Discussion Points

**Department of Human Services (General)**

1. New Jersey began to implement the Medicaid expansion under the Affordable Care Act (ACA) in January 2014, which now provides health care coverage to over 500,000 New Jersey residents with household incomes under 138 percent of the federal poverty level (page D-177), at 100 percent federal expense. In the absence of the ACA, these individuals would have been ineligible for Medicaid, or could have been covered under Medicaid at 50 percent State expense. The federal matching rate for the ACA Medicaid expansion population will decrease to 50% State expense. The federal matching rate for the ACA Medicaid expansion population will decrease to 90% in January 2020. The expansion has provided other positive budgetary effects for the State: Charity Care costs are down significantly from before the expansion, the State receives a higher “blended” federal matching rate for certain Medicaid programs such as Graduate Medical Education, and many services previously funded entirely at State expense in the Division of Mental Health and Addiction Services are being shifted to Medicaid, where they receive federal matching funds. The State, however, also faces increased expansion-related costs in other areas, such as Medicaid administration (generally requiring a State or county share of 25 percent or 50 percent of costs), certain presumptive eligibility costs (matched at 50 percent) and the increased costs of coverage for the expansion population to begin in January 2017.

• **Questions:**
  a. By component, what is the net fiscal impact to the State (inclusive of its counties) of the ACA Medicaid expansion in FY 2016 and FY 2017?
  b. Please provide an extended year-by-year estimate of enrollment and State cost for FY 2018 through FY 2021 (similar to that provided in response to FY 2016 Discussion Point #26).

---

**Medicaid Expansion Cost/(Savings)**

<table>
<thead>
<tr>
<th>Category</th>
<th>SFY 16</th>
<th>SFY 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Federal Match on FamilyCare Parents Previously Covered under 1115 CHIP Waiver Authority</td>
<td>(152,000)</td>
<td>(152,000)</td>
</tr>
<tr>
<td>FamilyCare Parents Previously Covered under 1115 CHIP Waiver Authority transitioned to Federal Exchange</td>
<td>(12,300)</td>
<td>(12,300)</td>
</tr>
<tr>
<td>General Assistance Population Previously Covered under 1115 Waiver Authority prior to 1/1/2014</td>
<td>(150,100)</td>
<td>(150,100)</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>(314,400)</td>
<td>(314,400)</td>
</tr>
</tbody>
</table>

**New ACA Costs/Savings**

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Woodwork</td>
<td>95,781</td>
<td>95,781</td>
</tr>
<tr>
<td>Payments for Newly Eligible Recipients</td>
<td>74,851</td>
<td>74,851</td>
</tr>
<tr>
<td>Presumptive Eligibility</td>
<td>40,865</td>
<td>43,822</td>
</tr>
<tr>
<td><strong>Impact of Expanded Eligibility</strong></td>
<td>134,644</td>
<td>212,454</td>
</tr>
</tbody>
</table>

**Reduction in Charity Care payments to hospitals**

A decreasing volume of Charity Care claims as a result of a drop in the uninsured population brought about by the implementation of the ACA will significantly reduce Charity Care Payments.

<table>
<thead>
<tr>
<th>Amount</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>(74,000)</td>
<td>(149,000)</td>
</tr>
</tbody>
</table>

**Reduction in FQHC payments**

A decrease in the uninsured population brought about by the implementation of the ACA will significantly reduce FQHC Payments.

<table>
<thead>
<tr>
<th>Amount</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>(20,052)</td>
<td>(20,052)</td>
</tr>
</tbody>
</table>

**Additional federal match for FQHC wrap payments**

The implementation of the ACA will significantly reduce the State share of the FQHC payments because a significant portion of recipients receiving care at FQHCs are newly eligible for Medicaid due to the ACA.

<table>
<thead>
<tr>
<th>Amount</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>(20,059)</td>
<td>(31,104)</td>
</tr>
</tbody>
</table>

**Increase in the Federal match for Graduate Medical Education (GME) payments**

The State will be able to claim higher Federal match on GME payments as result of the ACA.

<table>
<thead>
<tr>
<th>Amount</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>(21,656)</td>
<td>(32,000)</td>
</tr>
</tbody>
</table>

**Increase in HMO 3.2% Assessment Revenue**

The State will collect more revenue from this assessment as HMO enrollment increases due to the ACA.

<table>
<thead>
<tr>
<th>Amount</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>(173,420)</td>
<td>(253,415)</td>
</tr>
</tbody>
</table>

**TOTALS**

<table>
<thead>
<tr>
<th>Amount</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>(353,272)</td>
<td>(435,967)</td>
</tr>
</tbody>
</table>
Discussion Points (Cont’d)

Figures in thousands
Discussion Points (Cont’d)

Projections based on SFY17 enrollment and rates.

<table>
<thead>
<tr>
<th>(Rate and enrollment are flat)</th>
<th>MEDICAID EXPANSION PROJECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFYs</td>
<td>SFY 2018</td>
</tr>
<tr>
<td>FMAP</td>
<td>95% / 94%</td>
</tr>
<tr>
<td>STATE EXPENDITURES</td>
<td>$166,593,220</td>
</tr>
<tr>
<td>FEDERAL EXPENDITURES</td>
<td>$2,862,374,416</td>
</tr>
<tr>
<td>TOTAL EXPENDITURES</td>
<td>$3,028,967,636</td>
</tr>
<tr>
<td>AVERAGE MONTHLY ENROLLMENT</td>
<td>528,335</td>
</tr>
</tbody>
</table>

2. At least 30,000 direct support professionals in New Jersey provide personal care, social support, physical assistance, and help in learning independent living skills to aging individuals and individuals with disabilities in a wide range of activities of daily living. Concerns about the adequacy of the direct support workforce are longstanding. Low industry compensation standards and high levels of stress involved in direct support work often lead to high turnover rates and job vacancies, which, in turn, lead to higher costs related to overtime wages, recruitment, and lost productivity, as well as lower quality of care.

In FY 2015, the Legislature increased direct support workers’ wages by including in the Appropriations Act a “Community Provider Contract Adjustment” \(^1\). No such adjustment was included in the FY 2016 Appropriations Act. Several representatives of provider agencies have testified before legislative budget committees and requested a five percent cost-of-living increase for FY 2017.

The Division of Developmental Disabilities (DDD) funds access to the College of Direct Support for employees of all DDD provider agencies. This allows direct support professionals to attend online professional development courses, which can lead to State certificates and national credentials. In addition, state-licensed provider agencies are required to use the College of Direct Support’s Learner Management System to track the completion of state-mandated Pre-Service Training, which drives traffic to an extensive list of additional optional online courses.

• Questions:
  a. How does the DHS view the State’s responsibility with regard to the workforce attraction and retention challenges faced by community providers? To what extent do the terms of DHS community provider contracts specify compensation guidelines or requirements for direct support workers? Is the department considering updating the terms of its provider contracts so as to allow for improvements in the compensation of direct support professionals?
  b. How much money does the DHS anticipate spending on community provider workforce development in FY 2016 and FY 2017, and how do these figures compare to actual FY 2014 and FY 2015 expenditures?
  c. How frequently is the College of Direct Support used by direct support professionals to obtain optional credentials?
  d. How are providers incentivized to provide high-quality jobs to their employees, particularly to those with more advanced training and skills?

\(^1\) FY 2015 Appropriations Handbook page B-205
Contract budgets for cost reimbursement contracts, including the level of staff compensation and workforce development, are set by provider agencies when they respond to State funding opportunities. Cost models for the upcoming fee-for-service implementation reflect inflation-adjusted market wage data from the Bureau of Labor Statistics. The contract for the Learning Management System that supports the College of Direct Support is currently being rebid.

In the current contract reimbursement model, there is a cost containment policy that specifies an upper limit that the department will contribute towards the salaries of psychiatrists, advanced practice nurses and management staff. This policy will no longer be applicable when contracts convert to fee-for-service. For mental health and addiction services, the cost containment contract policy will no longer apply July 2016.

The DMHAS anticipates the following spending on community provider workforce development:

<table>
<thead>
<tr>
<th></th>
<th>FY14 (Actual)</th>
<th>FY15 (Actual)</th>
<th>FY16 (Proj)</th>
<th>FY17 (Proj)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addiction Services</td>
<td>$2,053,516</td>
<td>$1,790,023</td>
<td>$3,296,147</td>
<td>$4,348,053</td>
</tr>
<tr>
<td>Mental Health</td>
<td>$8,758,114</td>
<td>$9,294,270</td>
<td>$9,565,339</td>
<td>$9,174,342</td>
</tr>
<tr>
<td>TOTALS</td>
<td>$10,811,630</td>
<td>$11,084,293</td>
<td>$12,861,486</td>
<td>$13,522,395</td>
</tr>
</tbody>
</table>

The increase in FY16 and FY17 for Addiction Services is attributable to the Recovery Coach program. The increase in FY16 for Mental Health Services is attributable to Integrated Case Management training in the provision of rehabilitation services.

3. The Legislature often hears from State vendors whose contracts have not been renewed or have been curtailed upon renewal through no fault of the vendor. Such changes may be the result of the end of an experimental program meant to test the practicality of a policy, the expiration of a program with temporary legal authority, a reduction of demand for the service, expiration of temporary federal funding, or the agency’s judgment that its limited resources would be more efficiently used on another purpose that is better aligned with the agency’s objectives.

- **Questions:**
  a. Please describe any programs that were significantly reduced in scope or not renewed in FY 2016. In each case, please briefly indicate: (1) the reason for the non-renewal or reduction; and (2) what program or contract will receive enhanced or new funding as a result of the savings.
  b. Please describe any programs that are scheduled to expire in FY 2017 and are at risk of not being renewed.

The Department continually monitors its contracts to ensure they meet or serve the primary DHS constituency; align with a core DHS program model; and/or, align with DHS’s core mission. In the DMHAS budget for FY16, the NJ 2-1-1 contract for addiction services/hotline was reallocated to fund the Interim Managing Entity (IME) who now provides that function. In DFD, for FY16, DHS reallocated funding for 15 contracts that were duplicative of funding provided by another State department. These funds were reallocated to the family worker program used to fund technical assistance centers for Grow NJ Kids, New Jersey’s program to improve the quality of child care and early learning across the state. There are no programs scheduled to expire in FY 2017.

4. The DHS administers programs in which third-party providers furnish services under contracts, many of which have remained nearly unchanged over long periods of time. Some programs annually increase in value to
Discussion Points (Cont’d)

keep pace with inflationary pressures on the contractors (e.g. the Medicaid managed care program), but most do not. In programs that operate with cost-reimbursement contracts, this can create disparities in reimbursement rates within a particular program, as newer contracts typically reflect the current cost to provide the service. Grant recipients and contractors, many of which are small nonprofit organizations whose staff receive only modest compensation, often express concern to the Legislature that their staff’s wages have effectively gone down over time as inflation has diminished the spending power of their State funding.

• Questions:
  a. Please list any programs administered by the DHS for which the FY 2017 Budget Recommendation includes a rate adjustment meant to reflect the effect of inflation on the costs of the program.
  b. Please list any contracts that have been voluntarily terminated by the vendor in the past year, where the vendor specifically cited inadequate State funding as its reason for terminating the contract.

Cost models for the upcoming fee-for-service implementation in DMHAS and DDD reflect inflation-adjusted market wage data from the Bureau of Labor Statistics. The Department is not involved in individual provider strategy decisions to enter or leave particular business lines.

In DMAHS, the Division administers a contract with Managed Care Organizations to provide services to Medicaid recipients. On an annual basis, DMAHS’ actuaries develop rates that are appropriate for the Medicaid benefit programs and their intended populations. These rates are developed from an actual, historical cost base and trended forward, or inflation adjusted, to the period that the premium rates are intended. As it applies to the Contract to Provide Medical Services for Medicaid recipients, DMAHS is not aware of any contracts that have been voluntarily terminated.

In DMHAS, a rate analysis was conducted for the continuum of mental health and substance use disorder treatment services. Rate adjustments were made to reflect a uniform cost for providing services. Approximately 100 rate codes were modified including the following: partial care mental health, partial care substance use disorder, outpatient services (mental health and substance use disorder treatment), halfway house, residential detoxification, programs for assertive community treatment, integrated case management services, methadone and buprenorphine bundled treatment services, SUD short term and long term residential services, mental health group home and apartment services.

The Department is not aware of any providers specifically citing inadequate State funding as the reason for terminating their contracts.

5. Several pieces of legislation have been proposed that would raise the Statewide minimum wage from $8.38 per hour to $15 per hour. If enacted, this would affect many DHS staff and third parties that operate many of DHS’s services and programs.

• Questions:
  a. Has the DHS considered the financial impact of a $15 minimum wage on its operations, including services provided by third parties? What impressions or conclusions has it reached?
  b. All other things being equal, by what amount would the department’s operating expenses increase if a Statewide $15 minimum wage were in effect?

The impact would vary provider-by-provider based on the types of service provided and each businesses cost structure, particularly when addressing wage compression issues for staff currently making over $15 per hour. Providers’ budgets include individual employee’s salaries but generally do not itemize hourly
rates for front-line, direct care per diem staff. Because DHS is unable to identify the fiscal impact on the third party contractors, DHS would be unable to estimate the impact on the department’s operating expenses. It is likely, however, that this level of minimum wage would result in significant increases.

Division of Mental Health and Addiction Services (DMHAS)

State Institutions

6. P.L.2009, c.161 (C.30:4-3.23 et seq.) requires the DHS to establish and maintain a reporting system for unexpected deaths and physical assaults at State psychiatric hospitals, and publish quarterly reports on its website. The release of these reports has frequently been delayed, and the most recent reports (for the first three quarters of 2015) no longer include data on less serious assaults that result in minor injuries or no injury (which is not required by the statute). According to press reports, the DHS suggested that the decision to reduce the scope of the reporting may have been made, at least in part, to reduce the manpower needed to assemble the reports.

Questions:

a. Are the State psychiatric hospitals continuing to keep records of assaults that result in minor injuries or no injury? How are these reports investigated?

b. What have been the challenges that have caused the delays in the public release of the incident reports? With the revised reporting methodology, does the department now expect reports to be updated more regularly?

This information continues to be reported. They are recorded into a centralized DHS database for review and oversight and, when necessary, are individually investigated. On a quarterly basis, all assault data is examined for trends and opportunity for improvements. This data is taken to the hospitals violence prevention committees. Treatment teams use individual patient data in the care of the patients.

Recently, DMHAS has changed the data dashboard to comport with the required data elements in Chapter 161 and streamlined the review and reporting process. The department expects reports to be updated regularly in that the data dashboard will be available for publication approximately 90 days after the end of the reporting quarter.

7. In an audit report for the time period July 1, 2012 to June 30, 2014, on the Adult Diagnostic and Treatment Center, operated by the Department of Corrections (DOC), the State Auditor noted: “Annual cost savings of approximately $1.9 million could be achieved by eliminating the minimum wage requirement for civilly committed sex offenders.” In response to an OLS discussion point question in the last fiscal year, the DOC indicated that the DHS provides and supervises the sex offender treatment services and as such, DHS, not DOC, has authority over the residents' wages.

Questions:

Has the department implemented this recommendation? If so, what savings are expected in FY 2016 and FY 2017, respectively? If not, please state the reason(s) for not doing so.

The FY 2017 Budget assumes that DHS continues compensating institutional work of Special Treatment Unit residents at the State minimum wage. Since these individuals are not incarcerated there are legal issues around this concern and the Department is open to a discussion of the requirement.

8. In his State of the State address, the Governor stated that Mid-State Correctional Facility (closed for renovations in June 2014) would be converted to a correctional facility dedicated to treatment for substance use disorders, which would be licensed by the Department of Human Services. The facility is expected to reopen in early 2017. The Governor’s recommended budget for the Department of Corrections includes $2 million for the Mid-State Licensed Drug Treatment Program (page D-71).

- **Questions:**
  a. What role has the DHS played thus far in the planned conversion of Mid-State Correctional Facility into a substance use disorders treatment facility?
  b. What role will the DHS play in the operation of the Mid-State Licensed Drug Treatment Program once the program is operational?
  c. Does the DHS anticipate any DHS budgetary impact for the operation of the Mid-State Licensed Drug Treatment Program? If so, please detail these costs.

The Division and Office of Program Integrity and Accountability and Office of Licensing assisted the DOC in preparing substance use disorder (SUD) treatment program standards for inclusion in the DOC’s RFP for a SUD treatment program vendor at Mid-State Correctional Facility (MSCF; male inmates). The Division, in consultation with OPIA/OOL, is in the process of developing a policy to allow for a pilot program for the conditional licensure of a SUD treatment program(s) operating within the MSCF. The role of DHS will be limited to the licensure of any SUD treatment program vendors operating within MSCF (those vendors will have a contractual relationship with DOC). No impact is anticipated.

**Community Mental Health and Addiction Programs**

9. In July 2015, Rutgers University Behavioral Health Care (UBHC) began a partnership with the DHS as an “Interim Managing Entity” or “IME.” In this role, UBHC manages most of the State’s addiction services for adults, including those funded by DMHAS and NJ FamilyCare. UBHC operates a “one-stop” telephone hotline, and is responsible for organizing the system of screening, referral for assessment, and authorization of State-funded treatment. The contract provides for implementation in phases, with some administrative processes and certain services being incorporated later (e.g. community support services added in January 2016). The IME is regarded as an interim step towards converting the entire behavioral health care system to risk-based managed care similar to other Medicaid acute care services.

- **Questions:**
  a. Please provide a preliminary assessment of the rollout of the IME. Please share the timeline and milestones for implementation and indicate whether the milestones and timeline have been met and whether the rollout is on schedule.
  b. What metrics related to client referral and access to treatment are being tracked? Has there been any measurable improvement to date?
  c. Does the DHS anticipate expanding the IME to mental health care services, and if so, on what timeline?
  d. What factors are being considered in determining if and when to begin shifting services into a risk-based managed care system?

The IME rolled out Phase 1 of the IME July 1 of 2015. That roll-out included the implementation of a one stop call center for addiction services. The Call Center screens for caller need and available public financing and makes referrals based upon results of the screening. Phase 1 of the IME also included care coordination activities such as calling individuals regularly who are awaiting admission to treatment, following up on referrals made to assure connections to care, and assistance in finding continuing treatment services for individuals being discharged from detoxification treatment services. From the start
of the IME until 3/31/16, the IME received 42,354 calls from family members, those seeking substance use disorder services, administrative requests from providers and other callers.

Phase II of the IME, which began in January 2016, includes utilization management of Medicaid and managed state initiatives. This will include a clinical review of all treatment requests to determine medical necessity and assure that the client is receiving the right services at the right dose to meet their needs.

The MOA between UBHC and the DHS to implement the IME services included performance metrics in the areas of access to the call service, levels of assistance in the areas of care coordination and satisfaction with the service. At this time, the IME intends to issue prior authorization requests for mental health services provided in Community Support Services.

The Division of Medical Assistance and Health Services will be analyzing the possibility of moving the NJ Behavioral Health System to a managed care model through either a Managed Care Carve-In or a stand-alone Managed Behavioral Health Organization (MBHO). The move to FFS will enable the Division to collect utilization and cost data to assist with the analysis of moving to a managed care system.

10. On its website, the DMHAS lists integration of primary care and behavioral health care as one of its major initiatives. Patient advocates and researchers frequently observe the advantages of integrating care: some individuals who have no relationship with a behavioral health specialist may be more willing to discuss their problems in a primary care setting rather than seek out specialized help, which can thereby improve early detection and treatment of behavioral health conditions; conversely, individuals with chronic behavioral health conditions are far more likely than the general population to suffer from other physical ailments, such as diabetes or heart disease, which are often left untreated or inadequately treated due to lack of access to primary health care. A recently published report from the Seton Hall Center for Health and Pharmaceutical Law and Policy\(^3\) concludes, in part, that the current system for provider licensure, under which primary care providers are licensed by the Department of Health and behavioral health providers are licensed by DHS, is a significant obstacle to integrated care, and that a unitary license covering both types of care would simplify the system and improve patient care.

* **Questions:**
  a. How is DMHAS promoting better integration of primary care into its system of behavioral health care providers? What specific steps has DMHAS taken to integrate primary care and behavioral health care, and what is the initiative’s timeline going forward?
  b. Does the DMHAS track data on physical health diagnoses and outcomes of its clients?
  c. To what extent does the current licensure structure impede better integration of behavioral and physical health care services? Would a unified system of licensure be advantageous?
  d. Would legislation be required to permit providers to offer both physical and behavioral health care services under a unitary license? In considering such a policy change, what operational efficiencies or other advantages of the current bifurcated licensure system should the Legislature consider?

DMHAS has begun to integrate primary care into the current continuum of treatment through several efforts. The most prominent initiative is the Behavioral Health Home (BHH) initiative. The New Jersey BHH model is designed to treat persons diagnosed with Serious Mental Illness (SMI) and takes

\(^3\) [http://www.njspotlight.com/assets/16/0330/2027](http://www.njspotlight.com/assets/16/0330/2027)
Discussion Points (Cont’d)

responsibility for whole-person care. One treatment team coordinates all the treatment needs of the individual. New Jersey has approved State Plan Amendments for BHH services in Bergen and Mercer Counties and has a pending SPA for BHH services in Atlantic, Cape May, and Monmouth Counties.

In addition to the BHH, DMHAS and DMAHS have received a grant from the National Academy of State Health Policy (NASHP) to explore the development of integrating behavioral health services in primary care settings. DMHAS and DMAHS were also recently awarded a Medicaid Innovation Accelerator Program (IAP) to explore expansion of integration efforts throughout the Medicaid system. In the BHH program, physical health diagnoses are captured by the provider upon assessment and on Medicaid claims data.

DHS is working closely with the Department of Health to improve coordination between the two departments to increase access to coordinated behavioral health and primary care services, but as noted in the Seton Center for Health and Pharmaceutical Law and Policy report referenced above, an immediate transition to a single licensure could have negative consequences.

11. The DMHAS subsidizes housing for some of its clients. The DHS has recently begun shifting its housing subsidies away from specific slots at specific locations, and toward more portable vouchers. Housing vouchers funded by DHS are administered by the Supportive Housing Connection, a project of the Housing and Mortgage Finance Agency.

- **Questions:**
  a. How many individuals currently receive housing subsidies funded by the DMHAS? How many of these subsidies are in the form of portable housing vouchers, as opposed to specific “slots” at specific locations?
  b. What is the estimated cost for these subsidies in FY 2016 and FY 2017, and how much did DMHAS expend thereon in FY 2014 and FY 2015? What is the average cost per subsidized client under both housing programs?
  c. How does the DMHAS determine which of its clients receive housing subsidies and what subsidy amount a specific client will receive?
  d. Are DMHAS clients receiving housing assistance required to apply for aid under other housing State and local housing assistance programs (e.g. the State Rental Assistance Program)? How do these programs interact?

There are currently 3,028 consumers receiving subsidies through DMHAS. Out of the 3,028 subsidies, 1,230 are portable (recycled) subsidies. The cost for subsidies is as follows:

<table>
<thead>
<tr>
<th></th>
<th>FY2014</th>
<th>FY2015</th>
<th>FY2016 (est.)</th>
<th>FY2017 (est.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subsidies Paid</td>
<td>$20,909,225</td>
<td>$21,425,144</td>
<td>$25,200,000</td>
<td>$25,650,000</td>
</tr>
</tbody>
</table>

The projected increase between FY15 and FY16 is due to the fact that the DMHAS has added approximately 475 additional vouchers since the start of FY16. The average cost per consumer is approximately $12,364. DMHAS uses the Fair Market Rate (FMR) issued yearly by DCA to establish rental maximum limits for each county. FMR varies county by county.

DMHAS target population for subsidies are mostly for individuals being discharged for the state hospitals who are Conditional Extension Pending Placement (CEPP) under the Olmstead Settlement. These individuals are ready for discharge but lack a place to live. The amount of the subsidy is determined by the county where the consumer has chosen to live, usually between $10,000-$12,000 annually. In the consumer rental agreements signed by consumers, it is required that consumers seek other housing
voucher/subsidy opportunities from other housing resources such as Section 8 or State Rental Assistance Programs (SRAP) as they become available.
12. In his FY 2017 Budget Address, the Governor announced the expansion of the Recovery Coaches program (formally known as the Opioid Overdose Recovery Program). The program hires individuals who are recovering from addiction as coaches, who help to steer individuals who are hospitalized after an overdose and rescue with Naloxone into longer-term treatment and recovery. According to the Budget Summary (page 17), the program launched in January 2016 in the four counties hardest hit by the addiction crisis. The FY 2017 Budget recommendation includes an additional $1.7 million to expand the program to six more counties. A recommended language provision on page D-174 would dedicate $2.3 million in revenue from the “Drug Enforcement and Demand Reduction Fund” (DEDR) to support the program.

**Questions:**

a. What is the anticipated funding level for the Recovery Coaches program in FY 2016 and FY 2017? In what budget lines are the appropriations located? What is the FY 2016 funding source for the program?

b. Are DEDR excess balances being used to finance the program? If not, what programs formerly funded by DEDR are recommended to be reduced or eliminated to allow this funding to support Recovery Coaches?

The funding level and sources is as follows:

<table>
<thead>
<tr>
<th>Source</th>
<th>FY16</th>
<th>FY17</th>
</tr>
</thead>
<tbody>
<tr>
<td>SABG</td>
<td>$146,250</td>
<td>$195,000</td>
</tr>
<tr>
<td>DMHAS</td>
<td>$48,750</td>
<td>$65,000</td>
</tr>
<tr>
<td>DCF</td>
<td>$201,563</td>
<td>$268,750</td>
</tr>
<tr>
<td>DEDR</td>
<td>$465,938</td>
<td>$2,302,000</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$862,501</td>
<td>$2,830,750</td>
</tr>
</tbody>
</table>

DEDR excess balances are being used to support the Recovery Coaches program. This will not impact other programs currently supported through DEDR revenue.

13. New Jersey, along with other states across the country, is faced with a shortage of behavioral health treatment providers. In response, the DMHAS has committed to increasing credentialed alcohol and drug counselors through its Addiction Training and Workforce Development Initiative. This program provides scholarships to eligible individuals to participate in addictions training or academic study.

**Questions:**

a. How much DMHAS funding is allocated to behavioral health workforce training efforts in FY 2016 and is recommended to be allocated therefor in FY 2017? What is the specific funding source for the Addiction Training and Workforce Development Initiative?

b. How many individuals have obtained or are in the process of obtaining professional certification as a result of these efforts?

The amount of funding allocated to training is as follows:

<table>
<thead>
<tr>
<th>Service</th>
<th>FY16 (Proj)</th>
<th>FY17 (Proj)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addiction Services</td>
<td>$3,296,147</td>
<td>$4,348,053</td>
</tr>
<tr>
<td>Mental Health</td>
<td>$9,565,339</td>
<td>$9,174,342</td>
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Discussion Points (Cont’d)

<table>
<thead>
<tr>
<th></th>
<th>TOTALS</th>
<th>$12,861,486</th>
<th>$13,522,395</th>
</tr>
</thead>
</table>

Funding sources for the Addiction Training and Workforce Development initiative are Grants-in Aid (Addiction Community Care Account), dedicated (Intoxicated Driving Program), and Federal (Substance Abuse Prevention and Treatment Block Grants and Screening, Brief Intervention, Referral to Treatment Grant).

Since inception, 1,565 students have completed initial Certified Alcohol and Drug Counselor (CADC) coursework, 613 have completed all 270 required educational hours, and 316 are currently enrolled.

Additionally, 1,201 individuals completed mandatory renewal trainings for legal standards and cultural competence; 446 individuals attended certified clinical supervisor training and 2,338 individuals completed LCADC/CADC licensing or certification renewal courses and 79 enrolled and pursuing Certified Prevention Specialist Scholarships.


• Questions:
  a. What monitoring or reporting systems have been established to assemble data for the performance report?
  b. When does the DMHAS anticipate that the first annual report will be published?

The New Jersey Substance Abuse Monitoring System collects all the data indicators needed for the report and anticipates the first annual report, based on FY 2016 data to be produced by mid-year FY 2017.

15. Several reports over the past year have suggested a link between the current epidemic of heroin use and hepatitis C infections. The hepatitis C virus can be transmitted by users of intravenous drugs who share needles. It has been suggested that widespread testing of heroin users for hepatitis C may improve efforts at early detection and treatment of the virus, thereby improving the health of individuals infected with the virus and slowing the spread of the disease.

• Questions:
  a. Does the department encourage addiction treatment providers to test high-risk patients for hepatitis C and does it provide financial support therefor? If so, please describe the department’s efforts.
  b. What percentage of individuals receiving DMHAS-funded services related to intravenous drug use has been tested for hepatitis C infection?
  c. What would be the estimated cost to the State to mandate and fund hepatitis C testing for all intravenous drug users receiving treatment from State-funded providers?

The Standards for Licensure of Outpatient Substance Abuse Treatment Facilities recommends Hepatitis C surface antigen and antibody screening, but it is not required. Cost estimates for testing would depend on the details of the testing mandate and how those costs would be passed along to the State.

16. Data on page D-164 of the FY 2017 Governor’s Budget Recommendation indicate a growing trend in the number of clients who are served by the Involuntary Outpatient Commitment (IOC) program who would otherwise be committed to inpatient hospitalization (507 clients in FY 2015, an estimated 535 clients in FY 2016, and an estimated 570 clients in FY 2017). According to testimony provided by the department in previous budget cycles, the IOC program has not been widely used as an alternative to institutionalization on the front-end; rather,
it has been used almost exclusively to require ongoing treatment for individuals after their discharge from a psychiatric hospital. Even before the establishment of the IOC program, it was common for individuals discharged from psychiatric hospitals to be released on the condition that they comply with ongoing treatment instructions.

- **Questions:**
  a. What factors account for the anticipated growth in the IOC program caseload?
  b. Of the 570 clients in the IOC program projected for FY 2017, how many have entered or are projected to enter the program after discharge from hospitalization? How many entered or are projected to enter the program without first being involuntarily hospitalized?
  c. How many additional individuals are expected to be conditionally released in FY 2017?
  d. When employed as a mechanism for compelling a person’s ongoing treatment after discharge from a psychiatric hospital, how does the IOC program differ from a conditional release?

Growth will be driven by excess capacity available in IOC programs. For example, programs (e.g., Morris, Middlesex/Monmouth) that were awarded and implemented during 2015 have not yet “built up” to a capacity caseload. Additionally, several programs serving rural areas (e.g., Cape May, Cumberland/Salem/Gloucester) have available capacity as well.

IOC enrollment data has consistently indicated that 95%-97% of enrollments occur as the person is being transitioned from involuntary in-patient hospitalization to the outpatient commitment status. The number of those conditionally released has been decreasing in recent years. Based on data through April, we estimate that approximately 50 individuals will be conditionally released in FY16.

Involuntary outpatient commitment is a civil commitment to less restrictive treatment setting, i.e., a designated treatment provider agency in the community. Under IOC commitment, the court and IOC treatment provider are responsible for the supervision of a patient’s compliance with the approved treatment plan. If a patient is materially non-compliant with the treatment plan; the court can review, modify and if the patient poses an immediate or imminent danger, then the IOC provider is required to refer the patient to a screening center to determine whether or not inpatient commitment criteria is met. The court in an IOC can continue to monitor, modify and supervise the treatment of an individual with the IOC provider agency. In the case of a conditional discharge, a court discharges a patient from a psychiatric hospital with clinical conditions pursuant to N.J.S.A. 30:4-27.15 (c).

17. Via several conditional vetoes, the Governor has proposed creating a new legal standard for involuntary outpatient commitment, which would be less strict than the current unitary standard that applies for both involuntary inpatient and outpatient commitment to treatment. Legislation has been proposed embodying this recommendation (A-3224 and S-421 of 2016).

- **Questions:**
  a. How many individuals might be involuntarily committed to outpatient treatment under the expanded legal standard in the proposed legislation?
  b. How much would it cost the State to expand the IOC program to accommodate this larger population?

Based on FY 2015 systems review committees data, there were 10,220 episodes of care at the State’s Designated Screening Service programs in which the consumer had been on an involuntary in-patient psychiatric unit or to a Division funded psychiatric emergency service program within the previous 30 days. Further analysis of these individuals would be required to determine how many of these individuals...
Discussion Points (Cont’d)

could conceivably be deemed at risk of “deterioration of the mental condition” in the expanded legal standard.

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

Provider Reimbursement Rates

18. The FY 2016 Appropriations Act included an additional $45 million ($15 million State plus $30 million federal) to increase NJ FamilyCare physician reimbursement rates, embedded within several line items on page B-90 of the Appropriations Handbook, to take effect January 1, 2016. The Governor’s FY 2017 Budget Recommendation includes an additional $45 million to continue this rate increase for FY 2017. The targeted billing codes are categorized as preventative, primary, and postpartum care services. The goal of the increased reimbursement is to “support a continuing effort by the Division of Medical Assistance and Health Services to encourage physician participation in the NJ Family Care program, expand beneficiaries’ use of primary care services, and ultimately reduce episodic non-emergent emergency department visits by beneficiaries.”

Available information indicates that approximately $15 million of the original $45 million increase is to be distributed through the fee-for-service system, and $30 million will go through the managed care system. In November 2015, the division provided the managed care organizations (MCOs) with instructions on the distribution of the managed care system increases. The division did not provide MCOs with specific rate increases, but stressed that plans would be responsible for developing the distribution methodology, investment validation, and key performance indicators. The division indicated that it would receive quarterly reports from the MCOs on these points.

• Questions:
  a. What is the methodology used by each MCO for distribution? Which types of billing codes are increased?
  b. What measures does the division use to evaluate investment validation? What measures are the MCOs using to evaluate investment validation?
  c. What are the key performance indicators used by the division? What are the key performance indicators used by the MCOs?
  d. What information has the division received on incentive payments used by the MCOs to increase physician acceptance of new Medicaid patients?
  e. What measures does the division plan to use to evaluate if the increased rates are improving MCO enrollees’ access to care?
  f. What recourse does the division have if MCOs do not increase Medicaid reimbursement for the target providers?
  g. Please summarize the feedback the division has received from MCOs, providers, or other stakeholders regarding the increased rates.

In addition to some targeted fee schedule enhancements, the managed care organizations (MCOs) are moving forward on a variety of different methodologies including incentive and performance-based payments, bundled payments for episodes of care and enhanced care coordination add-ons. The Division and the MCOs will use baseline payment data for the period prior to implementation of the new funding and compare it to post implementation data that reflects the increased expenditures.

Discussion Points (Cont’d)

The Division and the MCOs will use the following key performance indicators to measure the impact of the rate increase for the focus service areas: number of physicians providing targeted services to NJ FamilyCare beneficiaries; number of unduplicated beneficiaries per month receiving targeted services; number of provider complaints, grievances and appeals; and number of low acuity non-emergent (LANE) visits. The MCOs will establish additional HEDIS-based metrics tied to alternative payment methodologies to monitor the change in quality and outcomes.

The MCOs are advancing a variety of incentive-based methodologies to increase physician participation. Episodes of Care (EOC) payments provide shared savings opportunities to specialists through a bundled payment model focused on procedural, surgical or chronic disease pathways. The MCOs also are developing focused recruitment plans that include increased rate schedules for certain specialists in targeted and difficult to serve geographic areas.

To measure the impact of the rate increase on access to care, the Division will measure change in the number of unduplicated beneficiaries per month receiving the targeted services. Additionally, the Division will measure the number of physicians providing the targeted services to NJ FamilyCare beneficiaries as well as the change in the number of targeted codes billed.

The Division has had multiple communications with the MCOs regarding the intent of this funding. Senior leadership, on both sides, have met on several occasions. In all discussions, the requirement to ensure that all funding moves to the provider community has been articulated and agreed upon. The Division will track expenditures quarterly to ensure compliance.

The Division has received positive feedback from the MCOs, the provider community and stakeholders who recognize this unique opportunity to rebalance a portion of Medicaid health care funding. In a recent correspondence, an MCO “commended the state for the decision to implement this critical program and provide plans with the opportunity to utilize the funds to support specific need areas.”

19. For many services, New Jersey has among the lowest Medicaid fee-for-service reimbursement rates in the United States, reportedly often paying less than a provider’s cost to provide a service. Information on the reimbursement rates paid by NJ FamilyCare MCOs to providers is not available to the public, but most anecdotes suggest that NJ FamilyCare MCO rates are generally comparable to fee-for-service rates.

Historically, these low reimbursement rates have been acceptable because providers balance their under-reimbursed Medicaid business with better compensated insured business, as well as Medicaid-based supplemental payment programs. Although low Medicaid rates have long been criticized, the Legislature has been presented with testimony suggesting that the traditional cross-subsidization model may be becoming less tenable, as insurance networks are becoming more restrictive and implementing tiered benefit structures. Simultaneously, Medicaid supplemental payment programs are becoming more restrictive: the growing proportion of Medicaid payments that are administered through the managed care system and do not allow the State to access federal funds for “upper payment limit” programs; the Health Care Stabilization Fund was eliminated in FY 2014; the Hospital Relief Subsidy Fund was replaced with the more demanding Delivery System Incentive Payments (DSRIP) program in FY 2014; federal funding for New Jersey’s DSRIP program is scheduled to expire in late 2017; and as of FY 2016 the State no longer supports Charity Care with the federal funds it receives based on State Charity Care expenditures. In effect, these trends may result in the closure of safety net acute care hospitals.

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6 See testimony to the joint meeting of the Senate Health, Human Services and Senior Citizens Committee and the Senate Commerce Committee, October 5, 2015; and testimony to the joint meeting of the Assembly Health and Senior Citizens Committee and the Assembly Regulatory Oversight Committee, December 2, 2015.
and other providers, and insured patients (including those covered under the State Health Benefits Plan and School Employees Health Benefits Plan) paying more to allow greater cross-subsidies.
Discussion Points (Cont’d)

- **Questions:**
  a. Does the division monitor provider reimbursement rates paid by Medicaid MCOs relative to the rates paid for the same services for privately insured patients? Please describe any benchmark the division may use.
  b. To what extent, if any, does DMAHS encourage higher reimbursement rates in regions where Medicaid demand for certain health care services is unmet?
  c. To what extent, if any, does DMAHS coordinate its MCO contract design with the State Health Benefits Commission or the School Employees Health Benefits Commission?
  d. In providing reimbursement rate guidance, does the division consider the business model and financial stability of safety net acute care hospitals?

Medicaid MCO capitation rates are set with the goal of improving quality and efficiency in service delivery in a cost-effective, efficient delivery of value-based care. The rates are set in accordance with federal rules and regulations and are certified to be in accordance with Actuarial Standards of Practice that include reasonable, appropriate and attainable costs.

The Division requires the MCOs to meet patient access and network standards so it is typical for MCOs to pay diverse fees between different locations of the State to attract and retain necessary providers. The Division aligns the Medicaid MCO contract to meet federal rules and regulations and coordinates with the NJ Department of Banking and Insurance on service package requirements.

The Division utilizes data sources such as actual Medicaid FFS and charity care claims adjudicated by the NJ Medicaid fiscal agent, along with submitted Medicare cost report data when establishing rates. Financial review of hospitals may be undertaken by the Division within the scope of the DRG rate appeal process, to determine whether the hospital is efficiently operated. If a formal rate appeal is submitted by the facility along with support data, and is deemed meritorious by the Division, a financial review would include review of financial ratios, efficiency indexes, debt structure, and changes in cost and revenue.

20. Federal law requires states to reimburse federally qualified health centers (FQHCs) 100 percent of “reasonable and related costs” for services to Medicaid clients. In part, New Jersey’s methodology for reimbursing FQHCs includes a limit on administrative costs at 30 percent of total allowable cost (N.J.A.C.10:66-1.5(d)ii). Federal courts have twice found that similar caps on administrative costs used in other states’ Medicaid programs were in violation of the federal requirement that FQHCs be reimbursed at 100 percent of “reasonable and related costs”. Some New Jersey FQHCs have expressed to the Legislature that they similarly feel that the 30 percent cap on administrative costs fails to accurately represent their costs.

- **Questions:**
  a. For the most recent full year available, what was the Statewide total of Medicaid payments to FQHCs?
  b. How does this total differ from the total of “reasonable and related costs” reported by the FQHCs?

FQHC payments totaled $135 million in FY 2015 and are projected at $151 million in FY 2016. Each individual FQHC baseline Prospective Payment System (PPS) encounter rate was calculated based on the guidelines issued and approved by CMS. Baseline FQHC encounter rates were calculated based on the greater of the two annual costs reports of their respective fiscal years. The overall per encounter limit on Medicaid costs is the base year Medicare limit plus $14.42 per encounter. The baseline PPS rate is inflated annually using the percentage increase in MEI (Medicare Economic Index) defined in section 1842(i)(3) of the Social Security Act. The PPS encounter rate may be adjusted for a change in scope of
services. FQHCs do not file an annual Medicaid cost report once the baseline PPS encounter rate is calculated and established.

21. Services provided at an FQHC to an individual enrolled in an MCO are reimbursed by the MCO at a negotiated rate. However, if a reimbursement is less than 100 percent of the FQHC’s “reasonable and related costs,” then federal law requires the Medicaid program to make a supplemental payment to cover the difference between the MCO’s payment and the cost to the FQHC. This supplemental payment is commonly referred to as a “wrap-around” payment.

**Questions:**
For FY 2015, FY 2016, and FY 2017, please provide the actual or estimated total cost to Medicaid for all wrap-around payments to FQHCs. What percentage of total Medicaid reimbursements to FQHCs do these payments represent?

Medicaid FQHC Expenditures:

<table>
<thead>
<tr>
<th></th>
<th>SFY 2015</th>
<th>SFY 2016</th>
<th>SFY 2017 (Projected)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO</td>
<td>$46.3</td>
<td>$56.9</td>
<td>$59.7</td>
</tr>
<tr>
<td>Supplemental (Wrap Around)</td>
<td>$56.8</td>
<td>$64.6</td>
<td>$67.8</td>
</tr>
<tr>
<td>FFS</td>
<td>$31.9</td>
<td>$29.7</td>
<td>$31.2</td>
</tr>
<tr>
<td>Total Medicaid</td>
<td>$135.7</td>
<td>$151.0</td>
<td>$158.7</td>
</tr>
<tr>
<td>% Supplemental (Wrap Around) to Medicaid reimbursement</td>
<td>41.9%</td>
<td>42.8%</td>
<td>42.7%</td>
</tr>
</tbody>
</table>

* based on 9 months of actual data and projected
** based on SFY2016 data projected with a 5% increase

Note: Significant increase in Medicaid FQHC expenditures (approximately 12%) from SFY 2015 to SFY 2016 due to significant improvement in support claim data submitted by FQHCs and increase in Medicaid-eligible recipients in conjunction with the Affordable Care Act (ACA)

**NJ FamilyCare Enrollment and Outreach**

22. During FY 2016, most applications for NJ FamilyCare have been processed by the department’s contracted health benefits contractor, Xerox. This differs from the traditional arrangement whereby county welfare agencies made most eligibility determinations and redeterminations. (State funding for Xerox and county welfare agencies is included in the Eligibility and Enrollment Services line item on page D-180.) County welfare agencies have struggled to manage the surge in NJ FamilyCare applications caused by the Medicaid expansion so that additional processing responsibilities for certain types of applications have been transferred to Xerox. County welfare agencies, in turn, have remained fully responsible for the processing of certain types of applications. The use of Xerox has relieved some of the workload on county welfare agencies and helped to dramatically reduce the backlog in applications for public assistance. (During the FY 2016 budget process, the DHS estimated that the State had a combined backlog of approximately 11,000 NJ FamilyCare applications that were not processed in the required timeframe – 45 days after submission for standard applications.) Various sources have suggested that the State plans to allow counties to resume their previous responsibilities for NJ FamilyCare applications at some time in the near future.
Discussion Points (Cont’d)

• **Questions:**
  a. Is there currently any backlog in the making of NJ FamilyCare eligibility determinations and redeterminations, and if so, how many are past due in each county?
  b. What is the current methodology for distributing responsibility for NJ FamilyCare eligibility determinations between county welfare agencies and Xerox? How many eligibility determinations are anticipated to be processed by each county welfare agency and Xerox during FY 2016? Does the department intend to adjust the distribution in FY 2017?

Below is the number of NJ FamilyCare applications at each county that have been in process for over 45 days. The numbers are self-reported by the counties as of April, 2016:

<table>
<thead>
<tr>
<th>County</th>
<th>Paper Application</th>
<th>Online Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlantic</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bergen</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Burlington</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Camden</td>
<td>69</td>
<td>158</td>
</tr>
<tr>
<td>Cape May</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cumberland</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Essex</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Gloucester</td>
<td>162</td>
<td>0</td>
</tr>
<tr>
<td>Hudson</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hunterdon</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>Mercer</td>
<td>65</td>
<td>6</td>
</tr>
<tr>
<td>Middlesex</td>
<td>464*</td>
<td></td>
</tr>
<tr>
<td>Monmouth</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Morris</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Ocean</td>
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<td>0</td>
</tr>
<tr>
<td>Passaic</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>Salem</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Somerset</td>
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</tr>
<tr>
<td>Sussex</td>
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<tr>
<td>Union</td>
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<td>50</td>
</tr>
<tr>
<td>Warren</td>
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<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1068</td>
<td>221</td>
</tr>
</tbody>
</table>

*Middlesex did not separate Paper and Online counts
Discussion Points (Cont’d)

All new online NJ FamilyCare applications are sent to Xerox, with the following exceptions:

1) Applications for residents of Cumberland, Salem, and Sussex counties go to county of residence
2) Applications for Pregnant Women go to the County of Residence

All paper applications go to the applicant’s county of residence except Morris County; Morris County began a pilot with Xerox to process NJ FamilyCare eligibility beginning November 2015, so all applications for family-related programs are processed by Xerox for Morris County residents.

We expect Xerox will perform 500,000 eligibility determinations in SFY 2016 and the CWA’S will perform approximately 800,000.

Counties without backlogs can request that online applications be directed to them instead of Xerox.

23. The Kaiser Family Foundation estimates that approximately 335,000 New Jersey residents were without health insurance in 2015, even though they were eligible for Medicaid. This cohort represents approximately 36 percent of all the nonelderly uninsured residents of the State. No appropriation is recommended in FY 2017 specifically related to outreach.

• Questions:
  a. Please describe the State’s current outreach and enrollment efforts for NJ FamilyCare.
  b. Are any funds specifically allocated for such outreach and enrollment efforts? In what line item(s) are these funds located?

NJ FamilyCare offers a training program to train helping agencies volunteer to learn how to help individuals apply for NJ FamilyCare. The training program was marketed to all current application assistance sites, including FQHCs, school districts, and hospitals as well as other social service agencies, and insurance brokers. The State Departments of Health, Education and Banking and Insurance helped support the training by encouraging attendance of the agencies they oversee. The training includes information on NJ FamilyCare and the new health law as well as how to help a family apply for NJ FamilyCare. To date, NJ FamilyCare has trained close to 1800 individuals on NJ FamilyCare.

There are also 28 volunteer Certified Assistors who underwent more in depth training (20 hours) and have access to the Assistor Portal to track the follow up with the individuals they have assisted. In addition there are 5 NJ FamilyCare Regional Offices throughout the State and local County Welfare Agencies that have kiosks and staff available to help families apply as well as help resolve any issues or answer questions they may have.

NJ FamilyCare continues to outreach through clinics, hospitals, and schools which have proven to be most successful. Below is a brief synopsis of our ongoing statewide outreach initiatives:

Schools

NJ FamilyCare is working in conjunction with the Department of Education and individual school districts’ student rosters to help identify and outreach the uninsured. New Jersey schools incorporated the
new requirement to inquire about health insurance into their existing forms and shared the information with NJ FamilyCare for follow up and outreach. School districts were given until October 30th to send an electronic mail file of their uninsured students with an indicator for their participation in the School Lunch program in a prescribed file layout so the parents can be outreached.

**Hospital and FQHC**

Hospitals continue to be reminded on the availability of Presumptive Eligibility for children and adults. We have met with FQHC and Hospital Providers to train on PE eligibility.

NJ FamilyCare continues to partner with the FQHCs which are focusing on helping eligible families apply for NJ FamilyCare instead of relying on Uncompensated Care for their uninsured populations.

**On the Web**

Our NJ FamilyCare website, www.njfamilycare.org, continues to be a great source of information for the public, with fact sheets available in 11 languages. Not only can families learn all about NJ FamilyCare, get program materials in various languages, and be updated about any program changes, but they can apply online as well. The website was re-launched in July 2013 with new updated federal health care law information. The website presented a new look to highlight the new NJ FamilyCare program. Electronic and hard copy letters were sent to alert stakeholders of the changes and upcoming trainings.

**Long Term Care**

24. The Managed Long Term Services and Supports (MLTSS) program, first implemented in July 2014, shifts most Medicaid long-term care into a managed care system. Medicaid recipients who are eligible for long-term care services must enroll in a Medicaid managed care plan, and the plan is responsible for managing the person’s care and reimbursing the entities that provide care. When the MLTSS program was first implemented in FY 2015, a “default rate” was established for nursing facilities that have not negotiated a reimbursement rate with a resident’s managed care plan. This was intended to allow more time for transition and minimize sudden shifts in reimbursement. (Individuals who were residing in nursing homes prior to the start of MLTSS are generally not required to enroll in MLTSS, and the facilities continue to be paid on a fee-for-service basis by the State.) This “default rate” was anticipated to end after two years, but information from the department indicates that it is continuing through FY 2017.

- **Questions:**
  a. What percentage of current Medicaid nursing home residents live in nursing facilities that are being reimbursed according to the MLTSS default rate?
  b. How many nursing facilities have not yet negotiated a reimbursement contract with at least one Medicaid MCO?

All Medicaid nursing home residents are reimbursed in accordance with the MLTSS default rate.

Under the Any Willing Provider (AWP) provision, the managed care organizations (MCOs) must accept and contract with any NF that wants to participate in MLTSS.
25. In July 2015, the Rutgers Center for State Health Policy issued a report on initial stakeholder feedback on implementation of MLTSS. The report noted anecdotal accounts of reductions in hours of service and service eligibility for MLTSS participants relative to what they had received in the previous fee-for-service program. Such reductions may be possible, as MLTSS participants were reassessed for service eligibility based on a more standardized process than had been used before. Although MCOs are required to report any reductions in services, the report indicates that the MCOs do not feel they have enough information about the services that consumers were receiving before the transition to determine whether the MCOs’ assessment results in a reduction of services. (Previous care plans, while available, were typically in a textual format that does not easily facilitate comparisons, and the MCOs cannot verify that consumers were actually receiving all services in their care plans.)

**Questions:**

a. Please share any reliable information the department may have that indicates whether reduction of services has been common since the implementation of MLTSS.

b. Going forward, how are MLTSS participants’ care plans and eligibility for specific services (and hours of service) tracked? Is the information kept in a format to allow for analysis by State officials, MCOs, or researchers?

Under MLTSS, the MCOs must conduct initial and annual assessments to determine the level of care needs of their members, which guides the development of their plans of care. MCOs are required to submit a report documenting the reduction in home and community-based care (HCBS) on a monthly basis. The report enables DHS to monitor changes in service utilization and take corrective action, when necessary. Per the contract agreement, the MCOs began submitting these service reports to DHS in April 2015. Between April and December 2015, the MCOs reported that 124 services were reduced; of those, 78 reductions were reported as “not appealed,” 19 reductions were going through the appeals process and the status of 27 reductions was “not reported.”

With the implementation of MLTSS, New Jersey is now serving more individuals with long term services and supports. New Jersey’s long term care population has grown by 11 percent from a total of 42,314 members when MLTSS began in July 1, 2014 to 46,891 members as of March 2016. Of this total, 37.9 percent of the long term care population is now receiving home and community based services, up from 28.9 percent when the program began.

Under the NJ Comprehensive Medicaid Waiver, DHS established the New Jersey Quality Strategy for all services to assure the application of a continuous quality, improvement process, representative sampling methodology, frequency of data collections, and analysis, and performance measures in these areas:

- Outcomes related to qualities of life; and the health and welfare of participants receiving services including the:
  - Development and monitoring of each participant’s person-centered service plan to ensure that the DHS and MCOs are appropriately creating and implementing service plans based on a member’s identified needs.
  - Specific eligibility criteria for each identified HCBS program that addresses level of care determination – to ensure that approved instruments are being used and applied appropriately and as necessary, and to ensure that individuals being served have been assessed to meet the required level of care for those services.

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DHS contracts with Island Peer Review Organization (IPRO) to perform this function. Additionally, the MCOs must submit monthly/quarterly reports documenting compliance with each performance measure. There are five measures that specifically address plans of care and six that address level of care (clinical eligibility).

These reports are maintained in a format that allows for analysis.

26. In December 2014, the State began to permit individuals in need of long-term care to use Qualified Income Trusts (QITs, also called Miller Trusts) in order to meet Medicaid/NJ FamilyCare financial eligibility criteria and enroll in MLTSS. A QIT allows individuals to deposit income in excess of the Medicaid limit into a trust account, where the income would not be counted for the purpose 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). This system replaced the Medically Needy program, which is now closed to new applicants. According to the department’s response to FY 2016 Discussion Point #48, this shift significantly expanded eligibility and enrollment at a projected State cost of approximately $14 million in FY 2016 relative to FY 2015.

Questions:

a. Please provide information on the number of QIT applications received, and the number approved, in FY 2015 (actual), FY 2016 (estimated), and FY 2017 (projected). What cumulative amount is currently held in QITs?

b. What referral options or services exist for individuals who are likely to benefit from a QIT, but who may not have the resources to hire a lawyer to draft the trust or a person to administer the trust?

FY 2015-Actual - 1,800 applications - 544 individuals determined eligible
FY 2016-Estimated – 2,200 applications and 800 eligible
FY 2017-Projected – 2,700 applications and 900 eligible

Cumulative amount of individuals eligible for Medicaid Only using a QIT from 12/1/14-3/1/16:

- Nursing Facilities – 763
- Assisted Living - 218
- Living at Home - 73
- Total individuals eligible using a QIT – 1,054

DMAHS has provided a QIT Template on its website along with general information and FAQs to assist a consumer or their representative. The CWAs are asked to inform their DMAHS Field Representative if someone lacks representation.

Other NJ FamilyCare

27. NJ FamilyCare allows some people to obtain blood lead screenings through Medicaid. In the event that a blood test finds a high level of lead contamination, NJ FamilyCare also covers some follow-up services, including case management and facilitating the local department of health’s environmental investigation and remediation activities.

Questions:

a. How many blood lead screenings were paid for by NJ FamilyCare annually from FY 2010 through FY 2015, and are anticipated to be paid for in FY 2016 and FY 2017?
Discussion Points (Cont’d)

b. How much was spent annually from FY 2010 through FY 2015 on lead screening follow-up activities, in total and by service type? What are the projected totals for FY 2016 and FY 2017?

c. Please describe the DHS’s efforts to encourage blood lead screening for high-risk populations.

<table>
<thead>
<tr>
<th>SFY</th>
<th>Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>122,700</td>
</tr>
<tr>
<td>2009</td>
<td>122,928</td>
</tr>
<tr>
<td>2010</td>
<td>125,635</td>
</tr>
<tr>
<td>2011</td>
<td>131,899</td>
</tr>
<tr>
<td>2012</td>
<td>140,918</td>
</tr>
<tr>
<td>2013</td>
<td>148,936</td>
</tr>
<tr>
<td>2014</td>
<td>147,571</td>
</tr>
<tr>
<td>2015</td>
<td>138,054</td>
</tr>
<tr>
<td>2016</td>
<td>142,635</td>
</tr>
<tr>
<td>2017</td>
<td>143,353</td>
</tr>
</tbody>
</table>

Source: NJ FamilyCare fee-for-service and managed care encounter data
Notes: Includes paid claims with procedure code 83655 Only (Lead Test)

Claim counts shown include claims serviced within each state fiscal year

Projected amounts for FY2016 and FY2017 assume lead screenings increase at the same rate as enrollment growth for the entire NJ FamilyCare population as shown in the FY2017 Governor's Budget Message

The costs for treatment of high blood lead levels are included in the Managed Care capitation payments. When a Medicaid enrolled child has tested with a high blood lead level, the Department of Human Services (DHS) becomes aware through the MCO or the Department of Health (DOH). The MCO is required to follow up to confirm that the result is from a venous blood draw, and if there is no confirmation, the DHS monitors that the MCO lead case manager arranges for a test to be completed. If the results are confirmed, the DHS acts a liaison between the MCO and DOH. The DHS monitors the development of a written case management plan, including relocation to lead-safe housing, abatement and education to the family about sources of lead exposure, consequences of exposure, good housekeeping, good hygiene and appropriate nutrition. If necessary, the MCO will coordinate with community resources and support groups. The DHS continues to act as a liaison with the MCO until the child’s blood lead level has returned to normal limits.

DMAHS sends out both a lead screening flyer and a general Early Periodic Screening Diagnosis and Treatment (EPSDT) letter, to all newly-enrolled beneficiaries under the age of 6 upon their enrollment into NJ FamilyCare, which encourages screening of all members under the age of 6. These describe procedures for lead abatement in the home and methods to minimize risk of lead exposure. In addition, annual letters are sent from DMAHS to all FFS members between the ages of 11 months and 6 years for whom there is no documentation of a lead test having been performed.

28. The Medicaid Disproportionate Share Hospital (DSH) program allows the State to receive federal matching funds for certain payments to hospitals for costs that are not otherwise eligible for federal Medicaid matching funds (e.g. Charity Care, and most payments to psychiatric hospitals). For federal fiscal year 2015, New Jersey was allotted $697.5 million, of which a maximum of $178.7 million is permitted for costs in
Discussion Points (Cont’d)

psychiatric hospitals. Although the Affordable Care Act requires reductions in Medicaid DSH allotments, subsequent Congressional action has delayed the cuts until federal fiscal year 2018.

State budget documents have historically represented most DSH funds as general revenue without indicating how DSH funds are spent. The recommended reduction of Charity Care funding, from $502 million in FY 2016 to $352 million in FY 2017, would seem to lower federal DSH funding.

• Questions:
  Please describe the distribution of all Medicaid DSH funding in FY 2016 and FY 2017 by program and budget line item. For each program, please indicate the amount of the federal subsidy and the source of the State share corresponding to the federal funds. How does the proposed reduction for Charity Care affect the distribution of DSH funding in FY 2017?

See the succeeding charts for the distribution of FY2016 and FY2017 DSH Funding. The proposed reduction in Charity Care reduces DSH funding by $75 million (SFY16 Charity Care federal share of $251million less SFY17 Charity Care federal Share of $176 million = $75 million).

<table>
<thead>
<tr>
<th>FY2016 ESTIMATED DSH REVENUE</th>
<th>Total Payments</th>
<th>Federal Share</th>
<th>Fiscal 2017 Governor’s Recommended Budget Revenue Line Item</th>
<th>State Funding Source(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charitable Care</td>
<td>$502.0M</td>
<td>$251.0M</td>
<td>$33.0M, $198.0M</td>
<td>State: Health Care Subsidy Fund</td>
</tr>
<tr>
<td>Hospital Relief Offset Mental Health</td>
<td>$24.7M</td>
<td>$12.3M</td>
<td>$12.3M</td>
<td>State: Health Care Subsidy Fund &amp; General Fund</td>
</tr>
<tr>
<td>State and County Psychiatric Hospital Uncompensated Costs</td>
<td>$339.5M</td>
<td>$169.7M</td>
<td>$169.7M</td>
<td>State and County: General Fund or general revenue appropriations</td>
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<tr>
<td>Public General Acute Hospital Uncompensated Costs *</td>
<td>$174.7M</td>
<td>$87.4M</td>
<td>$87.4M</td>
<td>State and County: General Fund or general revenue appropriations</td>
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<tr>
<td>Mental Health Contract Payments to General Acute Hospitals</td>
<td>$71.3M</td>
<td>$35.7M</td>
<td>$35.7M</td>
<td>State: General Fund appropriations</td>
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<tr>
<td>Other Agency Payments to Hospitals</td>
<td>$35.2M</td>
<td>$17.6M</td>
<td>$17.6M</td>
<td>State: General Fund and Dedicated Fund appropriations</td>
</tr>
<tr>
<td>Ambulatory Care Facilities Assessment - Impermissibility Adjustment **</td>
<td>($57.5M)</td>
<td>($28.8M)</td>
<td>($28.8M)</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Reserved Revenue ***</td>
<td>($26.0M)</td>
<td>($26.0M)</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>2016 ESTIMATED</td>
<td>$1,089.8M</td>
<td>$518.9M</td>
<td>$65.3M, $248.2M, $35.7M, $169.7M</td>
<td></td>
</tr>
</tbody>
</table>

* Includes $52.9 million in retroactive payments dating back to fiscal 2012
** Federal rules deem this tax as impermissible; therefore, the annual receipts generated from the tax must be deducted from DSH payments for federal matching purposes.
*** $26 million in revenue is reserved to account for the possibility that federally-mandated hospital-specific DSH audits may necessitate the return of matching dollars associated with payments in excess of actual facility costs.

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## Discussion Points (Cont’d)

<table>
<thead>
<tr>
<th>FY2017 ESTIMATED DSH REVENUE</th>
<th>Total Payments</th>
<th>Federal Share</th>
<th>Fiscal 2017 Governor’s Recommended Budget Revenue Line Item</th>
<th>State Funding Source(s)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Sch 1: Medicaid Uncompensated Care - Acute</td>
<td>Sch 1: Medicaid Uncompensated Care - Mental Health</td>
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<tr>
<td>Charity Care</td>
<td></td>
<td></td>
<td>$53.0M</td>
<td>$123.0M</td>
</tr>
<tr>
<td>Hospital Relief Offset Mental Health</td>
<td></td>
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<td>$12.3M</td>
<td>$12.3M</td>
</tr>
<tr>
<td>State and County Psychiatric Hospital Uncompensated Costs</td>
<td>$357.4M</td>
<td>$178.7M</td>
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<tr>
<td>Public General Acute Hospital Uncompensated Costs</td>
<td>$121.8M</td>
<td>$60.9M</td>
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<td>$60.9M</td>
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<td>$35.7M</td>
<td></td>
<td>$35.7M</td>
</tr>
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<td>$17.6M</td>
<td></td>
<td>$17.6M</td>
</tr>
<tr>
<td>Ambulatory Care Facilities Assessment - Impermissibility Adjustment *</td>
<td>($58.1M)</td>
<td>($29.1M)</td>
<td></td>
<td>($29.1M)</td>
</tr>
<tr>
<td>2017 ESTIMATED</td>
<td>$904.2M</td>
<td>$452.1M</td>
<td>$65.3M</td>
<td>$172.4M</td>
</tr>
</tbody>
</table>

* Federal rules deem this tax as impermissible; therefore, the annual receipts generated from the tax must be deducted from DSH payments for federal matching purposes.

29. The Office of the Inspector General for the U.S. Department of Health and Human Services frequently issues audit reports that conclude that state Medicaid programs inappropriately received federal reimbursement, and disallows some claims of federal funding. In many cases the DHS disputes such findings, and is often successful in reducing the amount of disallowed federal revenue by providing additional required documentation or filing alternative claims. Nonetheless, the amount of money in dispute can be a cause for concern. According to documents associated with a recent bond offering, 17 audit reports “which in the aggregate total in the hundreds of millions of dollars, are currently in draft or final form but, due to possible revisions or appeals, the final amounts and timing of any repayments are uncertain. The State is unable to estimate its exposure, but has currently reserved over a hundred million dollars in federal revenues to offset these potential disallowances.”

• **Questions:**

  How much federal Medicaid funding is currently subject to unresolved disputes between DHS and the federal government? Based on past experience, approximately what percentage of these disputed funds is likely to ultimately be received and kept by the State?

  The Department disagrees with the amounts identified by the Office of the Inspector General (OIG) ($479.6M) and notes that the recommended OIB disallowances are less than 1% of the total federal claims during the period cited. These audits date back to 2005, with approximately 90% of the

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Discussion Points (Cont’d)

disallowances rising from claims made between 2005-2010. DHS continues to have settlement discussions with CMS and believes it will be several years before these disputes are resolved. There is wide variation in past settlement outcomes which does not serve as a good basis for estimating the percentage of the disputed federal Medicaid revenue that will be retained by the State.

Division of Aging Services (DoAS)

30. P.L.2015, c.53 (C.44:15-1 et seq.) requires the DHS to use the New Jersey Elder Economic Security Standard Index (NJ Elder Index) “to improve the coordination and delivery of public benefits and services to older adults residing in the State and as a planning tool to allocate public resources more efficiently.” The FY 2016 Appropriations Act provided $200,000 to implement the bill, which is not recommended to be renewed in FY 2017 (page D-190).

• Question:
  Please provide an update on the implementation of the NJ Elder Index and its use in the department’s program design and planning.

  The Division of Aging Services has entered into a Memorandum of Understanding with the Edward J. Bloustein School of Planning and Public Policy at Rutgers. DoAS expects to have a final project report early in FY 2017. The report will provide an update to the NJ Elder Index for 2015 and allow DHS to update the data going forward.

31. The Governor’s FY 2017 Budget recommends funding two Community Based Senior Programs accounts at a combined $47.9 million, the same level as in FY 2016 (page D-190). Many of the programs aggregated in these accounts are described in evaluation data on page D-188. However, it is not clear how much is allocated to each of these programs in FY 2016 and whether those amounts are being modified in FY 2017.

• Questions:
  a. Please provide a breakdown of funding in the Community Based Senior Programs accounts by program.
  b. Is any redistribution of funds proposed for FY 2017?

The following is a breakdown of funding by programs in the Community Based Senior Programs (CBSP) accounts:

<table>
<thead>
<tr>
<th>Program</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Protective Services</td>
<td>$4,778,000</td>
</tr>
<tr>
<td>Social Services Grants to Area Agencies on Aging (Counties &amp; Agencies)</td>
<td>$13,303,000</td>
</tr>
<tr>
<td>Alzheimer’s Services</td>
<td>$4,132,000</td>
</tr>
<tr>
<td>Housing &amp; Transportation Services</td>
<td>$4,587,000</td>
</tr>
<tr>
<td>Home Delivered Meals</td>
<td>$1,645,000</td>
</tr>
<tr>
<td>Statewide Respite Care</td>
<td>$5,359,000</td>
</tr>
<tr>
<td>Jersey Assistance for Community Caregiving (JACC)</td>
<td>$10,027,000</td>
</tr>
<tr>
<td>DoAS Program Operational Funding</td>
<td>$4,041,000</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$47,872,000</td>
</tr>
</tbody>
</table>
The FY 2017 budget line item for CBSP provides the flexibility that DHS needs to reallocate funds where there is the greatest demand for services.

32. The Legislature included a language provision in the FY 2016 Appropriations Act requiring that the Alzheimer’s Medical Day Care Program be administered in the same manner as it was in FY 2013 and with payment rates not less than those that were in effect in FY 2013. The Governor deleted this language provision from the final budget by line item veto. (The Alzheimer’s Medical Day Care Program is funded at approximately $3.6 million annually under the Community Based Senior Programs accounts on page D-190.)

• Questions:
  a. What changes in program administration and payment rates for the Alzheimer’s Medical Day Care Program have occurred since FY 2013?
  b. What would it cost to increase all provider rates to FY 2013 levels?

To address the inequity of payment rates among the Alzheimer’s Adult day Services Program (AADSP) provider agencies, the Department conducted a cost analysis survey and developed a new rate methodology for the AADSP provider network.

The payment methodology focused on:

1. Direct service related costs,
2. Level of care needs,
3. Budget neutrality,
4. Maintaining current level to clients, and
5. Standardizing payment to providers.

As a result of the cost analysis:

• A new AADSP rate was established that reflected current operating costs, yet budget neutrality was maintained.
• Thirty-three AADSP providers’ rates were increased and only five out of 38 had their rates reduced, none of which withdrew from the program.
• Prior to the new rate, six AADSP agencies withdrew from the program due to the low reimbursement rate and this current fiscal year, two new agencies enrolled in the program.
• Enrollment increased 14% from FY15 (37,200 to FY16 TO 42,300) and there is no waiting list for services.

In SFY16, the rate for AADSP is above the SFY13 rate for 87% of the provider agencies. In addition, the program saw increased enrollment in the number of clients served and the number of agencies participating in the program. To increase the rate for all providers would require the DHS to increase the state fiscal year budget.

Division of Developmental Disabilities (DDD)

Budget Display

33. The budget display for DDD has been modified in FY 2017 to represent the division’s transition to providing a majority of its services to individuals through two Medicaid waiver programs: the Community Care Waiver (CCW), which provides services to individuals who are primarily living in State-licensed residential
programs; and the Supports Program, a part of the Comprehensive Medicaid Waiver which is directed to individuals who are residing in the community, but receive services funded by the department. The new budget display includes three main program classifications: (01) Purchased Residential Care, which funds supportive services provided to individuals who are funded through the CCW and reside in State-licensed residential programs; (02) Social Supervision and Consultation for individuals who are in the CCW and who are part of the Supports Program, and the Developmental Disabilities Council which has input in these services; and (03) Adult Activities, which funds employment and day services for both CCW and Supports Program enrollees.

A comparison of the FY 2016 and FY 2017 Budget displays indicates that there are three budget lines included in the FY 2016 Budget display which are not clearly transferrable to the FY 2017 budget display: ARC – Essex which received $75,000 in FY 2015 and FY 2016; Addressing the Needs of the Autism Community, which received $4 million in FY 2015 and FY 2016; and Autism Respite Care which received $1 million in FY 2015 and FY 2016.

Questions:

a. Please detail the anticipated funding for ARC-Essex, Addressing the Needs of the Autism Community, and Autism Respite Care in FY 2017. Please indicate which FY 2017 budget lines these programs are categorized under.

b. Please identify and comment on any other noteworthy changes in the display.

This funding and related provider contracts remains in the FY 2017 Budget unchanged and, as in previous years, supports service provision based on assessed levels of need as required by federal waiver programs and State eligibility regulations. Although added to the Budget in response to particular concerns, these line items historically only reflected a small portion of the funding provided to individuals with an autism diagnosis.

The Governor’s FY 2017 Budget Recommendation includes $84.6 million in funding for Contracted Services, an increase of $4.6 million (5.8 percent) from the adjusted FY 2016 appropriation, but a decrease from the $170.6 million in FY 2015 program expenditures. In FY 2016 and FY 2017, the Contracted Services are allocated in the Purchased Residential Care program class and are entirely supported by State funds, which indicate that these services are not eligible for federal Medicaid matching funds. A footnote on page D-203 explains that some FY 2015 Contracted Services are now allocated to the new federal Supports Program ($152.8 million recommended FY 2017 appropriation).

Questions:

a. Please define “Contracted Services” and provide a list of services that fall under this line item in FY 2016 and fell thereunder in FY 2015. To the extent that these services could also be funded within other related line items, please explain the significance of the funding being located in the Contracted Services line item.

b. Does the department anticipate that there will always be a need for Contracted Services outside of Medicaid (i.e. the Supports Program and CCW)? If so, what are the services?

c. Please list the services that fall under the Supports Program – Individual and Family Support Services and the Supports Program – Employment and Day Services budget lines in FY 2017. Please indicate on the list which services were funded under Contracted Services in FY 2015.

The OLS notes that due to the change in budget display, programs that previously may have been funded as “contracted services” are now funded under different lines. The OLS does not believe that the decrease from FY 2015 is an actual decrease in these types of services.
The Contracted Services line item primarily relates to services provided out-of-state in institutional or institutional-like settings that are not eligible for federal match, along with State-funded services that, at full implementation, will eventually shift to the Supports Program. Because the Supports Program was not operational in FY 2015, all services were funded from other line items.

Supports Program – Individual and Family Support Services include:
- Assistive Technology
- Behavioral Management
- Case Management
- Cognitive Rehabilitation
- Community Base Supports
- Community Inclusion Services
- Community Transition Services
- Environmental Modification
- Fiscal Management Services/Fiscal Intermediary
- Goods & Services
- Interpreter Services
- Natural Supports Training
- Occupational Therapy
- Personal Emergency Response System
- Physical Therapy
- Respite
- Speech, Language and Hearing Therapy
- Support Coordination
- Supports Brokerage
- Transportation
- Vehicle Modification

Supports Program – Employment and Day Services include:
- Career Planning
- Day Habilitation
- Prevocational Training
- Supported Employment

Fee-for-Service Conversion

35. On July 1, 2015, the division began the transition of shifting its method of reimbursement to a fee-for-service reimbursement system for community providers, 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. All providers must now be enrolled as Medicaid providers to receive reimbursement from the State. In response to the OLS discussion points in FY 2016, the department estimated that approximately 30 percent of providers were already fee-for-service billers. The division has held multiple information sessions and has staff dedicated solely to assisting providers become Medicaid eligible.

• Questions:
  a. What percentage of current providers are Medicaid eligible?
  b. When does the department anticipate that 100 percent of providers will be enrolled in Medicaid?

Currently 45% of providers are Medicaid eligible, with 100% enrollment anticipated by July 1, 2017.

36. Providers have expressed concerns that the shift from cost reimbursement contracts to fee-for-service billing will cause them financial hardship. In response to last year’s OLS discussion points, the division asserted that it would be designing a bridge funding process to assist agencies in good programmatic and financial standing with potential cash flow issues during transition. The FY 2017 Budget Summary indicates that “included in the fiscal 2017 budget is a one-time community provider increase for a combined State and federal

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12 http://www.state.nj.us/humanservices/ddd/providers/ratestudy.html
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investment of $10 million. These funds will allow developmental disability providers to make the infrastructure improvements necessary to transition to fee-for-service.” (page 20). There is no specific line item increase for community providers in the FY 2017 Budget Recommendation.

• Questions:
  a. How much funding will be provided in FY 2016 to bridge the transition process for designated agencies? How many agencies received or will receive this funding?
  b. Please specify where in the budget the $10 million appropriation referenced in the FY 2017 Budget Summary is located.
  c. Does the department anticipate that additional funding will be provided in FY 2018?
  d. How is the amount of bridge funding determined per agency or provider? What is the process for distributing the funds?

For display purposes, the $10 million is budgeted in the CCW – Individual Supports line and will be allocated proportionally based on provider contract ceilings, similar to the allocation of the FY 2015 legislative increase. Funding for FY 2018 will be determined as part of next year’s budget process.

37. The Supports Program is the 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. DDD is transitioning all individuals who receive services from the division and are not enrolled in the CCW into the Supports Program. This will allow the State to receive a 50 percent federal match for the program’s expenditures, but also subjects DDD to certain federal rules that do not apply to services funded entirely by the State. The FY 2017 Budget Recommendation outlines the funding for the individuals who will be enrolled in the Supports Program, although many of the individuals served through these budget lines are not enrolled in the Supports Program yet.

In FY 2016, the division stated that it intended to roll the program out slowly to optimize its performance when fully implemented. The division offered many learning opportunities for all stakeholders to be fully engaged in the process of implementing the Supports Program. It has held in-person meetings, webinars and consultations for all stakeholders.

The Supports Program began on July 1, 2015 with a select cohort of 100 individuals. In January 2016, the division announced that it was beginning Phase II of the Supports Program and enrolling the next 100 individuals. Performance data on page D-200 of the Governor’s FY 2017 Budget Recommendation indicate that the department anticipates enrolling 3,971 individuals in the Supports Program during FY 2017 after enrolling a projected 250 individuals in FY 2016. The Administration recommends appropriating $53.7 million for Individual and Family Support Services and $99.1 million for Employment and Day Services for individuals in the Supports Program (page D-202).

• Questions:
  a. What is the total amount of federal funding expected to be generated from the Supports Program in FY 2016?
  b. What is the total amount (state and federal) anticipated to be expended on contracts with Support Coordination Agencies and Supports Coordinators?
  c. When does the department anticipate full implementation of the Supports Program?
  d. How many individuals does the department anticipate serving under the Supports Program in FY 2017 who are not enrolled in the program or the CCW?
  e. How many of the individuals currently receiving services from the division are not enrolled in Medicaid and not eligible for the Supports Program?
The Division anticipates generating approximately $2.5 million of federal Supports Program revenue in FY 2016, with an average monthly enrollment of 3,971 individuals in FY 2017 leading to full enrollment during FY 2018. Once enrollment is complete, all individuals that are not on the CCW will be receiving services through the Supports Program. Support Coordination payments are based on a standard per member, per month rate and will fluctuate with actual enrollment.

Community Care Waiver

38. The 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, primarily in licensed residential facilities. 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 response to the OLS Discussion Points in FY 2016, the delay was due to heightened scrutiny of the State’s rate methodologies, but the State had received verbal approval of the submitted changes. Furthermore, the department responded that there were currently 10,824 individuals enrolled in the CCW and that the maximum number of allowable participants would be 12,664 in FY 2016 and 13,114 in FY 2017. Budget data indicate that a projected 7,639 individuals would live in Group Homes/Supervised Apartments; 650 in Supported Housing; and 630 in Community Care Residential Facilities, for a total of 8,919 individuals being supported outside of their own home. Additionally, 15,840 individuals would receive DDD services while residing in their own home. The budget data do not identify how many of the individuals who reside in their own home would be enrolled in the CCW.

Questions:

a. What explains the continued delay in fully renewing the CCW? What are the areas of disagreement between the State and the federal government?

b. What is the total number of participants in the CCW currently? How many individuals does the department anticipate serving through the CCW in FY 2017 and FY 2018?

c. How many individuals who are enrolled in the CCW live in their own home, as opposed to a division-funded residential placement?

The Division has addressed CMS’s concerns with the renewal and believes approval will be forthcoming. Average monthly CCW enrollment for FY 2015 through FY 2017 is projected at 10,972, 11,079 and 11,187, respectively, with approximately 2,500 individuals living in their own homes.

39. According to the department’s response to FY 2016 Discussion Points, there were 6,353 individuals on the CCW Waiting List for services. FY 2017 budget data indicate that 3,666 individuals were designated as Priority placements in FY 2015, and 3,216 individuals in FY 2016 and 2,821 individuals in FY 2017 are anticipated to be 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 budget displays in prior fiscal years included a line for Community Services Waiting List Placements which provided funding for individuals who were on the waiting list and needed to be moved into the CCW that fiscal year. The FY 2017 Budget Recommendation does not include this line. The department has indicated that the new Supports Program would provide services to individuals who are waiting to be placed on the CCW.

Questions:

a. How many individuals are currently on the CCW waiting list?

b. What will the effect of the implementation of the Supports Program be on the waiting list? Does the department anticipate that any individuals will be removed from the waiting list due to the receipt of services through the Supports Program?
Department of Human Services FY 2016-2017

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As of March 1, 2016, there were 5,436 individuals on the CSWL, of whom 729 are children that would receive services from other State or local authorities. All adults on the list are able to receive day and employment services through the Division at this time. Of the 4,707 adults, 3,253, or 69%, are currently choosing to receive a service from the Division. Supports Program enrollment is open to all individuals on the CSWL that meet financial and functional eligibility requirements.

40. According to information provided to the Office of Legislative Services (OLS) by the Office of Management and Budget, the Executive is seeking $24 million in supplemental appropriations to the FY 2016 Appropriations Act for the Community Care Waiver. In the past, supplemental appropriations have been sought due to lower than anticipated federal revenue. State expenses that are eligible for federal matching funds under the CCW receive a 50 percent federal match.

• Questions:
  For what reason is the department seeking an FY 2016 supplemental appropriation? If the reason is a shortfall of federal revenue relative to expectations, what caused the shortfall?

  The supplemental relates to trend-based estimates as of February 2016. We anticipate further adjustments by the close of FY 2016.

Client Housing

41. The Governor recommends $95.3 million for Client Housing in FY 2017 (page D-202). The appropriation is comprised of $33.5 million from the General Fund and $61.8 million from client contributions received by the State (page C-12). Housing services are not eligible for federal Medicaid matching funds.

  Historically, most of this funding was combined with funding for supportive services and provided within a single contract for each DDD residential provider. But the DHS has recently begun shifting its housing subsidies away from specific slots at specific locations, and toward more portable vouchers, in order to comply with the federal home- and community-based services rule (see next discussion point). Housing vouchers funded by DHS are administered by the Supportive Housing Connection, a project of the Housing and Mortgage Finance Agency (HMFA). Evaluation data on page D-201 indicate that an estimated 1,200 vouchers will be managed by the Supportive Housing Connection in FY 2017. A footnote indicates that this number reflects new programs or services in FY 2016 or 2017.

  According to the department’s response to the OLS Discussion Points in FY 2016, DHS signed a Memorandum of Understanding with the HMFA that redirected approximately $900,000 of existing State resources to HMFA for the administration and operation of the Supportive Housing Connection in FY 2016. The department also responded that the Supportive Housing Connection would not affect expenditures on purchased residential care, as DHS planned to continue to support the housing costs currently represented in contract with provider agencies, and that the funds would be administered by the Supportive Housing Connection instead of directly in contract with provider agencies.

• Questions:
  a. How many individuals currently receive housing subsidies funded by the DDD whether in the form of portable vouchers or purchased residential care? If some of these costs appear in line items other than Client Housing, what is the total cost to the State, excluding client contributions, for these subsidies and to what line items are they charged?
Discussion Points (Cont’d)

b. Does the division plan to transition any current housing subsidies from slots to vouchers during FY 2017 or does the anticipated 1,000 increase in vouchers managed by the Supportive Housing Connection represent new FY 2017 housing clients?

c. How does the DDD determine which of its clients receive housing subsidies and whether clients will receive portable vouchers or residential care slots? How does it determine the amount of subsidy a specific client will receive?

d. Are DDD housing assistance recipients required to apply for aid under other State and local housing assistance programs (e.g. the State Rental Assistance Program)? How do these programs interact?

Currently, approximately 100 housing subsidies are administered through the SHC, primarily for individuals being enrolled on the Supports Program. Other housing costs are supported through cost reimbursement contracts, including over 8,000 individuals living in group homes, supervised apartments and similar residential settings. The voucher increase for FY 2017 reflects both new vouchers and the transition from cost reimbursement contracts to fee-for-service reimbursement, although the start of the transition depends on the date of the CCW renewal by CMS. Under FFS, all housing support will be provided through portable vouchers with the intention that individuals apply for assistance under programs run by State and federal housing authorities.

In January 2014, the Centers for Medicare & Medicaid Services (CMS) issued a final rule 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). 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. After public hearings and comments, the State submitted the final Statewide Transition Plan in April, 2015. The final plan was reviewed by CMS and further information was requested of the department on aspects of the plan.15

Some of the DHS proposals that met with the most public comment were: 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 75 percent 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 shifted to a lease-based housing system (discussed in the previous discussion point) which 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). The department changed the draft plan to address some of the chief concerns of advocates. Specifically, the limits on numbers of individuals in congregate and non-congregate settings would only be applied to new housing. Additionally, individuals in day programs are not required to spend at least 75 percent of the day outside facilities which are dedicated to people with disabilities, but rather are to spend the majority of their time engaging in integrated activities with the broader community of non-HCBS recipients inside or outside of the day facility and DHS intends to work with the contracted provider agencies to develop policies and protocols in this regard. Housing is still intended to be slowly transitioned to a lease-based housing system.

13For 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
14http://www.state.nj.us/humanservices/dmahs/info/Statewide_Transition_Plan_FINAL.pdf
Discussion Points (Cont’d)

• **Questions:**
  a. What is the status of the federal review of the Statewide Transition Plan? By what date does the State anticipate receiving full federal approval?
  b. What changes has the department agreed to make to the Statewide Transition Plan to facilitate federal approval and what steps is the department already taking to implement the plan?
  c. Have any new congregate or non-congregate housing developments been initiated under the new rules in FY 2016 and does the department anticipate the initiation of any additional developments in FY 2017?

The Centers for Medicare and Medicaid Services (CMS) has asked for additional information regarding the Statewide Transition Plan by July 31, 2016. This information will be published for public comment prior to submission.

Out-of-State Placements

43. Some individuals who are aging into DDD services have been supported in facilities that are located out-of-State or may feel that their needs would be best met by specialized facilities located out-of-State. Pursuant to P.L.1977, c.82 (C.30:6D-9), “every service for persons with developmental disabilities offered by any facility shall be designed to maximize the developmental potential of such persons and shall be provided in a humane manner in accordance with generally accepted standards for the delivery of such service and with full recognition and respect for the dignity, individuality and constitutional, civil and legal rights of each person receiving such service, and in a setting and manner which is least restrictive of each person's personal liberty.” Furthermore, P.L.1983, c.524 (C.30:6D-21) states that a “transfer shall be made only when consistent with the best interests of the developmentally disabled person. The department shall ensure that a developmentally disabled person who fails to adjust to life in a community residential facility may return to the institution or other facility from which he was transferred or to a more suitable community residential facility.”

• **Questions:**
  a. What is the DDD’s procedure for selecting living arrangements for individuals who are transitioning into DDD that best meet the needs of the individual? What is the standard that must be met for an individual to receive an out-of-State placement? Please outline the application decision timeline.
  b. How many individuals aging into DDD in FY 2015 and FY 2016 have been permitted to remain in out-of-State facilities on a permanent basis?

DDD’s transition process begins when individuals or guardians express their desire to receive residential services in a NJ community based setting. A DDD transition worker then develops a service plan using information from the individual, guardian and current residential provider that clearly identifies the supports needed for the individual to live in the community. This information is used to generate referrals to various residential providers, which can then schedule a “Meet and Greet” with the individual, guardian and other members of the planning team to provide information and tours of potential homes. Concurrently the transition worker collaborates with service providers to secure appropriate and meaningful employment and/or day activities for the person upon transfer. Upon receipt of the signed offer of placement the transition worker completes all needed paperwork to facilitate transition and schedules a pre-placement meeting at least 30 days prior to the move date to ensure that all needed information is shared and obtained prior to move so that a smooth transition can occur. Approval for placement planning generally occurs within a week of application, and, after that point, an individual can be placed within weeks if a vacancy is available.
Individuals living in NJ seeking an out of state placement are not automatically referred, but can request placement after they have exhausted all in-state options that are currently available and it has been determined that an appropriate set of services cannot be created. Of those individuals aging out of educational placements, none remained in their out-of-state facilities in 2015 and 13 remained in 2016.

44. The Return Home New Jersey (RHNJ) initiative began in FY 2009 and aimed to bring back to New Jersey adults with intellectual and developmental disabilities who had been residing in out-of-State facilities. The department had stated that the in-State system of care was 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. 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 New Jersey residents receiving residential services in out-of-State facilities. As of March 30, 2015, 170 individuals had been moved to in-State placements and 382 individuals remained in one of 32 out-of-State facilities; 286 of these individuals were receiving New Jersey Medicaid. According to the department, the program’s estimated gross FY 2015 cost was $48.3 million, of which $1.4 million came from federal funds and $3.3 million was offset by contributions of care.

In July 2015, the Governor ended the RHNJ initiative and in December 2015, P.L.2015, c.192 was adopted which prohibits the division from compelling the transfer of individuals with developmental disabilities from out-of-State to in-State facilities unless certain exceptions apply. The law also states that the obligations of the department to ensure that individuals are placed in the best environment, pursuant to section 9 of P.L.1977, c.82 (C.30:6D-9) and section 9 of P.L.1983, c.524 (C.30:6D-21) are not alleviated. This section of the law ensures that individuals who had been moved in-State into placements that were not fulfilling their needs could be moved back to their previous placement or to a placement that was out-of-State and more satisfactory to their needs. Budget data indicate that 370 individuals are currently in out-of-State placement (page D-201) at an annual cost of $125,000 per individual and $46.3 million overall.

Individuals who reside in out-of-State facilities classified as Intermediate Care Facilities for Individuals with Intellectual Disabilities are not required through budget language to enroll in New Jersey Medicaid (page D-183).

**Questions:**

a. How many individuals who are currently receiving services from DDD have moved to an out-of-State facility in FY 2016? How many individuals who had been moved to an in-State placement from out-of-State have requested to move back out-of-State? How many of them have been moved? What is the cost associated with these moves?

b. How many of the 370 individuals who are currently receiving DDD-funded care in out-of-State placements are currently enrolled in Medicaid and in facilities that are Medicaid-eligible for New Jersey?

c. How many out-of-State facilities are hosting DDD consumers? Of these, how many are in Intermediate Care Facilities for Individuals with Intellectual Disabilities, and how many are in other types of residential facilities? How many facilities are Medicaid-eligible for New Jersey?

d. Of the $46 million in projected FY 2016 and FY 2017 costs for out-of-State placements, what portions are paid with State funds, federal funds, and individuals’ contributions to care? Have any out-of-State facilities become Medicaid-eligible for New Jersey in FY 2016? Does the department anticipate any out-of-State facilities becoming Medicaid-eligible for New Jersey in FY 2017?

Four individuals who had been moved from an out-of-state placement to an in-state placement have requested to move back, with one returning to date at a cost of approximately $300,000 per year. There
are currently 101 individuals living out-of-state who are enrolled in Medicaid (CCW). Only two of the thirty-three out-of-state providers are currently able to meet the CCW standards for community living. Of the $46M projected cost in FY16 and FY17 it is estimated $41.3M will be paid with state funds, $1.7M with federal funds, and $3M with individuals’ contribution to care.

Other DDD

45. DDD consumers who have a mental health condition or substance use disorder receive appropriate services through their Medicaid managed care organization (which also administers their physical health care). The organizations are required to meet several special requirements for DDD consumers, including maintaining a specialized network of providers who can deliver both physical health and behavioral health services, and providing care management and coordination of care services.

- **Questions:**
  a. How are behavioral health services coordinated with disability-related physical health services provided by DDD? Do individuals have two separate plans of care, or must all parties agree on a single plan that addresses the individual’s disability-related physical health and behavioral health needs?
  b. How have DDD’s recent reforms affected the coordination of these separately administered sets of services?

Behavioral health services for individuals with developmental disabilities are managed via MCOs and physical health services are provided by the Medicaid HMOs under the state plan services. The HMOs/MCOs provide a care manager to individuals with developmental disabilities when access to care is needed. DDD provides disability-related support services, and not physical health services. The DDD case manager may coordinate care with the HMO or MCO care manager when necessary to ensure continuity of care and DDD case managers have also assisted individuals with connecting with the care manager to obtain physical health or behavioral health care that is needed and/or identifying providers in those service systems.

DDD’s recent reforms include providing individuals with a Support Coordinator who assists with development and monitoring of a plan of care that includes identified physical or behavioral health issues. The Support Coordinators have been trained and policy has been established to ensure that the Support Coordinators assist individuals with linkage and coordination of care when needed. The Support Coordinators are also provided with a specific MCO contact list designated to receive their calls and assist with identification of physical or behavioral health care services. The DDD plan of care includes MCO/HMO care manager contacts as well as a requirement that all on-going services, even those not funded by DDD, are included in the plan of care.

46. P.L.2014, c.78 (C.30:4-25.20 et seq.) requires the DDD, in consultation with the Children’s System of Care (CSOC) in the Department of Children and Families, to develop a single process for determining eligibility to receive services from the two divisions related to an individual’s intellectual or developmental disability. The act took effect January 1, 2016.

- **Questions:**
  a. Have the DDD and CSOC agreed on a single eligibility determination process? If so, please describe the process. If not, please indicate by what date the DDD anticipates an agreement.
  b. How will the revised process change the demand for DDD services?
38

DDD will accept the CSOC eligibility as the one-time application of any individual who has gone through the CSOC process and is seeking to receive services from DDD once they reach the age of 21. DDD will process that application, seeking any updated or additional information as necessary. As stated in the law, the person will be required to complete the New Jersey Comprehensive Assessment Tool and any other ongoing assessments needed to comply with federal requirements, quality monitoring, and any other State or federal laws, regulations, or policies.

In 2012, CSOC began providing services to individuals with developmental disabilities under the age of 21. At that time, children were transferred to DCF for provision of services and no additional eligibility process by CSOC was required. In early 2015, the two agencies formalized a process for the transition of individuals receiving CSOC services to DDD for adult services. Because individuals currently transitioning to DDD were not required to reapply to CSOC for eligibility, no individuals have yet transferred who would require a single eligibility process, and this may not occur for some time. The two agencies are working on IT solutions to make the single eligibility determination process easier once the volume increases. It is not anticipated that the law will change the demand for DDD services.

47. In April 2012, the Governor made New Jersey an “Employment First” state, meaning that competitive employment is the first and preferred post-education activity for everyone, including people with disabilities. Employment-related objectives are now routinely included in DDD consumers’ care plans, though many of these individuals may need to develop many skills before they are ready for competitive employment. The FY 2017 Budget Recommendation includes two funding lines for Employment and Day Services. According to the department, Employment and Day Services include career planning, day habilitation, prevocational training, supported employment – group, and supported employment – individual. The appropriations are segregated by enrollment in the Supports Program ($99.1 million, page D-202) or the CCW ($183.3 million, page D-203). Some portion of the $84.6 million Contracted Services line item may also cover employment-related services (page D-202).

Questions:

a. Since New Jersey’s designation as an “Employment First” state, what policy changes has DDD made to improve its consumers’ opportunities to gain employment?

b. How has the proportion of consumers in competitive employment changed since 2012? Is there a discernible trend and is the DDD satisfied with the performance?

c. How does the division measure or plan to measure if the employment support services are assisting individuals in meeting the goal of employment?

Policy changes DDD has made to improve its consumer’s opportunities to gain employment include:
requiring an annual discussion about employment through the Pathway to Employment; incorporating the Employment First initiative within the Individualized Service Plan (ISP); and expanding employment services available through implementation of the Supports Program and within the proposed renewal of the CCW. The CCW changes include the following: providing training and education for stakeholders; adding additional funding available upon request for Supported Employment services if the individual has support that goes beyond what can be provided through his/her budget to find and keep a job; including WorkAbility as a Medicaid eligibility category for the Supports Program and within the CCW renewal; incentivizing providers to provide employment related services (Supported Employment, Career Planning, and Prevocational Training) through the standardized rates established in the implementation of the Fee-for-Service system.; revising the Memorandum of Understanding (MOU) with the State Vocational Rehabilitation Agencies – the Department of Labor & Workforce Development’s Division of

16 http://www.nj.gov/humanservices/involved/employmentfirst.html
Discussion Points (Cont’d)

Vocational Rehabilitation Services and the Department of Human Services’ Commission for the Blind & Visually Impaired (CBVI) – to include the Employment First initiative; and building mechanisms to collect employment related data within DDD’s new electronic case management system known as iRecord to track employment status, employment history, current employment, wages, hours working, availability of benefits through work, industry types, retention rates, and units of employment services received.

With the shift to a Medicaid-based, Fee-for-Service system, we will have exact numbers on the units of employment services each individual is receiving. In addition, the new mechanisms for tracking data through iRecord (hours, types of employment, wages, etc.) will be able to show any correlation between employment services and outcomes system-wide as well as on an individual basis.

48. 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.

According to the department’s response to the OLS Discussion point questions in the FY 2016 budget process, the division prepared and published an initial report in response to the legislation in January of 2013; however, 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 anticipated at that time that a report compiling this information would be available soon.

- **Questions:**
What factors account for the delay in the preparation and publication of the report? When will this report be made available?


**Division of Family Development (DFD)**

Supplemental Nutrition Assistance Program

49. The Supplemental Nutrition Assistance Program (SNAP, formerly food stamps) provides assistance to needy individuals and 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. Federal law limits the SNAP eligibility of able-bodied adults without dependent children (ABAWDs) to three months during any three-year period if they are unable to find work or approved job training activities for 20 hours per week. The State may seek a waiver of this eligibility time limit, either covering the entire State or any area within the State if there is exceptionally high unemployment in the area or a lack of sufficient jobs to provide employment for the individuals who would otherwise be subject to the time limit.

New Jersey has consistently applied for and obtained such waivers for many years, but at the end of 2015 the Administration announced that it would not seek any waivers beginning for 2016. Press reports have
Discussion Points (Cont’d)

indicated that DHS had informed food bank operators and anti-poverty groups of its intention to seek waivers for 15 counties in August, before the change in course in December.  According to DHS, 11,000 New Jersey residents are expected to be affected by the termination of the waivers. Counties will begin to enforce the time limits according to the following schedule:

- **January 1:** Hunterdon, Morris, Somerset, and Sussex
- **February 1:** Bergen, Monmouth, and Warren
- **May 1:** Burlington, Camden, Cumberland, Hudson, Mercer, Middlesex, Ocean, and Salem
- **August 1:** Atlantic, Cape May, Essex, Gloucester, Passaic, and Union

**Questions:**

- a. **What is the Administration’s rationale for not seeking waivers in counties that would qualify for waivers?**
- b. **Can the DHS ensure that job training or work activities can be arranged for those facing a possible loss of benefits? Has the DHS undertaken any special efforts in this regard for the 11,000 SNAP recipients who are estimated to lose benefits?**
- c. **Please indicate how many of the 11,000 SNAP recipients expected to lose benefits as a result of the time limits reside in each county.**
- d. **What is the combined value of the SNAP benefits of the 11,000 individuals expected to lose SNAP benefits?**

The Federal requirement is that all able-bodied SNAP recipients ages 18-49 with no children work or be in a work activity for 20 hours a week. If non-compliant, benefits are limited to 3 months in a 36 month period. This Administration has sought and received federal approval to phase in the reinstatement of this federal time limit requirement to allow more time for recipients to engage in work or work activities. An overarching goal of the Department of Human Services is to encourage all New Jersey residents to be as self-sufficient as possible.

DHS is working closely with Labor staff to ensure adequate availability of work activities, which includes Community Work Experience Program (CWEP), on-the-job training, and job readiness/life skills. Both Human Services, through the County Welfare Agencies (CWAs) and the Department of Labor and Workforce Development are working with clients to determine who is required to work, be in a work activity or is eligible for an exemption to this time limit. SNAP recipients who work or participate in a work activity will not lose SNAP benefits.

**Work First New Jersey**

50. The Work First New Jersey–TANF program provides cash and other assistance to low income families with dependent children. The amount of monthly cash assistance provided to a household is based on the household’s size. However, section 7 of P.L.1997, c.38 (C.44:10-61) prevents the amount of the grant from increasing as a result of the birth of a child, unless the child is born fewer than 10 months after applying for benefits or the birth of the child is a result of rape or incest. Certain limited exceptions to the family cap are provided pursuant to N.J.A.C.10:90-2.18 for families with a working parent and for children born to minors. Legislation has been introduced to repeal this “family cap” policy in the TANF program (S1854 and A3410).

**Questions:**

- a. **How many TANF households are affected by the family cap each year?**

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b. What would be the estimated cost to the State to repeal the TANF family cap?
The number of cases impacted by the family cap can vary annually. Based on recent data, the cost to
repeal the TANF family cap, as proposed in S-1854 and A-3410, is estimated at $2.3 million but will be
ultimately dependent upon the number of families potentially impacted annually.

51. The FY 2017 Budget Recommendation includes a $13.5 million decrease (24.0 percent) in funding for
Emergency Assistance (EA) for Work First New Jersey – General Assistance (WFNJ-GA) clients and a $5.3
million decrease (6.8 percent) in funding for EA for Work First New Jersey – Temporary Assistance to Needy
Families (WFNJ-TANF) clients (page D-210).

EA is generally provided as temporary rental assistance to very low-income households or individuals
who receive WFNJ benefits or Supplemental Security Income (SSI), who are in imminent danger of
homelessness. Benefits under the program include: essential food, clothing, shelter, and household furnishings;
temporary rental assistance or back rent or mortgage payments; utility payments (such as heat, water, electric);
transportation to search for housing; and moving expenses. EA is provided for up to one year, and can be
extended for one more year under certain circumstances and with the approval of the county agency
(N.J.A.C.10:90-6.4).

Budget data indicate that in FY 2017 the department anticipates that 3,269 WFNJ-GA recipients per
month will receive an average monthly amount of $1,049 for EA, equaling total expenditures of $41.2 million.
This is a 36 percent decrease from the average monthly 5,082 WFNJ-GA clients who received benefits in FY
2015. Additionally, a monthly average of 11,600 WFNJ-TANF recipients will receive an average monthly
amount of $558 for EA, equaling total expenditures of $77.6 million for EA – a 39 percent decrease from the
19,139 WFNJ recipients in FY 2015. County credits and expenditures offset these State funds and lower the total
State expenditure to $73.0 million. Additionally, 1,911 individuals who are receiving Supplemental Security
Income (SSI) benefits, or are pending the receipt of SSI, also receive $21 million in EA annually (pages D-207 to
D-208).

County welfare offices determine EA benefit eligibility and disburse EA payments, but expenditures for
the benefits are from State funds or federal TANF block grant funds. The State has implemented several
“compliance teams” to review EA approvals. Thus far, the compliance teams have largely reviewed current
cases, but the DHS has indicated that they are shifting their efforts to front-end reviews. According to the
department, the State is expanding the audit teams and including one more team in FY 2017. Budget documents
made available to the OLS indicate that this additional review team will result in a projected net savings of $2.57
million in FY 2017. Advocates have asserted to the Legislature\(^\text{18}\) that these reviews are now imposing a new and
more restrictive interpretation of eligibility for EA, under which applicants are denied benefits if they are
determined to have “caused their own homelessness” or “failed to plan.”

• Questions:
  a. Which counties have EA compliance teams reviewing their eligibility determinations?
  b. What are the most common compliance errors identified by the compliance teams?
  c. As the compliance teams educate county staff on State rules and guidance, are error rates
     improving over time?
  d. Please describe the current policies regarding disqualification for EA for those who have
     “caused their own homelessness” or “failed to plan.” Has the department changed its
     interpretation of these rules, or tightened enforcement through its compliance teams?

\(^{18}\) http://www.njleg.state.nj.us/legislativepub/budget_2017/032216/Rice_S.pdf
Discussion Points (Cont’d)

e. To what extent are the projected declines in the WFNJ-GA and WFNJ-TANF EA recipient counts attributable to eligibility disallowances by the compliance teams and stricter eligibility standards? How many county EA approvals have the compliance teams overturned in FY 2016? By how much has annual program spending been reduced as a result of tighter enforcement and stricter eligibility policies?

The EA compliance teams are reviewing eligibility determinations in six counties: Burlington, Hunterdon, Mercer, Middlesex, Monmouth, and Ocean. The most common compliance errors identified are: exhausted time limits, failure to provide appropriate eligibility documentation, and an applicant not meeting the overall eligibility requirement for the program. The Department continues to provide training and technical assistance to county offices to ensure that program rules are being followed.

The Department disagrees with the premise of the question. The disqualification rules have not been modified in any way and are available at N.J.A.C. 10:90-6.1(c). Caseloads increase and decrease for many different reasons. In addition to an increased federal focus on reducing the time people remain in emergency shelters, New Jersey has experienced a strengthening economy which is one of the factors that would lead to declining caseloads. Our budget projections are based on caseload trends. Between August 2015 and March 2016 481 cases have been overturned.

52. In July 2015, the Housing Assistance Program (HAP) and the Housing Hardship Extension (HHE) program, which were three-year pilot programs funded by the DHS to provide housing for certain Emergency Assistance clients, were not renewed. According to the department, as of July, existing HAP and HHE enrollees were continued in the program for the remainder of their eligibility, but no new clients were enrolled.

As of January 1, 2016, the department is funding, on a limited basis, Intensive Case Management (ICM) programs for individuals who were enrolled in HAP or HHE at the conclusion of the pilot. The ICM service is being provided as a contract modification on providers’ Social Services for the Homeless (SSH) program contracts. The ICM funding pays for staff to provide case management and limited rental subsidies. Informal information on six of the counties that have received SSH contract modifications indicate that counties have initially received between $24,500 and $70,000 to provide ICM services. The ICM contractors were informed that they would need to submit requests for additional rental subsidies on a monthly basis. ICM contractors are also required to submit information on the services offered to individuals through the Foothold Homeless Management Information System (HMIS), a system that reportedly is not used by county welfare agencies.

SSH’s recommended FY 2017 appropriation is $17.2 million, which is approximately $100,000 more than the FY 2016 adjusted appropriation (page D-210). SSH has received relatively stable funding for the previous five years.

• Questions:
  a. What are the expenditures for the ICM program, total and by contractor, in FY 2016?
  b. How long does the department anticipate funding the ICM program?
  c. From which SSH programs was funding shifted to the ICM program in FY 2016?
  d. Do county welfare agencies use HMIS to track spending? If not, what systems do the county welfare agencies use to evaluate and monitor emergency assistance spending?

The following chart illustrates the contracted amounts for the ICM program for FY 2016. DHS will examine utilization of this program to determine the need for funding beyond FY 2017. Unexpended SSH accruals and EA funds are being used to support the ICM program.
Discussion Points (Cont’d)

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<td>UNION</td>
<td>$84,500</td>
</tr>
<tr>
<td>WARREN</td>
<td>$54,500</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$ 2,008,487</strong></td>
</tr>
</tbody>
</table>

The counties do not use HMIS to track spending. The Family Assistance Management Information System (FAMIS) and the General Assistance Automated System (GAAS) are the primary eligibility systems that support benefits and services, including Emergency Assistance.

Child Care

53. The Governor recommends $329 million in appropriations for *Work First New Jersey Child Care* in FY 2017, an increase of $3.7 million from the FY 2016 adjusted appropriation (page D-209). The FY 2017 appropriation includes approximately $105 million from the General Fund, $112 million from the federal Child Care and Development Block Grant, $77 million from the federal TANF block grant, and $35 million in other funds transferred from the Workforce Development Partnership Fund.

In November 2014, Congress and the President re-authorize the Child Care and Development Block Grant (P.L.113-186). The reauthorization law and related regulations imposed a number of new requirements on states to receive the block grant. One new requirement is that staff of family child care homes must submit to a
Discussion Points (Cont’d)

FBI criminal history background check and a search of the National Sex Offender Registry. The department has indicated that the recommended $3.7 million appropriation increase is primarily intended to pay for these checks.

Additionally, the federal government now requires that payment rates for child care services are sufficient to ensure access for eligible families to child care services comparable to those provided to families not eligible to receive Child Care Block Grant assistance or child care assistance under any other governmental program. According to testimony submitted by Advocates for Children of New Jersey to Legislative budget committees, the DHS has not yet certified that it is in compliance with the equal access requirement due to insufficient market price data.

• Questions:
  a. How is the department examining the access to child care services by families receiving Work First New Jersey Child Care assistance relative to that of other families who are not receiving subsidies?
  b. If the department’s assessment finds that the access of families receiving Work First New Jersey Child Care assistance is inadequate, what steps is it prepared to take to improve access? What would these steps cost?
  c. What other policy changes has the department made, or does it plan to make, in order to comply with new federal requirements?

All eligible families are receiving child care. There are currently no waiting lists for any of our populations. In response to the federal changes, the Department will be developing policies related to health and safety (i.e., regarding the new background check procedures), professional development, and family protection and stability.

Other DFD

54. In November 2015, Governor Christie wrote a letter to President Obama indicating his concerns that the United States’ accepting of refugees from Syria could raise the risk of a terrorist attack in America, and that he was “directing the New Jersey Department of Human Services not to participate in the resettlement of any Syrian refugees in the State of New Jersey.”

Subsequent press coverage has indicated that at least one family from Syria was resettled in New Jersey since that time with the aid of nonprofit refugee resettlement agencies, though it is not clear if those agencies have received State funding in connection with these efforts.

• Question:
  Has the DHS withheld any funding from refugee resettlement agencies or other benefits for refugees in compliance with the Governor’s directive?

As is the case in 10 other states, the Department has notified the federal government that DHS will be returning supervision of the program to the federal Administration for Children and Families.

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