primary Care Provider Increase qualified claims and the total number of beneficiaries whose claims were eligible for the increase. At the conclusion of the ACA two year rate increase period, NJ FamilyCare discontinued the add-on payment at the end of December 2014.

ACA Primary Care Rate Increase				
	ACA Primary Care Rate Increase Paid Claims		NJ FamilyCare Beneficiaries Eligible Under Title XIX	
	<u>Paid Claims</u>	<u>% Chg.</u>	<u>Beneficiaries</u>	<u>% Chg.</u>
January - September 2012	4,277,069		1,177,212	
January - September 2013	4,242,009	-0.82%	1,196,824	1.67%
January - September 2014	4,394,830	3.60%	1,386,948	15.89%

Source: NJ DMAHS Shared Data Warehouse

Notes: Paid fee-for-service claims and managed care encounters with service dates 1/1/12 - 9/30/14 paid through 4/14/15; includes all claims with the following attributes:

- Procedure Codes 99201-99499 (Evaluation and Management) and 90460, 90461, & 90471-90473 (Vaccine Administration)

- Provider Taxonomy Codes within the specialties and subspecialties listed in CMS ACA Primary Care Rate Increase Guidance available at

<http://www.medicaid.gov/AffordableCareAct/Provisions/Downloads/Q-and-A-Managed-Care-Increased-Payments-for-PCPs.pdf>. Claims for providers with acceptable board certifications but not applicable taxonomy codes not included

- Claim Recipients within the following DMAHS Public Statistical Reporting Categories: ABP Other Adults Up To 133%FPL; ABP Parent Up To 133%FPL; Aged; Blind;

Children's Services; Disabled; M-CHIP Children 107%- 142%FPL; Medicaid Adults; Medicaid Children; Other

- Provider eligibility for the increase varied amongst NJ FamilyCare managed care plans; this analysis assumes a single set of eligibility rules to enable easier comparison over time.

24. Three recent research reports that looked specifically at Medicaid/NJ FamilyCare recipients in New Jersey found that they face greater access problems than people with private health coverage, but that New Jersey performs better than other states in many regards.

- A report by the Rutgers Center for State Health Policy¹⁹ found that survey respondents who were uninsured or covered by Medicaid/NJ FamilyCare had about twice as much difficulty finding a doctor or specialist and were less likely to eventually find one, when compared to those with other insurance. The study also notes that New Jersey adults with Medicaid/NJ FamilyCare were about twice as likely to report to the survey that they experienced access problems, when compared to the national average.
- A study published in *JAMA Internal Medicine*²⁰ found that callers posing as Medicaid recipients were able to obtain appointments at primary care offices 69 percent of the time, compared to an average of 58 percent across the 10 states studied. The median wait time for an appointment was four days in New Jersey, less than the 10-state average of six days.
- An article published in the *New England Journal of Medicine* (see discussion point #23 above) found that, of 10 states studied, New Jersey was among the best performing states with regard to the percentage of physician practices accepting new Medicaid patients, both before and during the period of enhanced Medicaid reimbursement rates for primary care physician services – though the percentage of practices accepting new patients with private insurance was higher than Medicaid in both survey periods.
- **Questions:** How does the department assess Medicaid/NJ FamilyCare fee-for-service recipients' access to care? Aside from enforcing network adequacy standards (described in #22 above), how does the department assess managed care enrollees' access to care?

Answer: DMAHS analyzes the provider network files, uniquely identifying providers by their National Provider Identification number (NPI), to ensure that each network meets enrollee to provider ratios and geographic accessibility standards governing primary care medical and dental services, and geographic accessibility standards governing access to specialists, hospitals and other ancillary services. Current standards for primary care are:

- 1 Full Time Equivalent (FTE) primary care physician or dentist for every 2,000 enrollees based on the maximum number the MCO is allowed to enroll per county;
- 90% of enrollees residing in urban counties must have access to at least 2 PCPs and 2 PCDs within 6 miles. 85% of enrollees in the 5 non-urban counties (Cape May, Hunterdon, Salem, Sussex and Warren) must have access to at least 2 PCPs and 2 PCDs within 15 miles.

Regarding specialty care, particular attention is paid to the 13 specialties specified in N.J.A.C. 11:24-6 (Cardiology, Dermatology, Endocrinology, Otolaryngology, General Surgery, Neurology, OB/GYN, Oncology, Ophthalmology, Orthopedic Surgery, Oral Surgery, Psychiatry and Urology). The current access standard for specialty care which governs not only the above specified specialties, but all specialties, requires each MCO to assure that 90% of its members within each county served have access to needed specialty care within 45 miles or 1 hour driving time, whichever is less. Additionally, 90% of managed care enrollees within a county must have access to at least 1 acute care hospital within 15 miles or 30 minutes driving time, whichever is less.

¹⁹ <http://www.cshp.rutgers.edu/publications/access-to-physician-services-in-new-jersey-before-aca-implementation-20122013-5>

²⁰ <http://archinte.jamanetwork.com/article.aspx?articleid=1857092&resultClick=3#Discussion>

The Contract requires the MCOs to monitor their provider networks for bona fide provider participation by:

- Monitoring claims inactivity and investigating the participation status of all primary care providers (PCPs) and primary care dentists (PCDs) with less than \$600.00 or 10 paid claims during a one-year period;
- Monthly, spot-checking Provider Networks to verify the accuracy of their provider network files. Each MCO must survey 50% of its specialty network (excluding hospital-based specialties) per county. Each monthly survey should be county-specific with all counties within the MCO's operating area surveyed at least annually. The MCOs are required to document any corrective actions taken as a result of spot check responses.
- Verifying provider participation during Annual PCP After-Hours Availability Studies.

DMAHS also conducts ad hoc spot checks to verify provider participation and in response to identified trends, complaints and/or special requests.

Regarding access, DMAHS monitors Complaints, Grievances and Appeals submitted by MCOs and received by the Office of Quality Assurance (OQA) and the Office of MLTSS Quality and Monitoring to identify problems with member access to services. OQA works closely with the MCO to address any access issues that are identified; if repeated deficiencies are found, DMAHS has the option to require a corrective action plan; issue a Notice of Intent to Sanction or an actual Sanction with financial penalties to the health plan with follow up to assure the need is met and the deficiency corrected.

DMAHS also monitors enrollment capacity and on a monthly basis, DMAHS provides each MCO electronic notification informing them of counties where enrollment capacity has exceeded 50% and strongly encourages the MCO to request capacity increases in counties where enrollment capacity has exceeded 80%. Once a capacity increase request is received, along with any updated provider network files and geographic accessibility reports, DMAHS analyzes the data to determine whether or not the network is robust enough to adequately serve the potential increased membership in that county. Once DMAHS is satisfied, the request with supporting documentation is forwarded to the Centers for Medicare and Medicaid Services for their approval.

25. The State currently contracts with LogistiCare to manage non-emergency medical transportation services for Medicaid/NJ FamilyCare recipients.²¹ (The contract is due to expire on June 30, 2015, and as of March 2015, no new RFP has been issued.) Although DHS has penalized LogistiCare for poor performance several times, two pilot programs launched in Trenton and Camden during 2013 appear to be dramatically improving performance, according to press reports.²² The programs feature confirmation calls to patients, monthly calls to on-site social workers, agreed-on pickup sites, a reduced number of transportation vendors serving each site (to reduce confusion), and direct communication between building security desks and drivers (to notify drivers when patients may be delayed, such as by a broken elevator). Advocates believe the pilot programs have already improved service, and are urging their expansion around the State.

- **Questions:** How does the State encourage performance improvements by the transportation manager, such as those described above? What sorts of incentives will the

²¹ DPP contract index # T-2503

²² E.g., <http://www.courierpostonline.com/story/news/local/south-jersey/2015/01/11/breakdown-system/21615737/>

RFP for a new contract, due to begin in July 2015, include to continue and expand such programs where they are beneficial? To date, have there been any cost savings attributed to the improved efficiencies?

Answer: As an overall incentive to reduce costs, the contractor's payments for provider services cannot exceed 80% of the total capitation payments. If they do, the capitation rate is reduced. The new RFP also includes items that will improve service, such as:

1. A call center with 24/7 service ability.
2. On-line scheduling for advance reservations.
3. GPS systems in provider vehicles that will track the location of vehicles as well as track when beneficiaries arrive at appointments and are picked up.
4. Reminder phone calls, emails, and/or texts will be sent to beneficiaries the day before a scheduled trip.

The RFP also requires the contractor to expand the service in Camden/Trenton to other complexes if there is a large enough Medicaid population in the complex. However, LogistiCare is expanding the service but there are not too many complexes that meet this criteria.

The cost savings from the Camden/Trenton pilot are not measureable and probably not very large. The benefit comes from improved services and less complaints.

Federal Medicaid funding

26. Under provisions of the ACA, health care costs for individuals who are newly eligible for Medicaid/NJ FamilyCare under the ACA Medicaid expansion (non-elderly childless adults with incomes below 138 percent of the federal poverty level) are supported entirely with federal funds. The federal reimbursement rate for these expenditures will begin to phase down to 95 percent in calendar year 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and subsequent years. Administration costs, such as eligibility determinations, are generally eligible for a 50 percent matching rate. Evaluation data on page D-177 indicate that average monthly enrollment during FY 2015 in the NJ FamilyCare Adult Expansion is 500,311 individuals, with a total cost of \$3.031 billion (\$3.002 billion federal and \$29 million State).

- **Questions:** Please provide an extended year-by-year estimate of enrollment and State cost estimates for FY 2017 through FY 2020, of expanding Medicaid coverage to newly eligible adults with incomes below 138 percent of the federal poverty level. Since benefits in the NJ FamilyCare Adult Expansion under the ACA are entirely federally funded, what does the \$29 million in State funding shown on page D-177 represent?

Answer: The table below shows the increased State cost for the Medicaid Expansion Population. The projections are based on SFY 2016 enrollment and rates.

SFY	SFY 2017	SFY 2018	SFY 2019	SFY 2020
FEDERAL MATCH	95% / 94%	94% / 93%	93% / 90%	90%
STATE EXPENDITURES	\$161,969,984	\$191,165,838	\$252,343,116	\$291,958,544
FEDERAL EXPENDITURES	\$2,757,615,457	\$2,728,419,603	\$2,667,242,325	\$2,627,626,897
TOTAL EXPENDITURES	\$2,919,585,441	\$2,919,585,441	\$2,919,585,441	\$2,919,585,441
AVERAGE MONTHLY ENROLLMENT	522,849	522,849	522,849	522,849

The NJ FamilyCare Parents up to 133% of the Federal Poverty Level were previously funded through the NJ FamilyCare Appropriation and are now entirely federally funded with the exception of the Presumptively Eligible (PE) Program. Expenses for recipients in the Medicaid Expansion Population who obtain eligibility through the PE process receive a 50% federal match. If the recipients later obtain full eligibility, the claims can be reprocessed for the full 100% federal match. Additionally, a population of legal aliens with less than 5 years residence were also funded through the NJ FamilyCare appropriation and continue to receive 65% federal funding, but are included in the Evaluation Data under “Medicaid Expansion”.

27. In December 2012, the federal Centers for Medicare & Medicaid Services (CMS) sent a letter to state Medicaid directors reversing its 17-year policy regarding Medicaid coverage of “free care,” so that it is now possible for the State to claim federal matching funds for health care services that are provided free of charge to the general population.²³ Most notably, this would allow the State to claim federal matching funds for services provided by schools to eligible children, such as vaccinations or management of chronic conditions such as asthma. However, because New Jersey typically covers these services under managed care, it is not clear how schools may be able to seek Medicaid/NJ FamilyCare reimbursement for these services. As of March 2015, the OLS is aware of no federal guidance on coordinating school-based services with Medicaid managed care systems.

- **Question:** What is the department doing to allow the State and its schools to receive the federal funds that have become newly available with CMS’s reversal of the “free care” policy?

Answer: The Departments of Human Services, Treasury, and Education are working with our SEMI contractor, PCG, to evaluate the “Free Care” policy and what needs to be done to change our claiming processes. There has been no guidance from CMS and Medicaid will have to get CMS approval of a State Plan Amendment in order to do this.

28. Pursuant to federal and State law, inmates are generally not eligible for Medicaid, except if they are admitted to a medical institution (e.g. a hospital or nursing facility) for at least 24 hours. By enrolling inmates in Medicaid for these inpatient stays, the State is able to claim federal matching funds for the treatment that would otherwise be paid entirely at State or local cost. During FY 2014 the division established a system to enroll inmates of State correctional facilities in Medicaid in appropriate instances. A similar mechanism for county inmates took longer to develop, and a language provision in the FY 2015

²³ <http://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf>

Appropriations Act requires the commissioner to work collaboratively with county corrections agencies to promote the proper enrollment of eligible inmates in Medicaid.

- **Question:** Please provide estimates for FY 2014, 2015, and 2016 for the State savings attributed to claiming Medicaid matching funds for State inmate hospitalizations.

Answer: The table below shows actual savings for SFY 2014 and projections for SFY 2015 and SFY 2016.

SFY 2014	\$2,025,143
SFY 2015	\$2,481,224
SFY 2016	\$2,555,660

- **Questions:** Please provide an update on progress in developing a process for counties to enroll their prisoners in Medicaid and obtain federal matching funds, where applicable. Under this process, is the State or the county responsible for the non-federal share of the cost of treatment? Please provide estimates, by fiscal year, for total county savings attributed to claiming Medicaid matching funds for county inmate hospitalizations.

Answer: Uninsured inmates who present at a hospital for admission can have a Presumptive Eligibility application completed which provides temporary Medicaid until their full eligibility can be determined by the local CWA. Medicaid can cover the hospitalization and related professional services. The State or County would be responsible for the non-Medicaid covered services.

Prescription Drugs

29. The Food and Drug Administration (FDA) has recently approved several new medicines for the treatment of hepatitis C, including Sovaldi, Harvoni, and Viekira Pak. These medicines are far more effective than previously available treatments, but they are also extremely expensive. (The cost for a full 12-week course of treatment with these drugs is over \$80,000 in all three cases, and some individuals could require multiple courses of treatment. Some of the cost to the State is offset by federal matching funds, manufacturer rebates, and avoided medical costs that would have been incurred for alternative treatments.) Most states have taken steps to limit Medicaid recipients' access in order to control costs; according to a report sponsored by the Medicaid Health Plans of America,²⁴ 35 states require prior authorization for Sovaldi (the first to come to market), which can require patients to meet a set of clinical or clinical-related criteria, and many require a liver biopsy to determine the severity of the disease before allowing treatment. Of those, 18 states also impose frequency, quality, or duration limits. New Jersey does not impose any such limitations in its fee-for-service program. Medicaid/NJ FamilyCare managed care organizations are not required to cover all drugs in the same manner as the fee-for-service program, and could impose their own access limits.

- **Questions:** What is the estimated annual increase in cost to the State, including fee-for-service costs and marginal increases to managed care capitation rates, as a result of the FDA approval of these new Hepatitis C drugs? What access limitations have the State's Medicaid/NJ FamilyCare managed care organizations established for these drugs? Has the department evaluated possible savings that may result from prior authorization or imposing other limitations?

²⁴ <http://www.mhpa.org/upload/SovaldiSqueeze-Oct2014.pdf>

Answer: The projected annual expense, based on a monthly tracking system of encounter and fee-for-service data, for Hepatitis-C will approximate \$92 million in SFY15, of which \$90 million is expected in managed care. Estimated pharmacy expenditures for SFY15 approximates \$961,000,000 or a per member per month cost of \$59.63 including all treatments for Hep-C. To date, the actual expenditures for all managed care pharmacy is a PMPM of \$57.00 a \$2.63 favorable variance to the planned rate.

The MCOs have adopted protocols for the Medicaid recipients treatment eligibility, monitoring the prescribed use/ duration and tolerance for the interruption of the drug treatment. This is evidenced by the monthly decline in Hep –C expenses for both Sovaldi and Harvoni since inception. To date, DMAHS has not seen expenses for the drug Viekira Pak.

30. Unlike 44 other states, New Jersey has not negotiated any supplemental rebates for prescription drugs provided to Medicaid/NJ FamilyCare beneficiaries. A December 2014 Inspector General report²⁵ found that supplemental rebate agreements are an effective cost containment tool, saving approximately \$1.7 billion in state and federal money in 2011 and 2012. (These agreements are typically characterized by a drug manufacturer agreeing to pay rebates to the state in exchange for their drugs being placed on a preferred drug list, which New Jersey does not currently have in the fee-for-service program.) The states with supplemental rebate agreements include 26 states that cover at least some prescription drugs through managed care organizations, though 20 of the states limit their collections to fee-for-service drugs.

- **Question:** Has the department considered instituting any supplemental rebate program for prescription drugs, either for fee-for-service enrollees or for managed care enrollees?

Answer: NJ's Medicaid program does participate and receive supplemental rebates through the managed care organizations (MCO's). Each of the MCOs participating in Medicaid/NJ Family Care utilize a formulary or preferred drug list in order to better manage pharmacy expenditures. As is the case with most drug formularies, product selection for inclusion in the preferred drug lists takes into consideration the 'per unit drug costs', net of any available supplemental rebates. Additionally, all supplemental rebate agreements negotiated between the MCOs and manufacturers are reported to the State of New Jersey and considered in the actuarial calculation of capitation rates. Considering that over 95% of Medicaid/NJ Family Care recipients are currently enrolled in managed care, the introduction of a FFS supplemental rebate program would not be cost effective.

31. In testimony given to the Assembly Budget Committee on March 18, 2015, the Independent Pharmacy Alliance²⁶ claims that Medicaid/NJ FamilyCare managed care organizations are making efforts to "lock out" aged, blind, and disabled enrollees from local urban pharmacies by directing them to mail-order pharmacies, whether or not it is more convenient for the enrollee.

- **Questions:** What proportion of managed care pharmacy claims are for drugs provided by mail-order pharmacies? What limitations, if any, are imposed to limit this practice of managed care organizations?

Answer: The MCOs do not offer mail-order pharmacies options to their NJ FamilyCare membership. Zero percent of the reported managed care pharmacy claims are for drugs provided by mail-order pharmacies. The use of mail-order pharmacies is at the discretion of individual MCOs.

²⁵ <http://oig.hhs.gov/oei/reports/oei-03-12-00520.asp>

²⁶ http://www.njleg.state.nj.us/legislativepub/budget_2016/031815/Reznik_A.pdf

32. The Independent Pharmacy Alliance also claims that, in contrast to the Medicaid/NJ FamilyCare fee-for-service program, managed care organizations often fail to make timely updates to their payments when prescription drug prices increase, and when prices are updated, the changes are not retroactive.

- **Question:** What does the State require of managed care organizations with regard to timely updating of drug pricing for purposes of pharmacy reimbursement?

Answer: As is the case with the State's FFS program, MCOs have established maximum allowable costs (MAC) for most generic drugs. The current market environment is such that pricing changes for particular generic drugs occur quite frequently, creating the need for the MCOs to adjust their MAC levels. Each MCO is responsible for correlating and reviewing acquisition cost information provided by pharmacies, drug manufacturers and wholesalers and then apply methodology to update MAC levels accordingly. This process should be conducted in a timely fashion and must consider the actual dates of the reported documentation in order to set the effective dates appropriately.

Other Specific Benefits

33. A study published in the journal *Health Affairs* in December 2014 found that, in the 22 states studied, nearly 9 percent of births covered by Medicaid were elective early deliveries (before 39 weeks of gestation).²⁷ Such early deliveries, including caesarian sections and induced labor when not medically indicated, have been associated with worse outcomes for mothers and children, as well as higher costs. Texas and Florida have stopped reimbursing providers for elective early deliveries, and many other states have established programs to discourage their use. The Leapfrog Group's most recent annual maternity hospital survey²⁸ found a dramatic reduction in early elective deliveries in New Jersey, from 15.7 percent in 2010 to only four percent in 2012. (These data include all births, not only those covered by Medicaid.)

- **Questions:** What percentage of Medicaid/NJ FamilyCare births are elective early deliveries? Has the trend in the proportion of elective early deliveries within the Medicaid/NJ FamilyCare population been increasing, decreasing, or remaining roughly flat over the past several years? Does the State discourage unnecessary early deliveries when they may be dangerous to the mother or child or unnecessarily costly to the State?

Answer: NJ FamilyCare is currently developing methodology to accurately determine the percentage that early elective Caesarian section deliveries constitute of all of our members' births. As stated in the question, the proportion of early elective deliveries in the NJFC population has decreased dramatically over the past several years. This is due to a combination of factors: the provider-targeted education provided by our Managed Care Organizations discouraging the practice of early elective Caesarian section deliveries, and the New Jersey Hospital Association (NJHA) Partnership for Patients – NJ initiative, in which a partnership forged with State agencies has resulted in the commitment of the 52 hospitals. New Jersey acute care hospitals providing labor and delivery services to discontinue the scheduling of elective deliveries prior to the 39th week of gestation. At this time, in light of these encouraging developments, the State has not drawn a firm line prohibiting the practice. The successful results of this initiative have been cited by the March of Dimes and The Leapfrog Group.

²⁷ http://kaiserhealthnews.org/news/nearly-9-percent-of-medicaid-births-delivered-early-for-no-medical-reason/?utm_campaign=KHN%3A+Daily+Health+Policy+Report&utm_source=hs_email&utm_medium=email&utm_content=15209721&hsenc=p2ANqtz-8DZuSI3V2G_33DSWPhiyN8_bGrLcgV-sn2XfMYW_zBbzE4mYYHb2OKB1sv6qMbjCkESI-Di7G7VcCpcypIQ5fErAyqhw&hsmi=15209721

²⁸ <http://www.njspotlight.com/stories/15/02/22/scheduled-induced-labor-deliveries-continue-to-decline-at-nj-hospitals/>

<http://www.njha.com/media/185129/p4phen1yrupdate.pdf>.

Medicaid/NJ FamilyCare Recoveries

34. Medicaid/NJ FamilyCare recoveries, such as for third party liability, fraud, or abuse, are not itemized in the State budget, instead manifesting as reductions in spending. Recoveries are difficult to predict, particularly when they are affected by large multi-state settlement agreements with manufacturers of medical devices or pharmaceuticals. In addition, the State may owe a portion of Medicaid/NJ FamilyCare fraud recoveries to the federal government or private parties, which can vary depending upon certain details of the case.

Medicaid/NJ FamilyCare managed care organizations are required to investigate potential fraud and abuse within their plans, and each managed care organizations is required to have a Special Investigations Unit responsible for fraud and abuse investigations, with one full-time employee per 60,000 enrollees. Historically, fraud recoveries have been much lower in managed care than in the fee-for-service program, despite the fact that most Medicaid/NJ FamilyCare spending is through managed care.

- **Questions:** Please provide, for FY 2014, 2015, and 2016, total Medicaid/NJ FamilyCare fraud recoveries, and the portion that can be retained by the State, disaggregated according to the following categories: (1) third party liability, (2) fraud and abuse, and (3) other recoveries. Please break down the amount of FY 2014, 2015, and 2016 estimates according to whether recoveries are associated with fee-for-service or managed care claims. For categories where recoveries in the managed care program are significantly lower than in the fee-for-service program, what explains the difference?

Answer: Please see the below chart:

RECOVERIES MADE, GENERATED OR OVERSEEN BY THE OFFICE OF LEGAL AND REGULATORY AFFAIRS (OLRA)				
<i>Recoveries by State Fiscal Year (in millions of federal and state dollars)</i>				
		2014 (actual)	2015 (annualized)	2016 (estimate based on 3% increase over SFY 2015)
Third Party Liability*		\$15.49	\$14.63	\$15.07
Fraud and Abuse**		\$5.12	\$5.09	\$5.24
Other Recoveries		\$16.34	\$17.75	\$18.28
TOTALS		\$36.95	\$37.47	\$38.59
*Includes tort and casualty insurance recoveries by OLRA and HMS				
**Includes recoveries by OLRA, the county welfare agencies, and Molina				

Medicaid Disproportionate Share Hospital (DSH) payments

35. A portion of the DHS budget is drawn from federal funds under the Medicaid Disproportionate Share Hospital (DSH) program, which provides a limited allotment of funding to the State each year (\$686.5 million in federal fiscal year 2014) to subsidize hospitals that treat a disproportionate share of uninsured and Medicaid patients. Approximately \$413.8 million is recorded as general revenue, under the three “Medicaid Uncompensated Care” items displayed in the Governor’s FY 2016 Budget

Recommendation (page C-5), but the remainder of the revenue is not clearly accounted for. Historically, this funding has supported State and county psychiatric hospitals and Charity Care. However, because the revenue is recorded in the General Fund rather than in federal accounts, the budget does not associate these funds with any specific spending accounts.

- **Questions:** What is the rationale for recording most DSH revenue in the General Fund, rather than as federal revenue? Where is DSH revenue recorded, other than the three “Medicaid Uncompensated Care” items? Where are DSH funds spent in the budget? What specific hospitals are supported with these funds, based on what allocation methodology? How does the State ensure that it does not claim against limited DSH funds when open-ended “regular” Medicaid matching funds could be claimed instead?

Answer: Once DSH matching revenues have been earned, they may be allocated at the discretion of the State and are not required to be used specifically for hospital payments. The Schedule 1 display of most DSH revenue is used because of the fact that these federal dollars are earned based on hospital payments originating from numerous accounts across several State agencies, making the tracking and reconciliation of revenue on Schedule 1 more efficient than budgeting, spending, and reconciling dozens of federal appropriations across the budget. There are only two exceptions to the Schedule 1 display - federal DSH revenue amounts are directly appropriated for the support of the Hospital Mental Health Offset Payments program (\$12.3m) and the support of the various State Mental Health hospitals (\$53m), both of which fall into the “Title XIX Medical Assistance” line on Schedule 2.

In the past, programs have moved from DSH to “regular” Medicaid as appropriate, however, these opportunities have been limited by the fact that fee-for-service payments to hospitals through the NJ FamilyCare program are subject to a federal Upper Payment Limit (UPL) and are not open-ended. In addition, the vast majority of expenditures currently generating a DSH match are related to programs that support care to residents who are uninsured and are unlikely to be eligible for NJ FamilyCare.

Medicaid/NJ FamilyCare service utilization

36. The Governor’s FY 2016 Budget Recommendation provides funding for the Medicaid/NJ FamilyCare Managed Care Initiative in a single line item, rather than differentiating funding by category of service provider, as it does for the fee-for-service program. Data on spending or utilization for specific categories of services provided through managed care organizations have not been available for consideration by the Legislature for several years, despite the growing proportion of enrollment and spending that occurs within the managed care framework.

- **Question:** Please provide a table displaying the following data, summed for all managed care organizations, for each major category of service: (1) total payments; (2) number of recipients; (3) number of service units; (4) type of service unit; and (5) average payment per service unit. Among major categories of service, please disaggregate the following (or disaggregate further, if appropriate):
 - Inpatient hospital
 - Primary care
 - Physician specialist services
 - Outpatient hospital
 - Other professional services
 - Emergency room
 - Durable medical equipment/other medical supplies
 - Prosthetics & orthotics

- **Dental**
- **Pharmacy**
- **HIV/AIDS Drugs and Blood Products**
- **Home Health**
- **Hospice**
- **Private Duty Nursing**
- **Transportation**
- **Laboratory & X-ray**
- **Vision Care**
- **Mental Health and Substance Abuse**
- **Family Planning**
- **Other Medical**
- **Administrative expenses**

Answer:

MANAGED CARE ENCOUNTERS WITH SERVICE DATES SFY2014 PAID THROUGH 4/1/2015

Code	Sub Capitation Prov Type	Recipient Count	Claim Count	Payment Amount	Payment Amount Per Claim
100	100 - MEDICAL - PRIMARY CARE	628394	5431679	\$81,916,088.46	\$15.08
300	300 - DENTAL - PRIMARY CARE	247121	1825576	\$19,773,798.04	\$10.83
500	500 - VISION	1083013	9794192	\$18,404,802.08	\$1.88
700	700 - MENTAL HEALTH	14708	124387	\$11,359,495.40	\$91.32
900	900 - LABORATORY	808212	7628415	\$7,639,833.21	\$1.00
910	910 - THERAPIES (PT, ST, OT)	226397	1170647	\$2,700,445.70	\$2.31
Sub Capitation Total				\$141,794,462.89	

The above are not for specific services but for the management thereof.

The MCOs pay subcapitations for certain services, like primary care, to specific providers and also some services like dental and vision to contracted vendors for their management and networks. To determine all that was spent for dental, for instance, the dental subcapitation amount above would have to be added to all of the dental categories below.

CoS Code	Category of Service	Recipient Count	Claim Count	Payment Amount	Payment Amount Per Claim
AUK	AUDIOLOGY	3,205	11,066	\$310,353.52	\$28.05
AUO	AUDIOLOGY - OUTPT HOSP, EXCEPT ER	12,619	40,128	\$4,886,185.14	\$121.76
DDD	DENTAL	192,499	1,447,717	\$86,510,980.23	\$59.76
EPD	EPSDT - DENTAL	419,282	3,765,935	\$112,930,930.93	\$29.99
EPO	EPSDT - OUTPT HOSP, EXCEPT ER	2,356	3,584	\$216,317.52	\$60.36
EPS	EPSDT - MEDICAL	489,063	757,395	\$35,494,149.68	\$46.86
EPY	EPSDT - PRIVATE DUTY NURSING	1,117	173,183	\$72,526,857.09	\$418.79
ERE	EMERGENCY ROOM - OUTPT HOSP	432,636	990,331	\$257,415,168.19	\$259.93
FPU	FAMILY PLANNING	34,394	125,391	\$12,262,627.98	\$97.80
HAI	HEARING AIDS	7,588	23,468	\$9,249,367.68	\$394.13
HHH	HOME HEALTH	39,165	4,821,340	\$249,782,922.11	\$51.81
HHO	HOME HEALTH - OUTPT HOSP, EXCEPT ER	8,746	58,754	\$1,259,635.29	\$21.44
HOH	HOSPICE SERVICES	318	10,808	\$2,310,312.15	\$213.76
IAI	INPT HOSP - ACUTE	94,179	134,538	\$879,721,964.03	\$6,538.84
LSL	LABORATORY SERVICES	682,294	6,049,109	\$46,075,498.13	\$7.62
LSO	LABORATORY SERVICES - OUTPT HOSP, EXCEPT ER	268,303	2,240,645	\$25,553,381.40	\$11.40
MDC	MEDICAL DAY CARE	15,543	1,018,650	\$79,884,097.87	\$78.42
MEB	MEDICAL EQUIPMENT - PHARMACY	28,563	68,859	\$658,642.01	\$9.57
MEO	MEDICAL EQUIPMENT - OUTPT HOSP, EXCEPT ER	144	327	\$48,603.79	\$148.64
MEQ	DURABLE MEDICAL EQUIPMENT	67,402	260,248	\$27,759,567.99	\$106.67
MHE	MENTAL HEALTH - OUTPT HOSP, ER	8,790	13,228	\$3,340,039.57	\$252.50
MHI	MENTAL HEALTH - INPT HOSP	1,012	1,269	\$3,324,193.04	\$2,619.54
MHM	MENTAL HEALTH	5,019	76,840	\$3,688,104.17	\$48.00
MHO	MENTAL HEALTH - OUTPT HOSP, EXCEPT ER	4,834	19,974	\$504,410.58	\$25.25
MSB	MEDICAL SUPPLIES - PHARMACY	56,489	124,152	\$3,037,499.13	\$24.47
MSO	MEDICAL SUPPLIES - OUTPT HOSP, EXCEPT ER	124,393	258,720	\$16,306,200.02	\$63.03
MSR	MEDICAL SUPPLIES	99,758	631,605	\$41,082,722.61	\$65.04
NFC	NURSING FACILITY - CUSTODIAL	579	808	\$2,111,282.78	\$2,612.97
NFI	NURSING FACILITY - OTHER	5,352	9,623	\$25,466,756.61	\$2,646.45
OOO	OUTPT HOSP - OTHER, EXCEPT ER	325,578	2,900,009	\$386,423,215.02	\$133.25
OT3	OTHER THERAPIES - PHYSICIAN	7,339	81,668	\$1,643,698.17	\$20.13
OTC	OTHER THERAPIES	13,069	273,762	\$4,050,837.97	\$14.80
OTF	PODIATRIST SERVICES	58,556	210,213	\$8,118,616.75	\$38.62
PCA	PERSONAL CARE ASSISTANCE	20,976	1,760,736	\$74,586,218.38	\$42.36
POP	PROSTHETICS & ORTHOTICS	49,947	118,550	\$18,381,725.49	\$155.05
RAO	RADIOLOGY - OUTPT HOSP, EXCEPT ER	309,969	826,718	\$98,726,918.20	\$119.42
RAX	RADIOLOGY	431,362	1,497,406	\$53,811,688.62	\$35.94
RXA	PHARMACY - REIMBURSABLES	6,412	99,296	\$129,166,434.51	\$1,300.82
RXB	PHARMACY - EXCLUDING REIMBURSABLES	1,036,837	14,806,932	\$761,321,511.63	\$51.42
RXO	PHARMACY - OUTPT HOSP, EXCEPT ER	260,364	573,475	\$36,691,678.26	\$63.98
SAE	SUBSTANCE ABUSE - OUTPT HOSP, ER	1,752	3,201	\$751,282.77	\$234.70
SAI	SUBSTANCE ABUSE - INPT HOSP	436	480	\$1,314,388.79	\$2,738.31
SAN	SUBSTANCE ABUSE	170	404	\$37,696.22	\$93.31
SAO	SUBSTANCE ABUSE - OUTPT HOSP, EXCEPT ER	2,067	17,750	\$449,296.13	\$25.31
SM3	STANDARD MEDICAL PHYSICIAN	1,133,183	9,714,360	\$464,454,074.31	\$47.81
SM4	NURSE SPECIALTY	91,660	230,465	\$7,799,171.69	\$33.84
SM5	PHYSICIAN ASSISTANT	21,311	37,264	\$1,524,155.52	\$40.90
TRO	TRANSPORTATION - OUTPT HOSP, EXCEPT ER	34,360	98,982	\$18,780,104.87	\$189.73
TRT	TRANSPORTATION	59,228	209,834	\$11,853,786.76	\$56.49
UNZ	UNKNOWN	155,314	2,263,512	\$211,012,708.47	\$93.22
VC3	VISION PHYSICIAN	84,915	341,232	\$17,314,410.24	\$50.74
VCV	OPTOMETRIST SERVICES	259,179	414,872	\$7,590,560.28	\$18.30
VCW	OPTICAL APPLIANCES	233,166	589,809	\$2,981,244.73	\$5.05
Specific Categories of Service Total				\$4,322,504,195.02	
Total Sub Caps and Categories of Service				\$4,464,298,657.91	
Total Administration SFY14				\$441,502,211	

MMIS

37. In September 2012, the Division of Purchase and Property issued a special notice indicating that the State was planning to release an RFP for the procurement of a new Medicaid Management Information System (MMIS). The MMIS is a computerized claims processing and information retrieval system central to the regular administration of the Medicaid program. In New Jersey, the MMIS is based on a mainframe system originally installed in 1991. The new system would be associated with the procurement of the division's Fiscal Agent Services term contract (T-2409), which is due to expire May 31, 2016.²⁹ As of March 2015, no RFP has been released.

- ***Questions:*** When will the RFP for a new Fiscal Agent and MMIS system be released? How much is the project anticipated to cost, over what time period?

Answer: On February 12, 2015, the Intent to Award the contract to Molina Medicaid Systems was announced by DPP. There was no protest filed following the announcement, and the contracting process is moving forward with a planned contract award date of May 1, 2015, pending federal approval.

The 30-month Design, Development, and Implementation period will begin shortly after contract award, at a cost of \$93M. Following implementation, the Maintenance and Operations period begins, with a 7.5 year base, and three optional extensions. The full 10.5 year period is anticipated to cost \$418M, for a total project cost of \$511M.

²⁹ <http://www.state.nj.us/treasury/purchase/notices/091812a.shtml>

Division of Aging Services (DoAS)

MLTSS

38. The Managed Long Term Services and Supports (MLTSS) program, which began in July 2014, is designed to rebalance the State's long term care system away from its traditional reliance on nursing homes and toward a greater emphasis on home- and community-based services. Under MLTSS, Medicaid/NJ FamilyCare home- and community-based services (excluding those for individuals with developmental disabilities) and nursing facility services (excluding individuals who were already residing in nursing homes on July 1, 2014) have shifted from fee-for-service reimbursement to managed care. The State contracts with managed care organizations (MCOs) to administer these long-term care services, and the MCOs are responsible for coordinating and delivering the services and supports to eligible elderly clients and clients with disabilities.

Over 11,000 recipients of services under four formerly separate home- and community-based waiver programs (Global Options, the Traumatic Brain Injury waiver, the AIDS Community Care Alternatives Program, and the Comprehensive Resources for Persons with Disabilities waiver) were automatically shifted to MLTSS on July 1, 2014. Previously, these individuals were eligible to receive only the services within the specific waiver in which the person was enrolled; MLTSS provides coverage for all of the benefits from all four programs, plus some additional benefits. In response to FY 2015 OLS discussion point #27, the department indicated that the cost to the State to expand these services was about \$94 million (75 percent of \$125 million)

- ***Questions:*** To what extent are individuals who were enrolled in the four former waiver programs utilizing their newly expanded benefits? Specifically, what was average per-capita spending in each waiver program prior to implementation of MLTSS, and after?

Answer: In the year prior to the start of the MLTSS program the state spent \$253 million for 11,300 recipients on services under four home and community based waiver program. This represents a monthly per capita expenditure of \$1,869. On July 1, 2014 the reimbursement methodology for this group shifted from fee-for-service to managed care. The portion of the monthly capitation rate for the 11,300 recipients related to MLTSS is \$2,151. Therefore, the monthly per capita expenditure for the four HCBS waiver programs was increased by \$282.

SFY 2014 Wavier costs Prior to MLTSS			Source: A6260R05	
	recipients	PMPM cost	total cost	
Global Options	10,620	\$ 1,538	\$ 195,986,000	
TBI	304	\$ 7,117	\$ 25,936,000	
ACAP	111	\$ 252	\$ 336,000	
CRPD	259	\$ 9,980	\$ 30,998,000	
	11,293	\$ 1,869	\$ 253,256,000	
Post MLTSS costs			Source: FY 2015 CRCS	
	recipients	PMPM cost	total cost	
Global Options	10,620	\$ 2,151	\$ 274,123,440.00	
TBI	304	\$ 2,151	\$ 7,838,244.00	
ACAP	111	\$ 2,151	\$ 2,862,981.00	
CRPD	259	\$ 2,151	\$ 6,681,006.00	
	11,293	\$ 2,151	\$ 291,505,671.00	

39. A major purpose of MLTSS is to encourage diversion from nursing homes, instead promoting home- and community-based services whenever appropriate. The State’s application for the Comprehensive Medicaid Waiver anticipated gross savings of \$20 million to \$220 million annually from such diversions. In response to FY 2015 OLS discussion point #28b, the department indicated that the Governor’s FY 2015 Budget Recommendation assumed nursing home diversions consistent with prior years (attributed to the waiver programs that have been consolidated into MLTSS, and other diversion programs), and did not take any further adjustments attributable to MLTSS. The department indicated that it would use actual data from FY 2015 to build a new trend for FY 2016 in order to estimate savings from nursing home diversions made possible by MLTSS.

- **Question:** What savings does the department estimate will be possible in FY 2016 from nursing home diversions attributable to MLTSS, above those assumed in prior years?

Answer: The Department estimates that each diversion from a Nursing Facility into Community Based Care saves the State approximately \$1,438 per month in reduced capitations payments. The current SFY 2016 estimate for diverted NF placements is 2,765.

40. “Managing long-term care” (i.e. MLTSS) was one of several delivery system reforms associated with the Comprehensive Medicaid Waiver that were, in aggregate, originally anticipated to produce between \$16 million to \$40 million in State savings in FY 2012, according to information provided to the Assembly Budget Committee in June 2011.³⁰ It is also noted that the State’s September 2011 application to the federal government for the Comprehensive Medicaid Waiver anticipated savings from managed long-term care in every year of the program, which at that time was anticipated to begin in 2012. Accordingly, budget neutrality calculations in the State’s original application suggest State savings of \$10 million in the first year of MLTSS, \$35 million in the second year, and \$60 million in the third year. In contrast to these predictions, the FY 2015 Appropriations Act includes \$125 million in new State appropriations for implementation of MLTSS, and the Governor’s FY 2016 Budget Recommendation includes an additional \$113.2 million (page D-188). In response to FY 2015 OLS discussion point #28a, the department indicated that the State was updating the Comprehensive Waiver budget neutrality analysis to reflect the new implementation schedule.

³⁰ See discussion point #1 and associated footnotes for more detail.

- **Question:** For FY 2015 and FY 2016, please provide an update on the actual and expected costs to the State of the MLTSS program in relation to estimated costs that would have occurred if MLTSS had not been implemented. Please explain any significant difference between these revised estimates and the estimates submitted to the federal government and the Legislative budget committees, described above.

Answer: The success of the MLTSS program cannot be measured by looking solely at the MLTSS appropriations and expenditures. Funding for the MLTSS program is included in 3 appropriations: the MLTSS appropriation, the Nursing Home appropriation and the Managed Care appropriation within the DMAHS budget. Expenses for nursing home recipients in the MLTSS program are budgeted in the Nursing Home line. Expenses for the Home and Community Based MLTSS recipients are budgeted in the MLTSS line. Prior to the implementation of the MLTSS program, non-waivered medical expenses were funded with appropriations from the DMAHS Managed Care budget.

Increased appropriations in the MLTSS account are offset by lower increases in the Nursing Home and DMAHS Managed Care Accounts. Additional savings are realized through the Balancing Incentive Program. The federal government recognizes the quality of life advantages and cost benefits of MLTSS programs. To provide incentive for States to shift from institutional care to community based care, the Balancing Incentive Program provides an additional 2% federal share for Home and Community Based Expenditures through September 2015. To date, the State has saved over \$70 million by participating in the program.

The increase of \$125 million in new State appropriations included \$90 million for additional enrollment in the MLTSS program. The increase in enrollment has not materialized as quickly as anticipated, resulting in under spending in the SFY 15 appropriation. We anticipate reaching our target enrollment by the end of SFY 2016.

The current estimate for the Home and Community Services portion of the MLTSS program is \$233 million for SFY 2015 and \$396 million for SFY 2016.

41. A language provision in the FY 2015 appropriations act (Appropriation Handbook page B-101) requires the commissioner to “issue quarterly reports on enrollment, State and federal expenditures, access to care and measures of care quality.” The department reports some, but not all, of this information at the quarterly meetings of the Medical Assistance Advisory Council.³¹ As of March 2015, the OLS is not aware of the department issuing any written reports pursuant to this language.

- **Question:** When and how does the department plan to issue these required reports?

Answer: The Budget Language did not delineate where the reports were to be issued. However, DHS has met the SFY15 budgetary requirements for the issuance of quarterly reports on Managed Long Term Services and Supports (MLTSS) with regard to enrollment, State and federal expenditures, access to care and measures of care quality. Since the program was launched on July 1, 2014, the DHS has provided the MLSSS Steering Committee with the latest MLTSS progress indicators as they become available—given that MLTSS was launched in July 2014. The DHS has used the forum of the MLTSS Steering Committee’s quarterly meetings to present the information to stakeholders and satisfy this budgetary requirement. In the current budget year, the Committee has met on July 8 and October 30, 2014; and January 29, 2015. An upcoming meeting is set for May 14, 2015. As the information becomes available, it is presented, including the most recent progress indicators, quality measures and member profiles. Information

³¹ <http://www.state.nj.us/humanservices/dmahs/boards/maac/>

is also presented at the Medical Assistance Advisory Committee (MAAC) which is posted on-line. The link to the MAAC presentations is:
<http://www.state.nj.us/humanservices/dmahs/boards/maac>

42. Media reports have indicated that, at least in some parts of the State, some individuals in need of long-term care services are facing delays of several months while awaiting approval of their applications for MLTSS.³² This can result in individuals going without needed care, or family members incurring large expenses that may never be reimbursed. Some providers (such as nursing homes and assisted living facilities) have reported incurring large unreimbursed expenses to provide care for patients whose MLTSS applications are pending. (Coverage is retroactive to the date of application, so the facilities are eventually paid if the individual's application is approved.) According to these media reports, some advocates suggest individuals are enrolled in Medicaid/NJ FamilyCare but managed care organizations delay enrollment in MLTSS; others (including the managed care organizations) suggest that backlogs of Medicaid/NJ FamilyCare applications at the county welfare agencies are the root cause of such delays. In response to media questions, the department has indicated that it had no substantiation of the wait times.

- **Questions:** Please describe the process of obtaining MLTSS coverage, including the expected wait time for each stage of the process. Once an application has received full clearance from the county welfare agency, how long should it normally take for the enrollee's managed care organization to begin to cover services?

Answer: Individuals seeking MLTSS coverage continue to apply through their county welfare agencies (CWAs) to determine financial eligibility. DHS requires CWAs to process completed applications within 45 days or 90 days for individuals applying for disability.

MLTSS effective date of enrollment is the date that both financial and clinical eligibility has been approved. Once the applicant is determined eligible it can take between 2 and 9 weeks for enrollment into MLTSS depending on whether they select their MCO or they are auto-assigned. Selecting an MCO is faster.

Question: What might cause delays at this stage in the process?

Answer: Most delays are due to the 60 month look back that requires families individuals/families to gather documentation such as citizenship, income from all sources, assets, value of life insurance policies, etc. and the CWA's verification of the documentation.

In addition to financial eligibility applicants must meet nursing facility level of care (NF LOC). The CWAs refer individuals to their county area agencies on aging's Aging and Disability Resource Centers (ADRC) to conduct an initial screening that assesses the person's potential for clinical eligibility. Individuals who meet the criteria are referred to the Office of Community Choice Options (OCCO) to conduct a comprehensive clinical assessment to determine NF LOC. Under current policies OCCO is required to conduct the assessment within 30 days of referral.

Nursing Homes

43. The Governor's FY 2016 Budget Recommendation includes a State appropriation of \$732.8 million for Payments for Medical Assistance Recipients – Nursing Homes, on page D-188, an increase of \$27.8 million over the FY 2015 appropriation.³³ This line item includes only fee-for-service costs, and

³² <http://www.northjersey.com/news/delays-seen-in-approving-home-care-for-north-jersey-elderly-1.1277843>

³³ A footnote on page D-189 indicates that the FY 2015 appropriation will be supplemented with resources from other accounts. Informal information from the department indicates that the FY 2015 appropriation underestimated

excludes costs for individuals enrolled in MLTSS. All individuals who newly enter Medicaid/NJ FamilyCare-funded nursing home care are now required to enroll in MLTSS, which would suggest that the fee-for-service nursing home appropriation ought to gradually decline as the MLTSS appropriation increases. The projected increase in MLTSS enrollees, from 12,723 in FY 2015 to 20,823 in FY 2016 (page D-185) and similar increase in recommended appropriations, from \$280.284 million in FY 2015 to \$393.520 million in FY 2016 (page D-188), is consistent with this expectation. However, the number of nursing home patient days is expected to barely decline, from 9.98 million to 9.93 million, and the nursing home appropriation is recommended to increase.

- ***Questions:* Which Medicaid/NJ FamilyCare recipients' nursing home care is funded through the fee-for-service program, rather than MLTSS?**

Answer: The State appropriation of \$732.8 million for Payments for Medical Assistance Recipients – Nursing Homes, line item that is in DoAS's budget includes fee-for-service for resident in NFs prior to July 1, 2014, as well as payments for residents who enter NFs after July 1, 2014, who are enrolled in MLTSS.

- ***Question:* Under current rules, is it possible for a person not receiving fee-for-service nursing home care to newly enter that program?**

Answer: No. Under MLTSS all individuals who qualify clinically/financially for LTSS must enroll in MLTSS, regardless of whether they choose to live in a NF or in the community.

- ***Question:* Why does the budget not anticipate a larger decline in nursing home patient days (and the associated appropriation)?**

Answer: The budget projection for SFY16 and SFY17 was based upon the most current data, which due to NFs/MCOs not reporting claims in a timely manner, can lag approximately 6 months; therefore, DHS did not have sufficient data to project a more significant decline in nursing home patient days. The initial data, however, does indicate that the shift from NF custodial care to home and community based services (HCBS) is trending towards serving people more in home and community based settings. According to February's data, the NF population has decreased by almost 1,500 residents since June 2014 and 32% of the NJ FamilyCare LTSS members are receiving HCBS (the highest percentage to date).

actual costs, and an additional \$15 million to \$20 million in State funds may be transferred from other accounts. Thus, the increase from FY 2015 to FY 2016 may be closer to \$8 to \$13 million.

- **Question: Where is the anticipated growth in MLTSS enrollment expected to come from, if not from nursing homes?**

Answer: DHS anticipates the growth in MLTSS will be due to NF diversions. One of the primary goals of MLTSS is to identify and assess individuals currently residing in the community who are in need of LTSS and counsel them on options that will avoid or delay nursing facility placements.

44. Medicaid/NJ FamilyCare recipients who were enrolled in Medicaid/NJ FamilyCare and were residing in nursing facilities on July 1, 2014 are not required to enroll in MLTSS, and the State continues to pay for their care on a fee-for-service basis. The OLS is not aware of any clear policy encouraging or prohibiting these individuals from enrolling in MLTSS on a voluntary basis.

- **Questions: On July 1, 2014, how many Medicaid/NJ FamilyCare recipients were residing in nursing homes and thus excluded from the requirement to enroll in MLTSS? Of these, how many have voluntarily enrolled in MLTSS? How would enrolling in MLTSS change a nursing home resident's care or options?**

Answer: On June 30, 2014, 28,338 were receiving services under Medicaid in Nursing Facilities. Those individuals receiving custodial nursing facility (NF) services on Medicaid remain in a fee-for-service environment. The Department is unaware of individuals who resided in a nursing facility prior to July 1, 2014 who enrolled into MLTSS. There are triggers which would cause a custodial fee-for-service (FFS) resident on Medicaid in a nursing facility (NF) or a specialty care nursing facility (SCNF) to move into MLTSS. The primary trigger is a change in a resident's level of care, meaning the resident is transitioning from a NF to a SCNF; transitioning from a SCNF to a NF, or transitioning from a SCNF to a different kind of SCNF (i.e. behavioral to ventilator). Additionally, NF FFS residents will be enrolled in MLTSS when residents have been admitted to hospitals, discharged and transferred to different NFs.

45. A language provision originally included in the FY 2014 Appropriations Act, continued through FY 2015, and recommended for FY 2016 (page D-189) requires the Commissioner of Human Services to periodically assess the financial status of the nursing home industry. This assessment would be based on information comparable to the information provided by hospitals to the Department of Health to support the "financial early warning system," which is intended to give the State time to plan for a hospital's closure or take action to prevent the closure. In testimony before the Assembly Budget Committee during the FY 2015 budget process, Deputy Commissioner Arye indicated that the nursing home early warning system had not been developed during FY 2014, but that a mechanism had been established within the Health Care Facilities Financing Authority that would be functional during FY 2015.

- **Questions: What is the status of the nursing home "financial early warning system"? How will the commissioner report on the financial health of the nursing home industry?**

Answer: The Department of Human Services signed a Memorandum of Understanding with the New Jersey Health Care Facilities Financing Authority (HCFFA). Beginning in the third quarter of calendar year 2014, long term care facilities were asked to submit twenty-one financial and statistical elements. From this data, thirteen ratios measuring profitability, liquidity and utilization will be calculated for each facility. A review of statewide medians and quartiles, industry literature and the current acute care early warning system methodology suggest that five specific ratios and metrics could be used to indicate financial stress. These ratios /metrics are: Days cash on hand; Days in current liabilities; Operating Margin; Earnings before depreciation; and percent of occupancy.

Qualified Income Trusts/Medically Needy Program

46. Beginning in December 2014, the State has received federal approval to permit individuals in need of long-term care to use Qualified Income Trusts (QITs, also called Miller Trusts) in order to obtain Medicaid/NJ FamilyCare eligibility for long-term care services in a nursing facility, assisted living facility, or at home. A QIT allows individuals to deposit income over the Medicaid/NJ FamilyCare limit into a trust account, which is not counted for purposes of determining eligibility. Income placed in the trust is irrevocably dedicated to certain purposes specified by federal regulation (personal or medical needs allowances, community spouse maintenance allowances, uncovered medical costs, and Medicaid cost sharing).³⁴

- **Question:** Thus far, how many people living at home or in assisted living facilities have qualified for Medicaid/NJ FamilyCare by using a QIT?

Answer: As of March 15, 2015 the Department's data shows:

Total QITs applications: 460
NH: 355
AL: 62
HB: 43

Eligible: 43
Denied: 32
w/drawn: 19
Pending: 366

47. Federal law prohibits a state that employs QITs to also have a Medicaid Medically Needy program, which allows certain individuals in need of nursing home care who do not meet financial eligibility standards to qualify for Medicaid. Consequently, New Jersey has terminated new enrollment in the Medically Needy program. Under federal law, Medically Needy programs are available only to individuals residing in nursing homes, not individuals living in assisted living facilities or at home. The department has indicated that its decision to adopt QITs in lieu of the Medically Needy program is primarily an effort to promote home- and community-based services over unnecessarily restrictive and expensive placements in nursing homes.

Although QITs are in many respects more advantageous for beneficiaries than the Medically Needy program, the change effectively results in a reduction of the resource limit for eligibility (from \$4,000 for an individual or \$6,000 for a couple, to \$2,000 for an individual or \$3,000 for a couple). The reduced resource limit applies to people already enrolled in the Medically Needy program, as well as new applicants.

- **Questions:** How many individuals enrolled in the Medically Needy program were affected by the reduction in resource limit?

Answer: None

Have any lost Medicaid/NJ FamilyCare eligibility as a consequence?

Answer: No, individuals enrolled in the Medically Needy program were grandfathered to maintain their Medicaid eligibility through the Medically Needy program; therefore, as long as

³⁴ Additional details are provided at <http://www.state.nj.us/humanservices/dmahs/clients/mtrusts.html>

they remain clinically/financially eligible under the Medically Needy guidelines they continue to maintain their coverage with no resource reduction.

- **Question: Prior to the freeze on the Medically Needy program, approximately how many people with resources over the standard \$2,000/\$3,000 limit per year were enrolled in the Medically Needy program?**

Answer: The Medically Needy Program is no longer available so this information is no longer tracked. Anyone enrolled in Medically Needy for Long Term Care prior to December 1, 2014 were grandfathered into the program under the Medically Needy rules. Approximately 2,700 people were grandfathered. The Department did not make anyone grandfathered from the Medically Needy program reduce their resources. If someone in Medically Needy wants to establish a QIT they would have then have to reduce their resources down to the \$2,000/\$3,000 level. The Department does not know of anyone in Medically Needy that has opted to establish a QIT to date.

48. Because QITs allow some individuals to qualify for long-term care provided by Medicaid/NJ FamilyCare that they could not receive through the Medically Needy program, this shift to QITs may result in increased costs to the State. However, since QITs may allow Medicaid/NJ FamilyCare beneficiaries to receive services at home or in assisted living facilities, which are usually less expensive than nursing home care, the shift to QITs could result in lower costs.

- **Question: What is the net fiscal impact to the State of the shift from a Medically Needy program to QITs? (Please provide FY 2015 and 2016 estimates, as well as a long-term estimate.)**

Answer:

Cost of shifting from a Medically needy program to QIT program		
SFY	SFY 2015	SFY 2016
FEDERAL MATCH	50%	50%
FEDERAL EXPENDITURES	\$ 3,232,652.54	\$ 31,637,917.39
STATE EXPENDITURES	\$ 1,616,326.27	\$ 15,818,958.70

Community Programs

49. The FY 2011 Appropriations Act established the Community Based Senior Programs line items, one representing General Fund expenditures, and one representing Casino Revenue Fund expenditures (page D-188). In response to FY 2015 OLS discussion point #35, the department indicated that the FY 2015 recommendation disaggregated as follows:

<u>Program</u>	<u>Allocation</u>
ElderCare Initiative/Jersey Assistance for Community Caregiving (JACC)	\$10,027,000
Demonstration Adult Day Care Center Program – Alzheimer’s Disease	\$500,000
Purchase of Social Services/Social Services Block Grant (SSBG)	\$10,579,000

ElderCare Advisory Commission Initiatives	\$2,309,000
Congregate Housing	\$784,000
Adult Protective Services	\$900,000
State Home Delivered Meals	\$625,000
Alzheimer's Disease Program	\$3,632,000
Adult Protective Services	\$3,878,000
Senior Citizen Housing – Safe Housing and Transportation	\$1,726,000
Respite Care for the Elderly	\$5,359,000
Congregate Housing Support Services	\$2,077,000
Weekend Home Delivered Meals	\$1,020,000
SSBG-like Grant Programs (reallocated from DCF)	\$378,000
Area Agencies on Aging Call Center	\$120,000
Administrative	\$4,041,000
Total	\$45,646,000

- **Question:** Please update the table above, providing information for FY 2014 (expended), FY 2015 (estimated), and FY 2016 (recommended).

Answer: See updated chart below:

<u>Program</u>	<u>Allocation</u>	<u>2014 Expended</u>	<u>2015 Estimated</u>	<u>2016 Estimated</u>
ElderCare Initiative/Jersey Assistance for Community Caregiving (JACC)	\$10,027,000	\$10,027,000	\$10,027,000	\$10,027,000
Demonstration Adult Day Care Center Program – Alzheimer's Disease	\$500,000	\$500,000	\$500,000	\$500,000
Purchase of Social Services/Social Services Block Grant (SSBG)	\$10,579,000	\$10,579,000	\$10,579,000	\$10,579,000
ElderCare Advisory Commission Initiatives (\$2,309,000)				
Congregate Housing	\$784,000	\$775,000	\$784,000	\$784,000
Adult Protective Services	\$900,000	\$900,000	\$900,000	\$900,000
State Home Delivered Meals	\$625,000	\$625,000	\$625,000	\$625,000
Alzheimer's Disease Program	\$3,632,000	\$3,349,000	\$3,632,000	\$3,632,000
Adult Protective Services	\$3,878,000	\$3,811,700	\$3,878,000	\$3,878,000
Senior Citizen Housing – Safe Housing and Transportation	\$1,726,000	\$1,715,000	\$1,726,000	\$1,726,000
Respite Care for the Elderly	\$5,359,000	\$5,332,000	\$5,359,000	\$5,359,000
Congregate Housing Support Services	\$2,077,000	\$1,901,000	\$2,077,000	\$2,077,000
Weekend Home Delivered Meals	\$1,020,000	\$1,020,000	\$1,020,000	\$1,020,000
SSBG-like Grant Programs (reallocated from DCF)	\$378,000	\$167,583	\$378,000	\$378,000

Area Agencies on Aging Call Center ¹	\$120,000	\$139,272	\$142,000	\$142,000
Administrative	\$4,041,000	\$3,332,599	\$4,041,000	\$4,041,000
Total	\$45,646,000	\$44,174,154	\$45,668,000	\$45,668,000

¹ \$22,000 from other resources was added to this line item in 2014 Expended; 2015 Estimated; and 2016 Estimated.

Division of Developmental Disabilities (DDD)

Community Services

50. Beginning on July 1, 2015, the division plans to shift to a fee-for-service reimbursement system for community providers,³⁵ replacing a system primarily based on cost-reimbursement contracts. The new reimbursement system is intended to promote fairness and equity in rates paid to providers, portability of benefits for consumers, affordability for the State, and simplicity and practicality for all involved parties. The new reimbursement system will result in some providers receiving increases in their effective reimbursement rates, and other providers receiving decreases. DDD has engaged several advisory committees and stakeholder groups, and has conducted several information and training sessions for providers and families in preparation for the new system. Press reports have covered one facility, the Arc of Monmouth County's Ambulatory Care Center in Tinton Falls, which had its contract with DDD terminated (but later to be partially reinstated).³⁶ The department indicated that the center's services were duplicative of those available through the Medicaid managed care system.

- ***Questions:*** Based on the stakeholder input received thus far, what challenges does the division expect in the implementation of the new reimbursement system? How will providers receiving lower effective reimbursement rates cope with the adjustment? How many provider contracts have been terminated or will be terminated, rather than transitioned into the new system?

Answer: The adjustment to the Arc of Monmouth contract was related to the type of services provided, not implementation of the fee-for-service reimbursement system. Individuals will still be able to receive these services through the State's Medicaid program.

During the transition to fee-for-service, providers may be required to account for costs and revenue in two systems and to develop new cash management strategies due to the difference in reimbursement timing. The Division has been actively engaged in discussing these issues with the provider community, presenting materials on the rate and reimbursement system, and working with the State's Medicaid offices and fiscal intermediary to ensure that coding, billing and other technical assistance trainings are available once an implementation date is set. To date, approximately 30% of the Division's providers are already fee-for-service billers in other service areas, so the developmental disabilities transition will actually improve the efficiency of their overall operations.

With respect to service provision and funding levels, the Division has sent providers projected funding totals based on current contract service levels and individuals assessments, and has agreed to perform a full reassessment of all individuals as they are transitioned into the fee-for-service system. This will ensure that providers are aware of an individual's funding level before they begin in the new model. As cost reimbursement contracts are transitioned, it will be the business decision of each provider as to whether or they will continue to provide certain services. In addition, the Division is designing a bridge funding process to assist agencies in good programmatic and financial standing with potential cash flow issues during transition

51. The Supports Program is a new Medicaid program, authorized by the Comprehensive Medicaid Waiver, intended for adults with developmental disabilities who are living in unlicensed settings, such as with family members or in their own homes. In effect, the Supports Program will replace the State's current Family Support Program, allowing the State to receive a 50 percent federal match for the program's expenditures, but subjecting the State to certain federal rules that do not apply to services

³⁵ <http://www.state.nj.us/humanservices/ddd/providers/ratestudy.html>

³⁶ <http://www.app.com/story/news/local/monmouth-county/2015/01/14/arc-clinic-funding-cut/21789781/>

funded entirely by the State. Eventually, the program is anticipated to enroll all DDD consumers not enrolled in the Community Care Waiver (CCW), including all individuals on the CCW waiting list.

Every individual enrolled on the Supports Program selects (or is assigned by the Division to) a Support Coordination Agency. The Support Coordination Agency then assigns a Support Coordinator to initiate the Person-Centered Planning Process with the individual and his/her family. Each individual will be able to access services with an “up to” budget amount within one of three levels: \$5,000, \$10,000 or \$15,000 based on their assessed level of need. DDD staff – called Waiver Assurance Coordinators – will review and approve the Service Plans, authorize services, and provide quality assurance. Support Coordinators will assist the participants to enroll in various programs which provide employment and day habilitation services and individual and family supports (e.g., adaptive technology, behavioral supports, respite).

The Supports Program is scheduled to begin on July 1, 2015. Performance data on page D-164 of the Governor’s FY 2016 Budget Recommendation indicate that the department anticipates enrolling 2,000 individuals in the Supports Program during FY 2016. The recommended appropriation on page D-203 shows \$11.3 million in federal funding resulting from the Supports Program.

- **Questions:** What is the total amount of federal funding expected to be generated from the Supports Program in FY 2016? What is the total amount (state and federal) anticipated to be expended on contracts with Support Coordination Agencies/Supports Coordinators? Of the 2,000 new enrollees anticipated for the Supports Program, how many are currently enrolled in Medicaid and receiving services from the State? When fully implemented, what are the total anticipated expenditures, federal and State, for the Supports Program?

Answer: The FY16 Governor’s Budget includes \$11.345 million of projected federal revenue related to Supports Program services, a 50% match on total projected expenditures of \$22.69 million. At full implementation, the Divisions anticipates spending approximately \$200 million annually, split evenly between existing State resources and new federal revenue. Recent regulatory updates require all individuals receiving services from the Division to enroll in Medicaid.

52. The Community Care Waiver (CCW) allows the State to claim federal Medicaid matching funds for a package of services provided to enrolled individuals with developmental disabilities who are living in the community. The CCW was originally scheduled to expire on September 30, 2013, but has received several short-term extensions. A CCW renewal application is currently pending federal approval. According to the department’s CCW application,³⁷ the maximum number of participants in the CCW is 12,562, with possible extensions for individuals moving out of developmental centers or for emergency placements. In response to FY 2015 OLS Discussion Point #42, the department indicated that the changes to the CCW may include the expansion of eligible groups to include NJ Workability; additional employment services and therapies such as Habilitative Occupational Therapy, Physical Therapy, and Speech and Language Therapy; and Behavioral Supports services as a result of stakeholder feedback.

- **Questions:** What explains the continued delay in fully renewing the CCW? What are the areas of disagreement between the State and the federal government? What is the total number of participants in the CCW currently? How many individuals does the department anticipate serving through the CCW in FY 2016 and FY 2017?

Answer: The delay in the CCW Renewal being approved by the Centers for Medicare and Medicaid Services (CMS) is their review of DDD’s rate methodology. CMS has heightened its scrutiny of Waiver Appendices (I & J) that focus on States rate methodologies. Upon initial review of the CCW Renewal, CMS requested that DDD update all Waiver Service methodologies

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and provide extensive supporting documentation. DDD complied with this request and participated in multiple phone calls to explain the supporting documentation and claiming process. CMS has verbally approved the Operational Appendices (A-H) of the Renewal.

As of April 2, 2015 there are 10,824 individuals on the CCW with 201 applications pending approval at the Division of Medical Assistance and Health Services (DMAHS) Institutional Services Section (ISS) of Medicaid.

The Division identified in the CCW Renewal that they anticipate a maximum of 12,664 unduplicated participants on the CCW for FY2016 and 13,114 unduplicated participants on the CCW for FY2017.

53. According to the department's response to FY 2015 Discussion Point #43b, there were 6,592 individuals on the CCW Waiting List for services, and 3,791 of these are designated as Priority placements. The Priority category indicates that the State has deemed these individuals to be at significant risk of homelessness or facing imminent peril if an emergency were to happen. The department has recommended an additional \$1.8 million in funding (page D-202) for CCW waiting list placements in FY 2016. Budget data indicates that the department anticipates additional housing for individuals in supervised apartments (+17); group homes (+106) and decreased numbers served in skill development homes (-77), supported living (-11) and private institutional care and residential facilities (-32).

- **Questions:** How many individuals are currently on the CCW waiting list? Of those individuals, please indicate the number currently on the Priority Waiting List and the General Waiting List. How many DDD consumers are not on the CCW or the CCW Waiting List? How many current recipients of DDD services are not enrolled in Medicaid/NJ FamilyCare?

Answer: There are 6,353 currently on the Community Services Wait List of which 3,666 are on the Priority Waiting List and 2,687 on the General Waiting List. It is important to note, however, that the CSWL pertains to enrollment on the Community Care Waiver – some individuals may not meet level of care for the CCW, but may be eligible for Supports Program enrollment. Of the 6,353 on the CSWL, 909 are children and not currently eligible to receive services. All of the adults are receiving employment, day and certain in-home support services, if requested. Recent regulatory updates require all individuals receiving services from the Division to enroll in Medicaid. There is a subset of clients who the Division is actively working to enroll in Medicaid/NJ FamilyCare.

Statewide Transition Plan

54. In January 2014, the Centers for Medicare & Medicaid Services (CMS) issued a final rule which incorporated amendments as part of the Affordable Care Act and other regulatory changes to ensure that Medicaid's home and community-based services (HCBS) programs provide full access to the benefits of community living and offer services in the most integrated settings (42 CFR Parts 430, 431, 435, 436, 440, 441, and 447).³⁸ The regulations were effective on March 17, 2014 and the State had one year from this date to develop and submit a plan to comply with the federal rules. The State released a draft Statewide Transition Plan which established requirements for services provided through the Supports Program and the CCW.

³⁸ For more information on the Final Rule, see <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html>

The department released the draft plan on the Internet the last week of January and held two public hearings on February 4, 2015 and February 19, 2015. During the 30-day comment period, the State received over 1,000 comments on the plan. In order to respond adequately to the many public comments, the department requested and received a 30-day extension to submit the plan to CMS.

The draft plan proposed several new requirements on programs that generated a large public response. Some of the more controversial proposals are: congregate settings (such as supervised apartments or group homes) may serve no more than four people, or six under certain circumstances; individuals who attend daily work or recreational programs must spend three-quarters of the day outside facilities which are dedicated to people with disabilities; no more than 25 percent of housing units in non-congregate settings may be set aside for persons with disabilities; and housing will be a separate service and be facilitated by the Supportive Housing Connection, a partnership between the DHS and the Housing and Mortgage Finance Agency (HMFA).

- **Questions:** What is the department's anticipated timeline for the implementation of the Statewide Transition Plan? How much State and federal funding does the State anticipate providing to the HMFA for the administration of housing subsidies? What will be the fiscal impact of the Supportive Housing Connection on the department's expenditures on purchased residential care, by type of facility as detailed on page D-200 of the budget?

Answer: The CMS rule requires that states achieve compliance with the final rule by March 2019 or risk jeopardizing their federal Medicaid Waiver funding. For New Jersey, that will affect all the initiatives that are implemented as of 2019 under what is currently the NJ 1115 Comprehensive Medicaid Waiver Demonstration (NJCW) and the Community Care Waiver (CCW).

No federal funding will be provided to NJHMFA for the administration of housing subsidies. Housing is not a Medicaid-eligible service and as such has always been supported through State funds. DHS and HMFA have signed a Memorandum of Understanding that redirects approximately \$900,000 of existing State resources to HMFA for the administration and operation of the Supportive Housing Connection.

The Supportive Housing Connection will not have an impact on the expenditures on purchased residential care, as DHS will continue to support the housing costs currently represented in contract with provider agencies. The funds will be administered by the Supportive Housing Connection instead of directly in contract with provider agencies.

Return Home New Jersey

55. The Return Home New Jersey initiative began in FY 2009 to bring back to New Jersey adults with intellectual and developmental disabilities who had been residing in out-of-State facilities. The department has stated that the in-State system of care is now capable of appropriately caring for these individuals, and that the State could achieve significant savings by relocating these individuals to New Jersey and enrolling them in the Community Care Waiver. Some of the out-of-State facilities may not be eligible to receive federal Medicaid matching funds, because they are presumed not to be in compliance with the Home- and Community Based Services Final Rule.

In testimony to the Assembly Human Services Committee on June 12, 2014, the department asserted that in FY 2009, the first year of the program, there were nearly 700 adult NJ residents receiving residential services in out-of-State facilities. Since that time, the department has moved approximately 150 individuals to in-State placements, but other information provided to the OLS indicates that there are currently 398 individuals in out-of-State facilities. Some families have objected to moving some individuals to New Jersey placements, asserting that their loved ones would be harmed by the disruption

caused by a forced relocation, are receiving excellent care in their current out-of-State placement, and/or are costing the State less than they would if moved in-State.

- **Questions:** To date, how many individuals have been moved from out-of-State placements to in-State placements under the Return Home New Jersey initiative? How many have been terminated from DDD's care as a result of their refusal to leave their current placement? What is the average cost of an in-State placement, which the DDD is required to annually publish in the New Jersey Register pursuant to its own regulations (N.J.A.C.10:46B-4.3)? How much has the State saved as a result of these relocations and terminations? In calculating these savings, how does DDD determine the total costs of an out-of-State placement compared to an in-State placement (that is, are medical care, transportation, room and board, and other costs included to create an "apples-to-apples" comparison)?

Answer: As of March 30, 2015, 170 individuals have been moved to in-State placements under the Return Home New Jersey initiative. The approved calendar year 2014 patient payment per diem rate for residential functional services is \$398.00. The State cost of medical care also declines as out-of-state treatments previously paid for by the Division through vouchers are now billed through Medicaid/NJ FamilyCare.

- **How many individuals are currently receiving DDD-funded care in an out-of-State placement? How many of these individuals are currently enrolled in Medicaid? What are the out-of-State facilities/providers are serving these individuals, and in which states are they located? What is the gross annual cost for each of these individuals? Of this annual cost, how much is paid by federal funds? How much is paid by individuals as a contribution to care?**

Answer: As of March 30, 2015, there are 382 individuals receiving DDD funded services in out-of-state facilities, of whom 286 individuals are receiving New Jersey Medicaid (as of 3/31/15). The estimated gross annual cost to the Division in FY15 totals \$48.3 million, of which \$1.4 million is federal funds and \$3.3 million is offset by contribution to care.

These services are being delivered in 32 out-of-state facilities, as follows:

Advoserv in DE; Advoserv in FL; Boston Higashi School in MA; Briarwood-Brookwood in TX; Camphill Village in PA; Center for Discovery in NY; Chapel Haven in CT; Deaf Independent Living Association in MD; Devereux Foundation in PA; Elwyn in PA; Four Winds Community in NH; Justice Resource Institute in MA; Keystone Community Resources in PA; Leander House in MA; Lukas Foundation in NH; Magnolia House in FL;

Martha Lloyd in PA; Melmark in PA; Milton Developmental Services in PA; New England Center for Children in MA; Pathfinder Village in NY; Pine Rest Christian Mental Health Services in MI; Plowshare Farm in NH; Prader-Willi Homes of Oconomowoc in WI; Re-Med Recovery Care Center in PA; Riverbrook Residence in MA; Shorehaven of Delaware in MD; Star Community in MD; Triform Enterprises in NY; Vista Vocational and Life Skills Center in CT; Waterfall Canyon Academy in UT; and Woods Services in PA.

- **Has DDD explored alternative routes to reducing its costs for individuals in out-of-State placements when the individual or family objects to the relocation? Such routes might include: (1) submitting to federal "heightened scrutiny" to demonstrate that facilities are compliant with the Home- and Community-Based Services Final Rule; (2) encouraging the facility to make adaptations so that it may come into compliance with the Home- and Community-Based Services Final Rule; or (3) moving the consumer's legal residence, and therefore Medicaid coverage, to the state in which the facility is located.**

Answer: The Division has made attempts to reduce the cost of out of state placements in cases where the family objects to relocation.

- 1) Submitting to federal “heightened scrutiny” to demonstrate compliance with HCBS Final Rule
 - a. Heightened scrutiny not needed as the Division of Developmental Disabilities is currently claiming for 120 individuals in out-of-state settings under HCBS standards. This leaves 264 for which we are unable to receive Federal reimbursement.
- 2) Encouraging facilities to make adaptations so that they can come into compliance with the HCBS Final Rule
 - a. The Division of Developmental Disabilities has worked with out-of-state agencies to bring them into compliance with HCBS Medicaid Standards. Currently, 120 individuals in out-of-state settings meet HCBS or ICF rules for claiming for which New Jersey is receiving a Federal match on the cost of care. These settings are Devereux in PA, Keystone Community Resources Inc. in PA and Melmark in PA. None of the other settings are able to comport to HCBS Medicaid standards.
- 3) Moving consumer’s legal residence, and therefore Medicaid coverage, to the state in which they are located:
 - a. The Division actively approaches other states about allowing individuals to remain there. For example, Wisconsin was recently approached about two individuals residing at Prader-Willi Homes of Oconomowoc whose families wish them to remain. Wisconsin declined to allow this to occur. Similar denials have been received from other states. The rationale has been that each state has its own waiting lists for services and by allowing a person to come through their DD systems intake and immediately be placed was not fair to current residents. This concept is also met with resistance by families as, in many cases, the out-of-state facility in which the individual resides is not a Medicaid provider in any state. For example, Woods Services in PA is not a Medicaid provider in its home state. Hence, even if PA residency was obtained and that state agreed to take over care, they would not allow the person to remain in that facility as no claiming could take place.

Developmental Centers

56. During FY 2015, both North Jersey Developmental Center and Woodbridge Developmental Center were closed, and their residents moved to community placements or other State developmental centers. According to budget data (page D-197 to D-198) the average daily population for all centers in FY 2014 was 2,056 and in FY 2016, it is anticipated to decrease to 1,495. The decrease in population is matched by an estimated decrease in positions, from 7,065 in FY 2014 to 4,820 in FY 2016 (page D-198). The centers are supported by State and federal funding.

- **Questions:** What has been the average cost per person to move individuals from the developmental centers? In calculating these savings, how does DDD determine the total costs of an institutional placement compared to a community placement (that is, are medical care, transportation, room and board, and other costs included to create an “apples-to-apples” comparison)? At what cost point does the population of an institution become too low to justify the costs of maintaining the physical and staffing needs of the institution?

Answer: Serving an individual in a DC costs approximately \$302,062 (based on the ICF/MR reimbursement rates, including the allocation of interdepartmental fringe and indirect costs), versus \$202,000 in the community (including approximately \$26,000 of Medicaid and case management costs, and \$16,000 of federally-match administrative expenses). Moving an individual to the community also results in a one-time capital investment, although the amount

varies depending on the housing type and the provider's preferred financing method. Given the cost differential, the institutional population is already too low to justify maintaining all of the centers at their current operational capacity. Hence, the two recent closures helps rebalance resources between the community and the developmental centers.

Data Reporting

57. Pursuant to P.L.2011, c.163 (C.30:6D-32.6 et seq.), the DDD is required to annually publish a report, to be made available on the department's website, containing non-identifying aggregate data about persons eligible to receive services from DDD. The DDD was also required to report to the Governor and the Legislature two years after the act's effective date (that is, by February 2015) as to the progress of the data collection and reporting required under the act, and the viability of including additional data within its data collection and reporting practices. As of March 2015, the OLS is unable to locate any data or report prepared pursuant to P.L.2011, c.163.

- ***Questions:*** What is the status of the DDD's reports required pursuant to P.L.2011, c.163? When does the division anticipate a report to the Governor and the Legislature will be made?

Answer: The Division prepared and published an initial report in response to the legislation in January of 2013. Due to the various system reforms the Division has been working on since that time, much of the data originally called for in the legislation is now routinely shared with stakeholders through other mechanisms. The Division anticipates that a report compiling this information will be available soon. Related information can be found within the following three sections of the Division's website:

http://www.state.nj.us/humanservices/ddd/programs/ffs_implementation.html,
<http://www.state.nj.us/humanservices/ddd/programs/supportsprgm.html>,
<http://www.state.nj.us/humanservices/ddd/news/news/index.html>.

Division of the Deaf and Hard of Hearing (DDHH)

58. Evaluation data in the Governor's FY 2016 Budget Recommendation (page D-213) indicate that the division has distributed approximately 1,000 smoke detectors and carbon monoxide detectors designed for individuals who are deaf or hard of hearing in the past four years. The DDHH website indicates that each eligible applicant may receive up to two smoke detectors and one carbon monoxide detector featuring strobe lights and loud alarms.³⁹ Some research has suggested that strobe lights may be ineffective at waking sleeping persons who are deaf or hard of hearing, and that low frequency audible alarms or tactile devices, such as bed shakers, may be more effective.⁴⁰

- ***Questions:*** Has the division considered offering bed shaker alarms through its equipment distribution program? What would be the estimated annual cost to provide bed shaker alarms to individuals who are currently eligible to receive smoke detectors and carbon monoxide alarms?

Answer: The division maintains a policy of distributing a limit of one strobe smoke alarm and one strobe carbon monoxide detector per eligible household. There are many variables DDHH considers in selecting devices for the division's equipment distribution program. These factors include degree of hearing loss, device effectiveness, cost, ease of installation and versatility. Compared to the vibrating smoke alarm, the division believes that a strobe/auditory alarm is cost efficient, versatile and equally effective in awakening individuals from their sleep. The strobe alarm is portable, fits into any electrical outlet and has a battery backup should electricity be lost in an emergency. The vibrating alarm, which is most often placed under the bed mattress, is functional only in the bedroom while the consumer sleeps. Further, the vibrating alarm is more costly.

³⁹ <http://nj.gov/humanservices/ddhh/equipment/catalogue/index.html>

⁴⁰ E.g.

http://www.nfpa.org/~media/Files/Research/Research%20Foundation/Research%20Foundation%20reports/alcohol_alarmsreport.pdf

Division of Family Development (DFD)

CASS

59. For at least eight years, the State has been working to replace the outdated computer systems used by county welfare agencies and the DHS to enroll applicants and manage several means-tested human services programs, such as SNAP, Medicaid/NJ FamilyCare, and Work First New Jersey with a new system called the Consolidated Assistance Support System (CASS). The original RFP for a contractor to develop the system was released in 2007, and work on the project began in 2009. In November 2014, the department announced the cancellation of its contract with Hewlett-Packard.⁴¹

At various times, department officials have indicated that the implementation of CASS would be instrumental in reducing the application processing and enrollment backlogs at many county welfare agencies, though it has been unable to deliver on this promise due to its repeated delays, and now its cancellation. In the absence of CASS, some advocates have suggested that increased staffing at county welfare agencies may be the only feasible way to quickly address the backlogs. The department has diverted some Medicaid/NJ FamilyCare applications to its contracted health benefits coordinator, Xerox, in attempt to ease the backlog at some county offices.

- ***Question:*** Please describe the methodology by which the State pays county welfare agencies and Xerox for their roles in processing applications for public assistance. How many applications for each program are processed by each county and by Xerox in an average month? What incentives and penalties are available to the State in encourage improved performance? With the cancellation of the CASS contract, how does the department plan to address the existing enrollment backlogs? Does the department have any near-term plans to upgrade or replace the existing computer systems? Will the State be able to retain any of the work done under the now-terminated CASS contract?

Answer: Beginning January of 2015, the State implemented a performance based payment methodology for the CWAs. The State pays \$35.80 for each new application processed resulting in an active case and \$35.80 for each processed redetermination resulting in an active case.

The annual compensation per enrollee for Xerox to perform Eligibility Determinations is approximately \$29.88 (\$3.98 – \$1.49 x12). Xerox is paid a monthly amount of \$1.49 for each Medicaid enrollee and \$3.98 for each NJ FamilyCare enrollee. The difference in the rates is the Eligibility Determination component. The Eligibility Determinations for Medicaid clients were previously performed by the CWAs and the \$1.49 is for Managed Care Enrollment.

The caseload at the CWAs has increased from 391,712 in December of 2013 to 693,104 in March of 2015 mainly due to the Affordable Care Act. The State received a waiver to suspend annual redeterminations through calendar year 2014. Despite the waiver, most CWAs have experienced trouble keeping pace with the increased volume of new applications resulting in substantial backlogs.

In order to assist the CWAs with the caseload, the State began to shift some of the caseload to Xerox:

- All new online applications are being routed to Xerox.
- All FFM renewals (100,000) are going to Xerox.

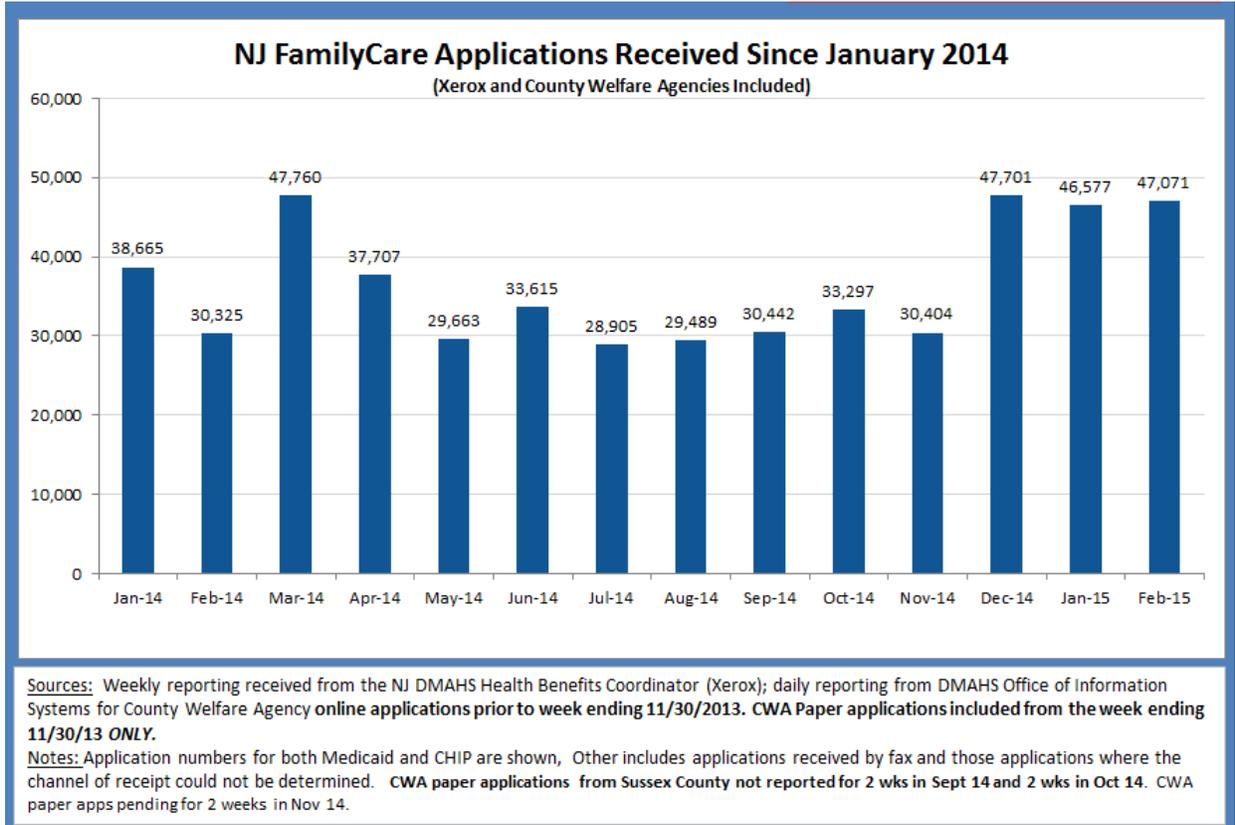
⁴¹ Contract number T-2496

- All new Presumptive Eligibility (PE) applications are going to Xerox (24,000 backlog PE cases from the CWAs have already been moved and completed by Xerox),
- Approximately 36,000 backlogged CWA cases were shifted to Xerox

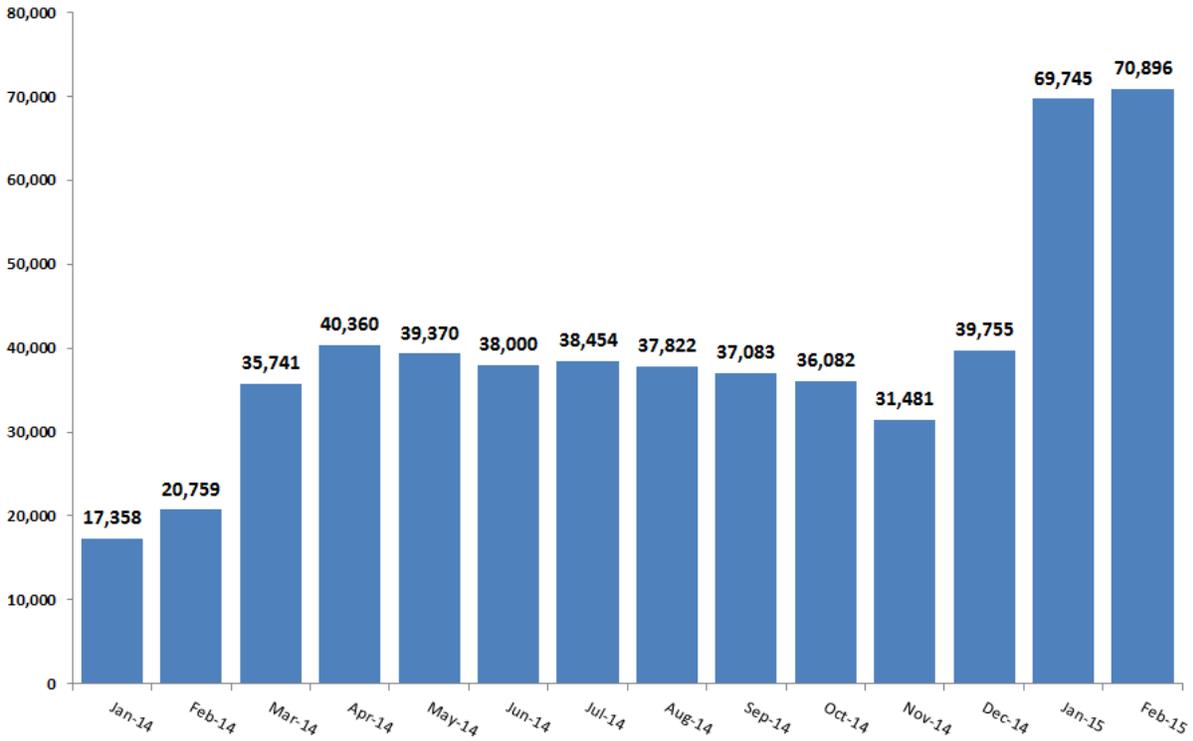
The remaining CWAs caseload is approximately 450,000 redeterminations to do in Calendar Year 2015 along with all new “walk-in” applications.

Following are 4 charts that provide some of the information requested:

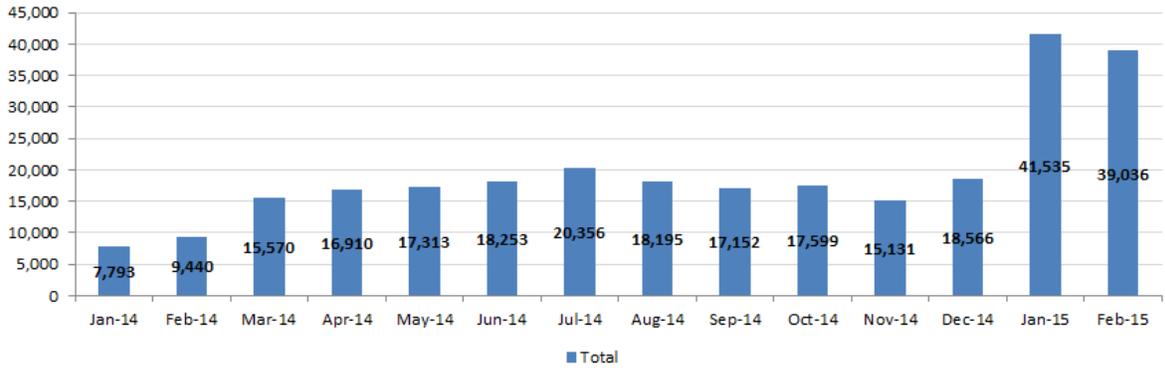
- Chart 1 shows all applications received by Xerox and the CWAs since January 2014
- Chart 2 shows all individuals receiving an eligibility determination, regardless of outcome (includes those determined eligible and those determined ineligible)
- Chart 3 shows only those individuals determined eligible by Xerox ONLY (no CWA information available) since January 2014
- Chart 4 shows only those individuals determined ineligible by Xerox ONLY (no CWA information available) since January 2014



Individuals Receiving an NJ FamilyCare Eligibility Determination, All Outcomes (Xerox ONLY; CWA information not included)



Individuals Determined Eligible for NJ FamilyCare (Xerox ONLY; CWA information not included)

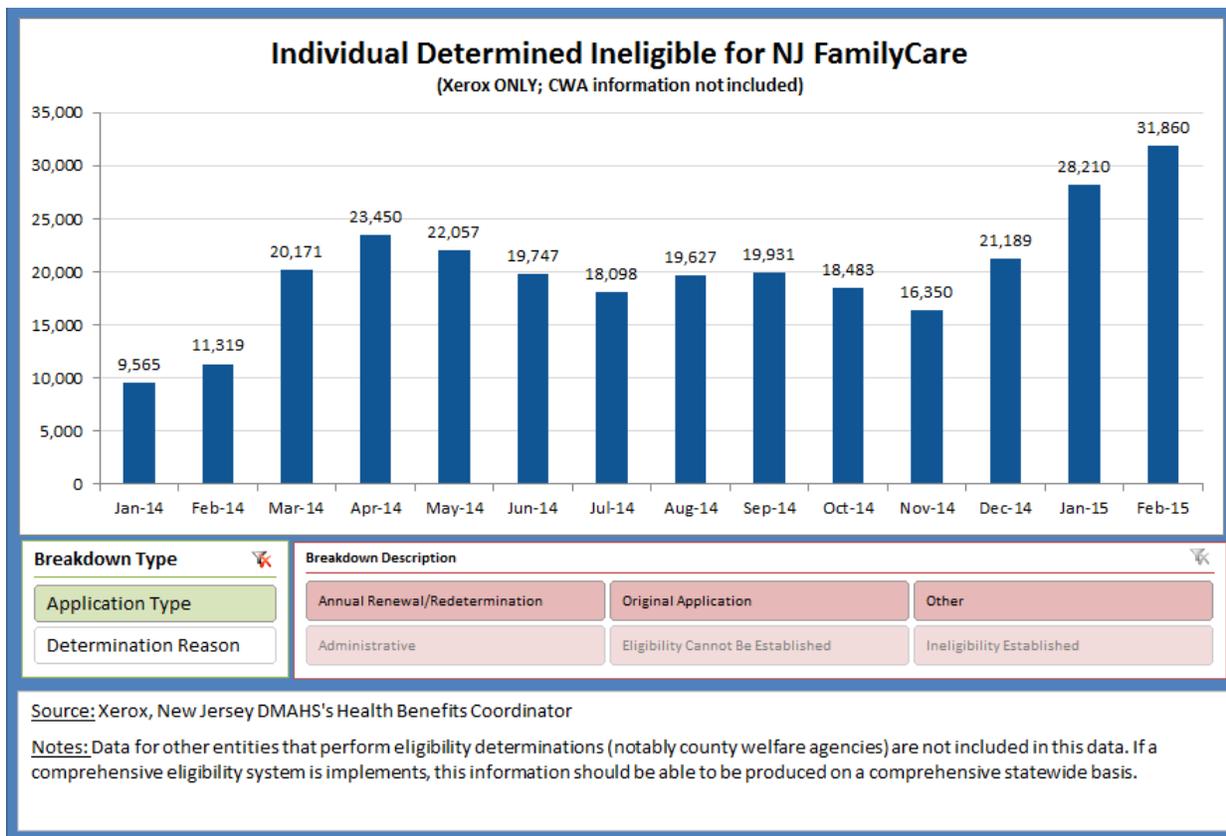


Program
CHIP
Medicaid
Total

Breakdown Description	
Administrative	Annual Renewal/Redetermination
Eligibility Cannot Be Established	Ineligibility Established
Original Application	Other

Source: Xerox, New Jersey DMAHS's Health Benefits Coordinator

Notes: Data for other entities that perform eligibility determinations (notably county welfare agencies) are not included in this data. If a comprehensive eligibility system is implemented this information should be able to be produced on a comprehensive statewide basis.



The Department has hired the consulting firm of KPMG to conduct a functional and technical assessment of the work completed on the CASS system to date and determine the best way forward on implementing a new integrated assistance system. As part of the functional and technical assessment, the KPMG team is reviewing all work conducted on the CASS project to determine what code, systems, and equipment may be used to develop and implement a new system for the Department.

60. The implementation of CASS has been delayed several times since the project's inception in 2007. The department has provided a variety of explanations for these delays, including the addition of Medicaid/NJ FamilyCare to the project, federal rule changes resulting from the Affordable Care Act, and problems with the vendor's performance. The State has contracted with a separate vendor, Maximus, to monitor the CASS development project and provide quarterly process and product quality assessments.⁴² The quality assurance reports have repeatedly identified problems since shortly after work began in 2009. However, research by the Office of the State Auditor (which was only tangentially related to CASS) failed to find any evidence of the department seeking to penalize the vendor or escalate performance deficiencies to the Purchase Bureau.⁴³ It appears that the State was very limited in its ability to encourage improved performance, as the development contract included few penalties for poor performance.

- **Questions:** Prior to the contract's termination, when the project appeared to be behind schedule, what steps were taken to improve the vendor's performance? What triggered the

⁴² Contract number T-2489

⁴³ <http://www.njleg.state.nj.us/legislativepub/Auditor/543213.pdf>

**decision to cancel the contract in November 2014, rather than at a previous point in time?
Why did the contract fail to include strong penalties for poor performance?**

Answer: In an effort to provide for effective and efficient oversight of the CASS project, the Implementation Vendor (IV) contract contained industry standard Project Management tasks. All major deliverables required the approval of the Quality Review Board (QRB) before payment could be made. In addition, DHS has the assistance of a Quality Assurance Vendor (QAV). The QAV reviewed all deliverables prior to final QRB review and approval.

The IV received payment for deliverables completed during Phase 1 (Mobilization), Phase 2 (Project Start Up), Phase 3 (Requirements Definition), Phase 4 (Design Definition), Phase 5 (Construction and Implementation Planning), and Phase 5.5 (Upgrade IBM Cúram COTS Product from Version 5.2 to 6.0). Phase 6 (System Test), from September 1, 2012 - December 28, 2012, and Phase 7 (User Test) beginning on Jan. 2, 2013, were to follow. The IV began System Test but did not complete it by the end of December 2012. The IV continued to work on System Test but it was still not completed by March 2013. The State required that the IV complete a Corrective Action Plan (CAP). The CAP, developed by the IV, did not meet the contract requirements. The State provided comments and suggestions as to how to revise the CAP but as of the summer of 2013, no agreement had been reached.

In early 2013, because of the then impending need to bring the State into compliance with the most critical ACA/Medicaid deliverables by October 1, 2013, the State and the IV had begun to discuss prioritizing the most critical ACA/Medicaid deliverables and holding off on further work on both the remainder of ACA /Medicaid deliverables and the “original system test.” Although work on those critical ACA/Medicaid deliverables proceeded and the IV completed some and was paid for those ancillary deliverables (two Security Assessment Report deliverables and three training deliverables associated with the Medicaid training during the fall of 2013); the IV did not deliver the functionality for the critical ACA/Medicaid requirements by October 2013. It is important to note that the State rejected repeated requests from the IV for payment based on incomplete deliverables; this included the original system tests that were part of the CASS contract and the critical ACA/Medicaid requirements, which was an amendment to the CASS contract.

At that point, DHS determined it was best to seek its own stand-alone solution to the most immediately required ACA requirements:

In order to meet the ACA requirements for Medicaid, DHS:

Developed an on-line streamlined application pursuant to federal rules; Developed a technology solution to receive Medicaid eligible enrollment data from the marketplace; Built and deployed to the 21 CWAs an automated MAGI calculator; Enhanced the administrative tools for the CWAs to track and process on-line applications; Received authority to connect to the federal data hub via another technology solution and; Expanded customer call center and enhanced capacity of health benefits coordinator.

By October 2013, the IV had not:

- provided an adequate CAP related to the entire CASS project, including a schedule to complete the entire CASS project;
- completed System Test for the entire CASS project, and
- as noted above, implemented ACA deliverables.

- The IV first proposed a November and then a December 2, 2013 delivery date for the critical ACA/Medicaid deliverables, but was unable to meet either new deadline.
- In December 2013, the DHS Team instructed the IV to develop a new CAP and schedule for the completion of CASS. The IV submitted a proposal, but DHS rejected it as not feasible.
- In April 7, 2014 – All state and federal partners (US DOHHS, CMS; US DOAg, FNS) and stakeholders met with the IV to review the project’s history, status and discuss how to proceed.
- After the April meeting, the State continued to work with the IV. The IV still remained unable to finish System Test and/or provide a fully resourced Project Schedule that would clearly specify the time and resources necessary to implement CASS. CMS sent the State the results of a review of the readiness of the CASS project, and found that the majority of requirements had not been met. By early fall 2014, DHS having sought an acceptable POC and Schedule for over one year, and not received, began working with the Division of Purchase and Property, the Division of Law and outside counsel (Lowenstein Sandler, the firm retained in anticipation of litigation over the termination of the contract), to plan for and to terminate the IV contract.
- The contract was terminated by mutual agreement of the State and the IV vendor effective *October 31, 2014*.
- By terminating, the State avoided incurring \$51.9 million in contract costs. Of the \$66.3 million paid to the IV for completed deliverables, DHS determined that the State received value for a portion of those deliverables and the IV Vendor reimbursed the State \$7.5 million.

61. In response to FY 2015 OLS discussion point #47a, the department indicated that the cost of the CASS development contract at that time was \$118.3 million (gross). More recent information provided informally by the department indicates that the State has spent \$66 million in total on the contract, of which \$20 million was the State share and \$46 million was federally funded. A subsequent settlement with the vendor allowed the State to reclaim \$7.5 million (\$2 million State and \$5.5 million federal), suggesting a final State loss of \$18 million.

Part of the federal funding for the CASS project included an enhanced matching rate of 90 percent (instead of the normal 50 percent rate) for costs related to the development of Medicaid eligibility information technology system changes associated with certain provisions of the Affordable Care Act. Once an alternative to CASS is identified, the State may be able to continue to receive this 90 percent rate for future development, but it could be in danger if the State fails to implement a system capable of “critical success factors” specified by Centers for Medicare & Medicaid Services (CMS) guidance. Notably, according to a December 2014 Inspector General report⁴⁴, in October 2014 New Jersey was one of only four states that was unable to send applications to the federally facilitated exchanges, and the only state unable to receive applications from the exchange. Informally, the department has indicated that CMS has offered to continue its enhanced matching rate so long as the State continues to move forward on a project.

- ***Question:*** Does the department anticipate moving on an alternative to CASS during FY 2016, whether by beginning development on a new system, acquiring an “off the shelf” system, partnering with another state, or taking some other steps?

Answer: DHS wanted to correct the costs highlighted in OLS’s preamble above. The contract award was \$118.3 million (gross), however, net of the settlement reimbursement, gross

⁴⁴ <http://www.gao.gov/products/GAO-15-169>

expenditures totaled \$58.8 million (\$43.8 million federal share/\$15 million State share). As stated previously, the Department has contracted with the consulting firm of KPMG to conduct a functional and technical assessment on the CASS project. The Department will look at all options presented and available to determine the next steps for the development and implementation of a system that consolidates and automates our current eligibility determination processes.

SNAP

62. The Supplemental Nutrition Assistance Program (SNAP, formerly food stamps), provides assistance to needy families to buy food and groceries. Benefits are funded by the federal government, but the State and counties administer the program and pay part of the costs of administration.

In FY 2013, the State earned a \$1.6 million performance bonus from the federal Food and Nutrition Service (FNS) as a result of the State’s high payment accuracy rate in the SNAP program.⁴⁵ FNS has indicated that the bonus must be reinvested in the SNAP program. Some advocates have urged that it be used to hire additional county welfare agency staff.

- **Question: How has the State applied the SNAP performance bonus? Are any State funds freed for other uses as a result of the bonus?**

Answer: DFD received over \$1.637 million from FNS for a performance bonus and used \$318,000 to assist counties in reducing their processing backlog and used the remaining \$1.3 million to fund the design and implementation of SNAPTrac. This new system will enable the county agencies and the State to better track and manage SNAP caseload processing and ultimately improve SNAP timeliness. The SNAP bonus funds are designated for reinvestment back into the program and as such cannot be used to supplant other state expenditures.

63. The State has been threatened with a possible loss of SNAP administrative funding from the FNS (which totals approximately \$139 million annually), as a result of the State’s poor performance in timely processing of SNAP applications. (Applications generally must be processed within 30 days of receipt.) Under the State’s approved corrective action plan, the State must achieve 85 percent average Statewide timeliness for the six-month period from October 2014 to March 2015, and 95 percent timeliness for the following six months. According to a December 10, 2014 letter from Commissioner Velez to the Assembly Human Services Committee, for the week ending December 2, 2014, the reported 30 day timeliness rate was 93 percent, and the 7-day timeliness rate was 90 percent.

- **Questions: What were the Statewide average 30-day and 7-day timeliness rate for the six month period from October 2014 to March 2015? What were the rates in each county? Based on recent feedback from the FNS, is the State likely to face any loss of federal funds?**

Answer: The Statewide 30-day timeliness was 92% and the 7-day statewide timeliness was 90% which results in a statewide timeliness rate of 91%. DFD does not anticipate any loss of federal funds due to timeliness at this time.

The rates for each county are listed below:

COUNTY	30 DAY	7 DAY	OVERALL
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⁴⁵ <http://www.fns.usda.gov/sites/default/files/snap/FY2013SNAPHighPerformanceBonuses.pdf>

ATLANTIC	76%	98%	87%
BERGEN	96%	100%	98%
BURLINGTON	89%	98%	94%
CAMDEN	88%	85%	87%
CAPE MAY	100%	100%	100%
CUMBERLAND	96%	97%	96%
ESSEX	86%	88%	87%
GLOUCESTER	94%	100%	97%
HUDSON	100%	100%	100%
HUNTERDON	100%	100%	100%
MERCER	100%	98%	99%
MIDDLESEX	94%	100%	97%
MONMOUTH	100%	100%	100%
MORRIS	89%	100%	98%
OCEAN	99%	100%	99%
PASSAIC	96%	95%	96%
SALEM	100%	95%	98%
SOMERSET	100%	100%	100%
SUSSEX	100%	100%	100%
UNION	89%	95%	92%
WARREN	94%	94%	94%

STATEWIDE	92%	90%	91%
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64. Some advocates have noted an increase in anecdotal reports of individuals whose SNAP applications were lost by county welfare agencies. They have expressed concern that this could be the result of “case banking,” a practice whereby responsibility for a single application is spread across several staff members, which has a side effect of increasing the opportunity for the application to be misplaced. (The department is encouraging counties to adopt case banking in order to improve their timeliness rates.) These advocates have also expressed concern that the reported improvements in the processing time for SNAP applications may have been achieved in part as a result of lost applications, since lost applications are not counted in calculating the timeliness rate. Individuals whose applications are lost are effectively required to apply again, which restarts the entire process.

- **Questions:** Is the department able to track the rate of misplaced applications? What processes does the department recommend to counties to minimize such errors?

Answer: Actually, case banking should have the exact opposite effect on a case. Each application, once the interview is completed, is placed in the case bank. The agency no longer has cases all over the agency or on workers’ desks. The development of the statewide tracking system, *SNAPTrac*, allows the county as well as the State to see all applications that are pending in the agency and for how long. For quality assurance purposes, the agency should match the

reception log with the daily application log to ensure all applications have been logged. The Division's field representatives check periodically to verify securing the client application date and registration of all applications.

65. In general, eligibility for SNAP and the Low Income Home Energy Assistance Program (LIHEAP) are linked in New Jersey, so a household that is eligible for one program is typically eligible for both. Aside from administrative simplification, this linkage provides an additional benefit for some households, as households that receive LIHEAP benefits also qualify for a SNAP "heating and cooling standard utility allowance" that may result in increased SNAP benefits as a result of complex income-calculation rules.

A notable exception is that, pursuant to N.J.A.C.5:49-2.2 and the LIHEAP State Plan, households in publicly operated housing whose utility costs are included in their rent are ineligible for LIHEAP, and thus effectively ineligible for the increased SNAP benefits. (This exclusion does not apply to households in subsidized housing whose utilities are billed separately, or non-subsidized housing with utilities included in the rent.) Many other states do not exclude such households from LIHEAP.

- ***Question:*** What is the rationale for exempting from LIHEAP households in public housing whose utilities are included with their rent? How many households are affected by this exemption? If this exclusion were eliminated, would the Department of Community Affairs (DCA) incur significant additional costs to verify that the households have qualifying energy costs? How might it be possible to encourage operators of subsidized housing to provide separate bills for utilities and rent? How many households are excluded from LIHEAP as a result of this policy? (Please coordinate a response with DCA as appropriate.)

TO BE ANSWERED BY DCA

66. The enactment of the federal "Agricultural Act of 2014," Pub.L.113-79, changed federal law regarding "heat & eat" programs, so that the State must now provide a minimum \$20 annual energy assistance benefit in order for a household to qualify for a SNAP standard utility allowance. Prior to July 2014, the State had provided a nominal \$1 payment to some households in order to qualify them for the additional SNAP benefits. The Executive terminated the "heat & eat" program effective July 1, 2014, and affected households have begun to see benefit reductions as their eligibility is redetermined.

- ***Questions:*** Prior to the termination of the heat & eat program, how many households were receiving the \$1 nominal LIHEAP payment (rather than a full LIHEAP payment)? Of these, how many received additional SNAP benefits as a result of the nominal payment? (Please coordinate a response with DCA as appropriate.)

Answer: Prior to the implementation of revisions under the 2014 Farm Bill, there were 292,000 households in receipt of the \$1 LIHEAP benefit. Approximately 150,000 households received additional SNAP benefits as a result of their receipt of the nominal LIHEAP benefit.

Work First New Jersey

67. Pursuant to N.J.S.A.44:10-48, the Work First New Jersey General Assistance (WFNJ/GA) program currently prohibits persons with drug distribution convictions on or after August 22, 1996 from receiving benefits. The State lifted a similar ban for families with dependent children (that is, those in the WFNJ/TANF program) pursuant to P.L.2009, c.328.

- **Questions:** On average, at any point in time, how many individuals with drug distribution convictions are receiving WFNJ/TANF benefits? Annually, how many applications for WFNJ/GA benefits are denied as a result of drug distribution convictions? What would be the estimated cost to the State to permit individuals with drug distribution convictions to receive WFNJ/GA benefits?

Answer: DFD does not have the ability to track the number of TANF cases that are receiving benefits that include individuals convicted of drug distribution. DFD estimates that, for SFY 2014, there were 1,381 GA cases that were denied for drug distribution convictions. DFD further estimates that if all these cases received GA for the entire year the estimated cost would be \$2.3 million in basic assistance payments and an additional \$1.6 million in EA.

Division of Management and Budget

68. In addition to their role in providing security at State psychiatric hospitals and developmental centers the Human Services Police Department provides escort and intervention services to child welfare caseworkers employed by the Department of Children and Families (DCF). In November 2014, the Human Services Police was reorganized to eliminate a separate unit of approximately 25 officers that had been dedicated to DCF child welfare workers, in part as an attempt to reduce the police department's perennially high overtime costs. (In response to FY 2015 OLS Discussion Point #23, DCF indicated that the FY 2013 overtime expenditures for the Human Services Police assigned to DCF totaled \$795,414, and the FY 2014 overtime expenditures were projected to be \$716,117.) Instead of reporting to DCF offices, officers are now centrally stationed at the three State psychiatric hospitals (Greystone Park Psychiatric Hospital in Morris Plains, Trenton Psychiatric Hospital in West Trenton, and Ancora Psychiatric Hospital in Hammonton) and are dispatched to escort DCF caseworkers when needed. According to press reports, all Human Services Police officers are now to be "cross trained" to serve in both institutional security and community escort roles.

- ***Questions:*** How has the reorganization of the Human Services Police Department affected overtime costs? Has the cross-training of officers been successful in ensuring that all officers are capable of both securing State facilities and escorting DCF caseworkers?

Answer: We have been experiencing reductions in overtime since the reorganization partly as a result of filling vacant Sergeant positions and providing first line supervision training. This is an ancillary benefit and not the main reason behind the reorganization. One of the driving principles behind this initiative was to give the Supervisors the ability to utilize police resources in a more efficient manner with enhanced supervision and accountability of their subordinates. Officers are capable of responding to calls related to both DHS and DCF incidents.