Assemblyman Mukherji:

- What is the average Supplemental Nutrition Assistance Program (SNAP) benefit provided to able-bodied adults without dependents (ABAWDs) in New Jersey?

**Answer:** The average SNAP benefit for a one person ABAWD household is approximately $183.00 per month.

Assemblywoman Muoio:

- Please provide information on applications for Emergency Assistance in the past three years. How many applications were filed? How many were denied? For the denied applications, please provide data on the reasons for denials.

**Answer:** The Emergency Assistance pilot began in August 2015. Under this pilot, state staff members review applications for TANF, SSI, and General Assistance (GA) eligibility determination.

From August 2015 through April 2016, 1,943 applications were filed.
From August 2015 through April 2016, 481 applications were denied.
Eligibility determinations are based on NJAC 10:90-6.1(c)3v, NJAC 10:90-6.1(c)1ii, NJAC 10:90-6.1(c)3, NJAC 10:90-6.4, and NJAC 10:90-6.6(a).

Assemblywoman Pintor Marin:

- Please provide data on the number of children served and the total spending for Abbott-related wraparound child care for each fiscal year, beginning in fiscal year 2009.

**Answer:** Child care expenditures in the former Abbott districts reflect a variety of reforms instituted since fiscal year 2008 under Governor Corzine in order to align eligibility criteria, including income eligibility, work requirements and permissible absenteeism. Additionally, in 2012, eChildCare was implemented statewide to reduce the impact of billing errors, such as duplicative payments, and to ensure that services paid for were being provided. This created a more efficient child-care system, eliminating a 10,000 child waiting list in just over a year. As such, the annual state appropriations reflect the utilization trend for child-care. As a result of these systematic reforms, DHS is now serving eligible children in an equitable way among all Districts. It should also be noted that when comparing Actuals from FY2013 to Estimated 2017, the Average Monthly Children served and the Annual Expenditures are expected to increase by 13% and 22%, respectively. The chart directly below is reflective of what has historically been displayed in the Governor’s Budget. This chart only lists the children that the Division of Family Development pays for. The chart below further reflects the number of children who have applied and were determined eligible for child care regardless of who is paying for them. This would include programs that are not in DFD’s budget such as the Early
Employment Initiative (EEI), Kinship, and Post Adoption Childcare (PAC). As it pertains to the original question above, it is important to note that, despite the previously aforementioned reforms, the percentage of children served in Abbott Districts continues to be over 50% as a measure against total child care.

<table>
<thead>
<tr>
<th>ABBOTT WRAPAROUND</th>
<th>TOTAL CHILD CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Fiscal Year</td>
<td>Average Monthly Children</td>
</tr>
<tr>
<td>Actual 2009</td>
<td>22,351</td>
</tr>
<tr>
<td>Actual 2010</td>
<td>21,654</td>
</tr>
<tr>
<td>Actual 2011</td>
<td>16,440</td>
</tr>
<tr>
<td>Actual 2012</td>
<td>9,278</td>
</tr>
<tr>
<td>Actual 2013</td>
<td>6,578</td>
</tr>
<tr>
<td>Actual 2014</td>
<td>5,169</td>
</tr>
<tr>
<td>Actual 2015</td>
<td>4,880</td>
</tr>
<tr>
<td>Revised Estimate 2016</td>
<td>4,108</td>
</tr>
<tr>
<td>Budget Estimate   2017</td>
<td>4,026</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Month-Year</th>
<th>Total Child Care</th>
<th>Child Care in Abbott Districts Only*</th>
<th>% Child Care in Abbott Districts to Total Child Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>April-2009</td>
<td>66,244</td>
<td>48,490</td>
<td>73%</td>
</tr>
<tr>
<td>April-2010</td>
<td>66,338</td>
<td>47,568</td>
<td>72%</td>
</tr>
<tr>
<td>April-2011</td>
<td>54,559</td>
<td>37,476</td>
<td>69%</td>
</tr>
<tr>
<td>April-2012</td>
<td>49,984</td>
<td>30,924</td>
<td>62%</td>
</tr>
<tr>
<td>April-2013</td>
<td>56,659</td>
<td>33,242</td>
<td>59%</td>
</tr>
<tr>
<td>April-2014</td>
<td>60,262</td>
<td>33,690</td>
<td>56%</td>
</tr>
<tr>
<td>April-2015</td>
<td>61,884</td>
<td>33,426</td>
<td>54%</td>
</tr>
<tr>
<td>April-2016</td>
<td>64,545</td>
<td>34,126</td>
<td>53%</td>
</tr>
</tbody>
</table>

* The numbers in this column include Abbott “wraparound”, which is before- and after-
school child care for 3- and 4-year-olds.

Assemblyman Burzichelli:

- Please provide the most recent report or other available data from the nursing home financial early warning system, operated by the Health Care Facilities Financing Authority. Please include in this report data on each indicator tracked by the early warning system. Can the department offer any explanation for the apparent disagreement between the early warning system’s findings of a fairly healthy industry, and the industry’s claims that their Medicaid reimbursement rates are $35 lower than their costs per day?

Answer: The following is the most recent Early Warning System quarterly data report (December 2015) provided by the Health Care Facilities Financing Authority:

Methodology
On a quarterly basis, long term care facilities are asked to submit 21 financial and statistical elements. From this data, 13 ratios measuring profitability, liquidity and utilization are calculated for each facility.

HCFFA has determined five ratios/metrics as indicators of a risk of financial stress. Any Nursing Facility (NF) that triggers at least four of five ratios/metrics are considered for future monitoring.

According to the December 2015 quarterly report, the data collected indicates that the NF industry is fairly healthy:

- Days of cash on hand at the NFs has not deteriorated.
- Statewide median resident service revenue per resident day increased approximately 2.7% year-to-year;
- The median operating expense per resident day declined approximately 2%. This suggests operators are focusing on expense control to improve performance.
- Operating margins of NFs have not deteriorated; in fact it has increased from 2.0% for the 12-31-2014 reporting period to 4.1% currently; and
- Since the Department has begun collecting data in 2014, there have been no wide swings in occupancy percentage at the NFs (slight decrease from 90.1% to 89.2%).

<table>
<thead>
<tr>
<th>Ratio/Metric</th>
<th>Background Question</th>
<th>12/14 Statewide Median</th>
<th>12/15 Statewide Median</th>
<th>EWS Screen</th>
<th>Desired Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days cash on hand</td>
<td>Does the facility have adequate cash reserves?</td>
<td>10.6</td>
<td>12.4</td>
<td>14.0</td>
<td>↑</td>
</tr>
<tr>
<td>Days in current liabilities</td>
<td>How quickly is the facility paying creditors?</td>
<td>50.7</td>
<td>47.5</td>
<td>90.0</td>
<td></td>
</tr>
<tr>
<td>Operating margin</td>
<td>Does revenue cover expenses?</td>
<td>2.0%</td>
<td>4.1%</td>
<td>0.0%</td>
<td>↑</td>
</tr>
<tr>
<td>Earnings before depreciation</td>
<td>Does operating revenue cover cash expenses?</td>
<td>$452,000</td>
<td>$700,000</td>
<td>$0</td>
<td>↑</td>
</tr>
<tr>
<td>Occupancy %</td>
<td>How many beds, on average are occupied at the facility?</td>
<td>90.1%</td>
<td>89.2%</td>
<td>84%</td>
<td>↑</td>
</tr>
</tbody>
</table>
In addition, the committee would appreciate a written response to the following questions that were not raised during the hearing due to time constraints:

**Home Health Care**

- Private Duty Nursing services are provided to assist seniors, adults, and children with complex medical needs. With Private Duty Nursing rates currently below the previous fee for service rate, home care agencies are experiencing extreme difficulty with recruiting a qualified nursing workforce. And, while the state is focusing on enhancing professional registered nursing education and have a moratorium on Licensed Professional Nurse (LPN) training courses; the managed care organizations are now insisting LPNs rather than Registered Nurses (RNs) service patients in certain situations to save money and pay agencies a lower rate for care. How is the department going to ensure adequate rates are paid to guarantee there are enough quality nurses servicing the complex home care population?

**Answer:** Most complaints and issues received related to private duty nursing services and the hiring and maintaining of staff have been related to two issues: the service location and related travel expense and staffing of weekend/holiday hours. Clients in remote areas of the state receiving minimal services, as well as those requiring weekend coverage, have traditionally been difficult to service. It is the managed care plan’s responsibility to pay a rate that will ensure that all clients are able to obtain needed services regardless of their location. Generally, we have not heard of any rate issues related to private duty nursing in well populated areas. Clinical need, guided by practice laws and regulations, determines the licensure of the staff required to provide nursing services, and this has not been presented as an issue during any stakeholder meetings. By contract, the MCO is responsible for negotiating a rate that ensures cost containment as well as accessibility. The Office of Managed Care, within the Division of Medical Assistance and Health Services, monitors access; tracks and trends complaints, grievances and appeals; and is increasing efforts to monitor provision of these services through field and network adequacy monitoring. Areas of deficiency are being addressed through contract management.

- Under the managed care construct for Personal Care Assistant (PCA) services, we are seeing some MCOs reduce rates—in at least one case to an all-time low of $13.80 per hour. How does the department expect providers to attract and retain a qualified workforce and keep patients in their home at $13.80 an hour, which is inclusive of home health aide service, nursing supervision, training costs and overhead – all the while providing quality care? How is the department working with personal care, home health, and other community stakeholders to monitor patients' access to care as the managed care companies acknowledge they can't provide service in several counties? How is the department currently measuring the “quality of the encounter” to ensure that the beneficiaries are receiving quality care and are satisfied with their care and services?
Answer: MCOs are responsible for assuring access to all covered services in the Medicaid benefit package. The Office of Managed Health Care monitors the MCOs for compliance with contract requirements and access, and tracks and trends complaints, grievances, and appeals. To our knowledge, there has not been a significant rate reduction implemented by the MCOs in recent years. The MCOs negotiate rates and are responsible for assuring access regardless of where the members live. In addition to the Division’s monitoring of the MCOs, the Division administers the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and performs a face-to-face interview with MLTSS members using the National Core Indicator for Aging and Disabilities survey. These are two means of gathering information from members themselves.

The leadership at the Division of Medical Assistance and Health Services meet regularly with provider associations. In addition, we maintain an open dialogue with organizations and providers to address their concerns, including access to care. At times, stakeholder meetings include the managed care organizations to discuss these types of issues.

- How many providers have each of the managed care organizations contracted with to participate in the personal care assistance program each year since 2011?

Answer:

<table>
<thead>
<tr>
<th>Provider Locations</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amerigroup</td>
<td>107</td>
</tr>
<tr>
<td>United HealthCare</td>
<td>266</td>
</tr>
<tr>
<td>Horizon NJ Health</td>
<td>208</td>
</tr>
<tr>
<td>WellCare</td>
<td>214</td>
</tr>
<tr>
<td>Aetna</td>
<td>24</td>
</tr>
</tbody>
</table>

The providers submitted fall under the description from the MCO Contract A.7.1.F Quarterly Provider Network Certification Form.

“…..that all of the Network providers whose names appear on the attached and/or transmitted Provider Network File dated (Date) have documented relationships or where required, signed valid, written contracts with (Name of MCO) which are currently in effect...”

The information above is based on the 2016 1st quarter provider network data (due to the size of the network files, the system only holds the most current quarter data).
• Please provide data from the managed care organizations that supports their position that an access to care issue does not exist.

   **Answer:** Please see the chart supplied in response to the previous question.

• What is the number of PCA appeals for 1st, 2nd and 3rd level and what are the outcomes at each of the three levels for each year since 2011?

   **Answer:** Year totals for 1st level and 2nd level appeals addressed by the MCOs are available; 3rd level appeals are not applicable to PCA services.

   **Total number of Denials of Home Health Care**
   
<table>
<thead>
<tr>
<th>Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of Denials of Home Health Care</td>
<td>106</td>
<td>1667</td>
<td>2776</td>
<td>557</td>
<td>1020</td>
</tr>
</tbody>
</table>
   
   The Office of Managed Health Care conducted a manual review of 1st and 2nd level appeals for 2015. The results are indicated in below table.

<table>
<thead>
<tr>
<th>Year 2015</th>
<th>1st level appeals - 777</th>
<th>Upheld - 735</th>
<th>Overturned - 27</th>
<th>Partially Upheld - 15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2015</td>
<td>2nd level appeals - 243</td>
<td>Upheld - 215</td>
<td>Overturned - 8</td>
<td>Partially Upheld - 20</td>
</tr>
<tr>
<td>Year 2015</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td></td>
<td></td>
<td>Total - 1020</td>
</tr>
</tbody>
</table>

• Please provide the number of single-case agreements for PCA services by county in each year since 2014

   **Answer:** This information is not collected by the State.

• How many clients have waited for service for more than 30 days for PCA services in 2014 and 2015?
**Answer:** This information is not collected by the State.

**NJ FamilyCare Managed Care**

- Does the department’s contract with the Medicaid managed care companies require prior notice to the State and providers before changes are made to MCO operations which may affect payments to providers? If there is any such notice provision in the contract, does the contract impose sanctions for the failure to comply with the notice provision?

**Answer:** The following provisions require notice to DMAHS of substantial or significant changes that the MCO makes; only the first cited provision explicitly requires DMAHS approval.

**4.11 ADDITIONS, DELETIONS, AND/OR CHANGES (Article 4 is Provision of Health Care Services)**

**7.30 CHANGE BY THE CONTRACTOR (Article 7 is Terms and Conditions (Entire Contract))**

- Does the department’s contract with the Medicaid managed care companies require MCOs to complete successful claims testing prior to implementation of changes to MCO operations which may affect payments to providers? Is there any requirement to provide verification of the successful completion of claims testing?

**Answer:** Although not specific to claims testing, the applicable provision regarding a substantial change in programming that would affect payments could be considered a significant change which would be addressed in **7.2 GENERAL PROVISIONS (Article 7 is Terms and Conditions (Entire Contract))** G. Significant Changes. The Contractor shall report to the Contracting Officer (See Article 7.5) immediately all significant changes that may affect the Contractor’s performance under this contract.

- If there is any such provision concerning claims testing in the contract, does the contract impose sanctions for failure to comply with the claims testing provision?

**Answer:** The applicable provision is **7.15 SANCTIONS (Article 7 is Terms and Conditions (Entire Contract))**

- If the answer to any of the above are no, will the department consider changes to the contract with the Medicaid managed care companies to include requirements of a) prior notice to the State and providers before changes are made to MCO operations which may affect payments to providers; b) verification of the successful completion of claims testing prior to implementation of changes to MCO operations which may affect
payments to providers; and c) imposition of sanctions for failure to comply with these new contractual provisions?

**Answer:** N/A

**Note:** All of the provisions referenced above can be found at: http://www.nj.gov/humanservices/dmahs/info/resources/care/hmo-contract.pdf

**Behavioral Health Reimbursement Changes**

- Is the $127 million in recommended new funding dedicated to community-based mental health, substance use treatment and supportive services in FY2017 in addition to current contract funding? If not, what amount of the current grant funding is being reduced from community-based mental health and substance use treatment programs?

  **Answer:** The $127 million in new funding is in addition to current contracted funding, in aggregate, across the mental health and substance abuse programs.

- When does DMHAS expect to conclude their review of the rates they are currently examining?

  **Answer:** The review of the rates being examined is complete. The final rate sheet was released in June 2016 and communicated through a newsletter to the provider community.

- Is DMHAS reviewing rates beyond the list they provided (Psychiatric Evaluation, Medication Management and Intensive Outpatient) that providers are saying are inadequate to cover costs?

  **Answer:** DHS has conducted additional reviews for those services where providers expressed concern that they were not sufficient to cover costs (Psychiatric Evaluation, Medication Management and Intensive Outpatient). No additional rates beyond those listed above are being reviewed.

- The Legislature has been informed that the DHS anticipates no longer being able to support services to the under-insured. What is the reason for this change?

  **Answer:** Currently, in the deficit-funded contract model, state dollars are the last dollar, which means that all other revenues (such as insurance reimbursement) offset the agencies’ costs first and the balance between the negotiated budget and revenues collected is what is covered with state dollars. In FFS, reimbursement is provided for each service provided, by encounter.
However, it is important to note that if someone has private insurance but is accessing a service that is not a covered service (e.g., programs for assertive community treatment, long term residential services for a substance use disorder) than state dollars can be used to reimburse for the services provided.

- What are the final provisions of the “bridge” funding being made available to providers who are transitioning to fee-for-service?

**Answer:** Final provisions of the bridge funding are under final review with the Attorney General’s office. Upon completion of this review, they will be made available to providers.

- What were the fee-for-service rates recommended by the firm Myers and Stouffer, as a result of their analysis of the cost structure for mental health and substance abuse services? How do those rates compare to the ones which were released by DMHAS? What are the reasons for any variations from those recommendations?

**Answer:** The recommended rates produced by Myers & Stauffer (M&S) did not adequately reflect the requirements for all services reflected in rules and regulations. As such, the M&S recommended rates were pre-decisional, had to go through extensive Division reviews and modifications and are not comparable to the final rates to be implemented by DHS. As a result, many of the rates were increased from the pre-decisional rates provided by M&S.

- What is the total projected spending for community-based mental health and substance use disorder services in FY 2017? Of the total, how much (in both dollar and percentage terms) is (1) federal Medicaid funding; (2) block grant and other federal funding; and (3) State funding? What is the source of New Jersey matching dollars? Are these new appropriations?

**Answer:** The total projected spending is as follows:

<table>
<thead>
<tr>
<th></th>
<th>Amount</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Medicaid Funding</td>
<td>$280.6m</td>
<td>31.5%</td>
</tr>
<tr>
<td>Block Grant and Other Federal Funding</td>
<td>$69.7m</td>
<td>7.8%</td>
</tr>
<tr>
<td>State Funding</td>
<td>$541.4m</td>
<td>60.7%</td>
</tr>
<tr>
<td>Total Funding</td>
<td>$891.7m</td>
<td>100%</td>
</tr>
</tbody>
</table>
The source of the New Jersey matching dollars are state general fund appropriations and include an additional $20 million in state funds as a result of the rate increases.

- Have you studied the impact of the fee-for-service transition on community mental health agencies? What feedback have you received from the provider community?

**Answer:** The financial impact to providers is an additional $127 million into the system. In most cases rates went up, however, there are a few rates that were decreased. For those rates where we received significant concern from the provider community, DHS has reexamined those rates and made adjustments, if appropriate.

- Please describe how, and in what time frame, the department will conduct the shift to a FFS system.

**Answer:** For those services moving to a FFS system, Addiction Services will be transitioning on July 1st, 2016. For Mental Health services, providers have the option of transitioning on January 1st, 2017 or July 1st, 2017. Rates have also been modified as of July 1, 2016 for any Medicaid-related Mental Health or Addiction Service.

- The Legislature has been told that next year the federal/State Medicaid match requirements will be 70/30. Where will the additional State dollars come from?

**Answer:** The 70% match is the approximate “blended Medicaid match” rate based on the current case mix of the Title XIX population (50% match), the CHIP population (88% match) and the ACA Expansion Population (100% match changing to 95% match on January 1, 2017). The DMAHS Medicaid budget includes $75 million in additional State appropriations (the impact of the 5% reduction in the ACA Expansion Population federal match).

**Emergency Assistance**

- The most recent data on the Emergency Assistance (EA) caseload show dramatic reductions in the first quarter of 2016, (more than 40 percent year-over-year, reflecting more than 2,000 fewer households assisted). What evidence can the department produce to show that this reduced assistance has not destabilized housing for vulnerable people, or to demonstrate that the people who have lost assistance have, in fact, secured stable, safe, appropriate, affordable housing?

**Answer:** Emergency Assistance caseloads fluctuate for a variety of reasons. The recent decrease in the EA caseload is likely due to efforts to ensure program consistency and a strengthening economy.
In addition, there has been an increased federal focus on housing subsidies. The NJ Department of Community Affairs (DCA) just announced that 400 rental vouchers will be allocated to chronically-homeless households, many of whom are served through DHS programs and who have been caught in a cycle of short-term housing programs that have kept them from entering long-term housing. These rental subsidies, coupled with DCA’s recent release of 1,000 new Section 8 vouchers represents the most substantial push for permanent housing opportunities for low-income families in a generation.

- The Department of Community Affairs has announced various housing vouchers (including 400 new SRAP vouchers for chronically homeless households and 1,000 Section 8 vouchers), but these resources have their own targeted eligibility criteria (including existing waiting lists). What portion of these vouchers is actually available to clients who have lost EA program eligibility due to time limits or more restrictive eligibility determinations?

**Answer:** Any clients whose time on EA ended due to them reaching the time limits or any clients who have been properly determined ineligible for EA have the right to apply for the new DCA vouchers unless somehow prohibited by DCA rules.

- Given that families lose eligibility for cash assistance with very minimal levels of earned income (below even the federal threshold for extreme poverty, which is about $10,000/year for a family of three or $837/mo.), is it not inevitable that many families will lose eligibility for assistance based on incomes that are in no way adequate to meet their needs as measured by the Department of Human Services own published Standard of Need (which is more than $2,700/month in 2016)?

**Answer:** The goal of Work First New Jersey is to help people become employed. Many families who come off of cash assistance do so because they have successfully obtained a job. Furthermore, the amount of money earned by a recipient upon leaving the cash assistance program, even at a minimum wage working 35 hours a week, is more than the cash assistance grant. There are also non-financial factors that come with a job – for example, the dignity of work as well as the opportunity for advancement. In addition, New Jersey has a number of supports in place for TANF recipients who are leaving welfare for work, such as the state Earned Income Tax Credit, the child care subsidy program, and SNAP food assistance. And, as a family moves off of welfare, they may still keep a portion of the cash assistance under a transitional program within Work First New Jersey.

- It would be helpful to have a full understanding of all services provided to the population of individuals with developmental disabilities. By building a picture of the entire “ecosystem” of services an individual could receive, we can build a more effective
service network. Does the State track this sort of information on individuals with developmental disabilities in its system? Do geographic or restricted areas exist which have a significant shortage of providers? If so, where?

**Answer:** The services funded by the Division of Developmental Disabilities are outlined in the Supports Program Policies & Procedures Manual, which can be accessed at: [www.nj.gov/humanservices/ddd/documents/supports_program_policy_manual.pdf](http://www.nj.gov/humanservices/ddd/documents/supports_program_policy_manual.pdf)

There is currently no shortage of providers in any geographic area; however, if one were to occur, the Division would work closely with the individual and his or her family via the case manager to locate an alternative service while a provider could be recruited and qualified.

- The Legislature is informed that the Governor’s budget proposal includes a significant cut to partial hospitalization services for the mentally ill. What planning has the department done to identify where these clients would now be served from closed programs? What is the larger rationale around these cuts in the midst of wanting to do more for the mentally ill?

**Answer:** The partial hospitalization rate and partial care rate are now reflective of the fact that partial hospital programs are currently licensed as partial care programs and the services and requirements will be virtually the same for both services. For those provider agencies who no longer wish to provide partial hospitalization, DHS will be monitoring access to these services and allow for additional partial care providers to be licensed in accordance to demonstrated need in the particular geographic location of the services.

**Other**

- The Centers for Medicare and Medicaid Services (CMS) recently finalized it rule on access to mental health and substance use services to provide parity for individuals in Medicaid and the Children’s Health Insurance Program. The final rule is intended to ensure that individuals in these government programs have the same access to care as those in private health plans. The government program plans must disclose information on mental health and substance use disorder benefits and the criteria for determinations of medical necessity. The final rule also requires the state to disclose the reason for any denial of reimbursement or payment for services with respect to mental health and substance use disorder benefits. Does the Fiscal Year 2017 budget contemplate this mandate, including the rules on denials? What is the anticipated cost?

**Answer:** This is referring to the Mental Health Parity and Addictions Equity Act (MHPAEA). At this time, we do not use managed care plans for the mental health services so this rule does not apply.

DHS manages addiction services through the Interim Managing Entity (IME) and will be
including these prior authorization processes in the state plan amendment. We are tracking reasons for denials in the IME but it is not yet available for review.

Medicaid is working on the equalization of the CHIP plans to Plan A.

In addition, we have created the benefit for addiction services in the expansion population to equal the benefit in the Title XIX or Plan A population. This cost was included and contemplated as part of the $127M rate increase in the FY17 budget proposal.

- Health care spending operates in silos with different budgets for medical, hospital, pharmaceutical, and long-term care. There are some innovative models that are bearing fruit right here in New Jersey in value-based benefit designs and care coordination. From the remarkable work of Dr. Jeffrey Brenner with the Camden Coalition to the recent news about improvements in maternity care through the value-based partnership between Horizon Blue Cross Blue Shield and University Hospital. There are also some new ways of thinking about the best patient treatment options through outcomes-based contracting – where overall costs can be decreased and patient outcomes are improved. This approach can take many forms, such as performance-based contracting, but essentially provides for lower rebates when a drug meets its metrics/goals and higher rebates when it doesn’t. Has the State considered such options? Could this new approach be a way to ensure access to medications for patients while keeping those therapies affordable?

**Answer:** The Centers for Medicare and Medicaid Services (CMS) is the federal body responsible for administering the Medicare and Medicaid programs. CMS sets the drug rebate reimbursement rates for the entire country. The State does not currently have the authority to adjust drug rebate percentages.

- The Supplemental Nutrition Assistance Program (SNAP) provides nutrition assistance to low-income individuals and families. This benefit is funded by federal resources, although administered by the State. New Jersey’s program has undergone two substantial cuts in the last two years – the first with the termination of the Heat & Eat program, which reduced benefits for many, especially seniors; and the second the imposition of strict time limits on Able-Bodied Adults Without Dependents (ABAWDs). Can you provide data on the number of recipients who saw reductions in SNAP benefits as a result of the Heat & Eat cuts, the average amount of those cuts, the demographic breakdown of the recipients who experienced cuts, and the total amount of benefits lost to residents of New Jersey in federal SNAP benefits? Can you provide data on the number of ABAWD households that have reached or are expected to reach the three-month time limit in the current budget year?

**Answer:** Contrary to inaccurate reporting New Jersey has not terminated the “Heat & Eat” program but merely updated NJ SNAP policy to remain compliant with federal law. NJ SNAP policy now accurately reflects the federal law, federal regulations, and guidance provided by the Secretary of the federal Department of Health and Human Services pertaining to this issue. Households that receive the requisite amount of
LIHEAP assistance continue to receive the corresponding utility deduction, which often leads to a higher benefit amount.

We did not track, nor are we able to produce data that reflects the number of recipients who saw reductions in SNAP benefits as a result of the change in NJ SNAP policy to adhere to federal law. As a result, we cannot provide the total amount of federal SNAP benefits lost by residents of New Jersey nor do we have a demographic breakdown of the recipients whose benefit amounts changed.

According to data available as of June 1, 2016, 151 households have reached the ABAWD time limit. We are unable to provide the number of households expected to reach the three-month time limit because there are several factors that would allow a household approaching the time limit to “stop their clock.” Such factors include the timing of when an individual starts to participate in a work activity or provides documentation that would allow the household to be exempt from the time limit. Importantly, even those individuals who reached the ABAWD time limit can again receive SNAP benefits if they fulfill the monthly work activity requirement.

- The Department of Human Services is responsible for implementing the state’s Child Care Development Block Grant (CCDBG) plan that must now incorporate new federal mandates resulting from the law’s reauthorization in November 2014. There are provisions now required in the state plan that coincide with this budget cycle. One of the most significant funding issues is addressing the child care reimbursement rate. In developing its federal child care and development plan, the Department of Human Services was supposed to certify by March 1, 2016, that payment rates for subsidized care are sufficient to ensure equal access to care for families receiving subsidies. This deadline was not met. We know that center-based providers who accept subsidy payments have not received an increase since 2008, making New Jersey, according to data from the National Women’s Law Center, among the worst states in nation at paying for child care. The existing State-subsidy payments of $34.75 per day for an infant and $28.65 for a preschooler are often the sole source of income for these providers and these dollars cannot support increases in business costs, such as salaries, rent, food, supplies, and security. As a result, raising program quality is taking a back-seat in some cases, and in others, keeping program doors open is becoming more and more difficult. Access to child care allows parents to go to work and children to spend their days in safe and nurturing environments. What steps are you taking to (1) be in compliance with the federal mandates, and (2) to make an increase in the child care reimbursement rate a higher DHS priority?

**Answer:**

(1) States were required to provide an implementation plan for achieving compliance with certifying that rates are sufficient to ensure equal access requirement by September 30, 2016.
New Jersey asked for an extension to further conduct a provider rate data analysis to help inform policy to set adequate payment rates and ensure equal access. The CCDBG Act of 2014 revised the requirement for a market rate survey (MRS) so that it must be statistically valid and reliable; represent the child care market; and reflect variations in the cost of child care services by geographic area, type of provider, and age of child for setting payment rates. The response rate of the survey, slightly more than 30 percent, did not provide a statistical dependable sample size to truly reflect the market rate for all providers.

To meet the above requirement, DHS’s Division of Family Development has taken the following steps:

- Partnering with the Child Care Resource and Referral Agencies (CCR&R) to gather market rate data;
- Contracting with Rutgers University School of Social Work Research Department to conduct a market rate study;
- Obtaining technical assistance to explore other cost estimation models;
- Reviewing all payment related policies and payment rate structure; and
- Exploring Grow NJ Kids, New Jersey’s quality rating improvement system as a measure to structure the reimbursement rate to improve the delivery of child care services for providing higher quality care.

(2) DHS recognizes that child care is a significant expense for New Jersey families and essential for low-income working families. Supporting working families and being fair to child care providers has always been a top priority for DHS. The need for child care has steadily grown and reached historic highs as DHS was able to serve more than 90,000 children last year. DHS believes the MRS report findings will help inform policy consistency with the objectives of the federal requirement.

- New Jersey was the recipient of a four-year federal Race to the Top, Early Learning Challenge Grant in December 2013, aimed to achieve quality in early learning and care programs across settings, through the state’s Quality Rating and Improvement System, Grow NJ Kids. By the end of the four years, it is anticipated that more than 83,000 infants and young children in about 1,800 sites will benefit from a higher level of program quality. As December 2017 is just around the corner, what measures is DHS taking in this budget cycle to sustain Grow NJ Kids once the federal grant is completed?

**Answer:** The Child Care Development Block Grant (CCDBG) Reauthorization Act of 2014 requirements seamlessly align with Grow NJ Kids (GNJK), which focuses on increasing children’s access to higher quality child care. Through DHS quality initiative contracts, DHS is involved in various activities to improve the availability and quality of early and school-age care and education programs. These activities are supported by quality set-aside funds from the Child Care and Development Fund (CCDF).
• The 2015 Statewide Transition Plan for Medicaid home- and community-based services (HCBS) states that no more than four people can live together in a group home (or six people in some cases) and no more than 25% of multi-family dwellings can be individuals with developmental disabilities. Why are you keeping the density restrictions? Why not remove these numeric (e.g., 4/6/25) and setting (e.g., farms, intentional communities, collocated programs) restrictions and make all determinations based on the individual’s quality of life, rather than on numbers alone? What process will be used to make “case-by-case” determinations of compliance with HCBS rules? For day programs, are they still required to provide community integration for the “majority” of the day? Please provide an overview of your discussions with CMS on the Statewide Transition Plan and the timeline and major milestones leading to the eventual approval of the Plan. Will there be another public comment period before another version of the Plan is submitted to CMS?


**CASS Related Questions**

• Is the department working on an overarching modernization/replacement strategy that specifies the underlying framework for these “modules?” What is the plan for ensuring that modules are all going to work together during any final roll-out?

**Answer:** Yes, and we expect that many future enhancements can utilize existing applications that the Divisions of Medical Assistance and Health Services and Family Development have in production. We were advised on May 24, 2016 of an agreement among CMS, USDA, and ACF that the Federal Data Services hub now can be used for multiple applications. This development among our federal partners reaffirms that an electronic, modularly-based approach is a more effective and strategic model to pursue.

• How does the department intend to procure the framework/underlying architecture if not via RFP?

**Answer:** To the degree possible, DHS expects to use its existing contract/collaborative resources as it advances in the development of program applications and consumer portals. There are no plans to RFP for a large, comprehensive systems development project, such as CASS.

• If so, what then would be the next “module” purchased? How does the department define “module?” Does the department mean “program” (e.g. Medicaid first, then SNAP, then TANF)? Or does the department mean technical modules (i.e. Portal, mobility, case management)?
**Answer:** With “module” defined as an enhanced service that allows clients and staff increased functionality, the Division of Family Development very recently released a Document Imagining System for SNAP applications and it soon will release an asset verification and fraud tracking system. The next planned module will be integrating an application for the Aged, Blind and Disabled residents to apply for NJ FamilyCare.

- Has the department submitted Advance Planning Documents to CMS for approval for any “module”?

**Answer:** Yes, CMS currently has a plan to approve Aged, Blind and Disabled application.

- Has the department requested any funding to move forward?

**Answer:** All funding for IT enhancements and new functionality, including those procurements eligible for enhanced federal participation, are included in the base resources as part of each Division’s IT Spending Plan incorporated into the FY17 Budget.

- Is the department still engaged with KPMG or any other third party advisor to support next steps? If so, what does the contract entail?

**Answer:** No.

- Why does the Commissioner believe the Curam product is proprietary and therefore can't be used or repurposed?

**Answer:** The Curam product is written for and developed by Curam. Translating that was the biggest obstacle and one of the factors that led to the termination of the contract associated with the CASS project. It should be noted that the company was sold to HP and is now part of IBM.

- Has the department contacted other States on how they use Curam software in a modular fashion for CASS project equivalents?

**Answer:** DHS has participated in many conversations with other states and national organizations and in surveys with CMS and FNS on the subject of and the advances of Integrated Eligibility Systems. Staff is not aware of any other state using Curam in a modular fashion.
• Has the State investigated how their current software assets can be repurposed and reused for other projects and with other departments?

**Answer:** KPMG was contracted to provide a full feasibility assessment of materials, data and product when the HP/CASS contract ended. Its report and recommendations now guide the modular electronic strategy currently underway.