

Assemblyman Mukherji:

- Please provide a list of the seven behavioral health care providers who are participating in the pilot reimbursement program which permits a per member reimbursement rate as opposed to a fee-for-service reimbursement.
- How many behavioral health care providers requested bridge funding for the transition to fee-for-service reimbursement?
- How many behavioral health care providers received bridge funding for the transition to fee-for-service reimbursement?
- What was the total cost to the State for bridge funding for these behavioral health care providers thus far in FY 2017, and anticipated in FY 2018?

Answer:

Below are the agencies that will be in the Certified Community Behavioral Health Clinics (CBHC) pilot. These providers will also be moving into fee-for-service since not all clients are Medicaid eligible and therefore cannot be reimbursed with the CCBHC per member per month rate.

Atlanticare Behavioral Health (Atlantic County)
Care Plus (Bergen County)
Catholic Charities of Trenton (Mercer County)
CPC Behavioral (Monmouth County)
Northwest Essex (Essex County)
Oaks Integrated Care (Mercer County)
Rutgers UBHC (Middlesex County)

Separately, eight providers requested and received bridge funding, i.e., cash advances, for the transition to fee for service reimbursement. The total amount of the advances in FY17 was \$2.96 million. In FY18, the anticipated amount is \$14.5 million. In each year, providers are expected to repay the advances to DMHAS over several months.

- What would be the financial impact on the State if the federal government eliminated presumptive eligibility?

Answer:

There have been numerous changes contemplated concerning the Affordable Care Act. There is significant overlap and interplay between various proposals under consideration, and the financial impacts of their various elements cannot be projected in isolation.

However, it should be noted that, none of the hospitals in NJ have exercised the option of Hospital Presumptive Eligibility (PE), authorized by the ACA, which allow hospitals to make PE decisions for children using state policies and procedures and establish the eligibility to receive payment of the services they rendered.

NJ has a Presumptive Eligibility program whereby the hospital provider applies on behalf of an uninsured patient, but the State actually establishes eligibility, when appropriate.

Assemblyman Burzichelli:

- Please provide details of the department's strategy to create integrated eligibility modules for all department programs. Please name the programs which currently have developed modules which allow applicants to access and apply remotely for the programs. Please also identify which programs are currently linked to provide single point of entry and tracking for the department. For those programs which do not yet have modules, please provide timeline for the development of these modules.
- Please provide the report which is guiding the department's strategy to create integrated eligibility modules for all of the department's programs.

Answer:

The Modified Adjusted Gross Income (MAGI) Medicaid program is in production in the Integrated Eligibility System (IES) client and worker portal modules. The Aged, Blind and Disabled (ABD) Medicaid program will be added to the IES client and worker portal modules in Q3 2017. An integrated screening tool for Medicaid, SNAP, TANF and GA will be added to the IES client portal module in June 2017. The Child Care program electronic application will be added to the client portal module next and the go-live date will be determined in Q1 2018.

DFD program eligibility determination and case management will continue to be completed in their existing eligibility determination systems.

Please provide the Department with the name of the specific report you are requesting.

Assemblyman Singleton:

- Please provide the average cost per individual served by the department who resides in: the community; a licensed residential facility; a developmental center; and any other setting which the department identifies as being on the continuum of care.
- Please provide the number of complaints the department has received annually regarding private duty nursing for FY 2015 through FY 2017.

Answer:

The average annual cost of serving an individual under the Supports Program in an unlicensed community setting is \$23,794. The average annual cost under the Community Care Waiver, for individuals that would otherwise require institutional care, is \$97,299. Additionally, individuals receive housing vouchers calculated using the fair market rent in their county of residence, less an income-based contribution. The average annual cost of serving an individual in a State-operated developmental center is \$330,876.

The average annual cost of serving an individual in a State-operated psychiatric hospital is \$328,500. The average gross cost (not all of which is funded by DMHAS) for a consumer in Residential settings ranges from about \$31 per day (B-level apartments) to roughly \$275 per day for Specialty A+ Group Homes.

The number of complaint calls that the Office of MLTSS Quality Monitoring received regarding Private Duty Nursing in each fiscal year is: FY14 = 28, FY15 = 13, FY17 = 14 (through May).

Assemblywoman Pintor Marin:

- On page D-167 of the FY 2018 Budget Recommendation, the department provides performance data indicating the number of general assistance cases which were, or anticipated to be, closed or denied due to review by the Compliance Review Teams. How many cases were closed and how many cases were denied in FY 2015, FY 2016, and anticipated in FY 2017 and FY 2018?
- How many cases were denied due to procedural discrepancies? How many cases were denied due to substantive problems with an applicant's eligibility? Please provide this data for FY 2015 and FY 2016 and thus far in FY 2017.

Answer:

From January 2015 to December 2016, the General Assistance Compliance Teams reviewed 15,116 cases. Of those reviews, 2,699 were found not to be eligible. All denials were based on eligibility according to regulations. No cases are denied based on procedural discrepancies. General Assistance case reviews are now completed on a sampling basis after the county board of social services determines a case eligible. The DFD review is to provide guidance to the county and to ensure all counties are applying the regulations uniformly.

Assemblywoman Rodriguez-Gregg:

- Please provide the homelessness rate on a per county basis for the most recent year it is available.

Answer:

Data on the homeless in New Jersey is provided in the report entitled: *NJ Counts 2016*, New Jersey's annual Point-In-Time (PIT) Count of the Homeless, which is available at: <http://monarchhousing.org/wp-content/uploads/njcounts16/2016PITReportStatewide.pdf>. This report was prepared for the New Jersey Housing and Mortgage Finance Agency (HMFA) by Monarch Housing Associates. Monarch is the official agency overseeing the point-in-time count of individuals and families experiencing homelessness or at risk of becoming homeless. Information about the survey is available on Monarch's website at: <https://monarchhousing.org/endinghomelessness/njcounts/>.

Assemblyman Wimberly:

- Please provide any statistical information the department has gathered on the impact of opioid addiction at State colleges or universities located in New Jersey. Please provide statistical information on the impact of opioid addiction on individuals aged 17 through 23.

Answer:

National data regarding college drug use is available from the 2015 *Monitoring the Future* study, which is available at: <https://www.drugabuse.gov/related-topics/college-age-young-adults#trends-and-statistics>.

State Police data indicate that there were 628 Narcan administrations among 17-23 year-old New Jerseyans in 2015, which increased to 856 in 2016.

Data from the NJ Substance Abuse Monitoring System (NJSAMS) indicate that of the 11,005 clients admitted during 2016 who were 17 to 23 years old, 4,201 (38%) were admitted due to a primary drug of heroin and there were 615 (6%) admissions for other opiates.

In addition, please provide responses to the following questions, which were not raised during the hearing due to time constraints:

- Recently the Medicaid Fraud Division was presented with the results of a claims analysis for persons eligible for both Medicare and Medicaid, detailing how NJ Medicaid (State and federal dollars) was paying \$19.2 million for claims that should have been paid for by Medicare (Federal dollars). As a result of these incorrect payments, nursing homes would have gained \$12.9 million of additional revenue since Medicare pays a higher rate. What will the department do moving forward to collect these claims, paid by Medicaid that should have been billed to Medicare and to assure proper billing in the future?

Answer:

The DHS is in process of procuring a vendor to ensure that Nursing Facility (NF) bills for dually eligible (Medicaid/Medicare) are being paid by the proper payer. When a client is transferred from a hospital to a Skilled NF an assessment needs to be completed for Medicare. Since the clients are also Medicaid eligible and the assessments can be time consuming, facilities were billing Medicaid. The vendor will ensure that all assessments are being performed. As noted in the question, this will result in a savings for the state as well as a benefit to the provider.

- The department informed the committee during the hearing that seven provider agencies will be in a pilot program and not moving into fee-for-service. Which agencies are in the pilot program and how were they selected? What is the purpose and duration of the pilot program?

Answer:

See the above answer to the question by Assemblyman Mukherji the names of the seven agencies participating in the CCBHC pilot program.

- In the Acting Commissioner's opening remarks, it was noted that 21 out of 24 recommendations issued in the NJ Health Care Quality Institute Medicaid 2.0 report are in progress, or that the department is awaiting waivers and approvals. Please indicate which recommendations the department is implementing or trying to implement in partnership with the federal government and the status of each recommended initiative.

Answer:

Since the hearing, only the recommendation on pharmaceuticals (#14) is being further reviewed. The remaining recommendations are in the developmental phase, have been implemented or are awaiting federal approval.

- Assistant Commissioner Mielke advised the committee that the department had extended bridge funding to some mental health providers that transitioned to the fee-for-service payment model. Please provide the number of both mental health and addiction services providers that requested bridge funding, whether any providers were denied bridge funding, the basis for any denials, and the total amount expended in FY 2017.

Answer:

See above for response to Assemblyman Mukherji's question.

- Acting Commissioner Connolly denied the continued need for the Holocaust Survivors Assistance funding, which was funded at \$400,000 in FY 2017, because those utilizing the program could access other services. Please provide the number of individuals who utilized the Holocaust Survivors Assistance funding, the services they received as a result of the program, where those same services and supports could be elsewhere obtained, and whether the individuals would have to meet eligibility requirements in order to obtain those services through other programs.

Answer:

This funding has been included in the Final FY18 Appropriations Act.

- The department informed the committee that the remaining 10 counties not currently in the Opioid Overdose Recovery Program would be brought into the program in FY 2018. When is that expected to occur? Where in the FY 2018 recommended budget is that accounted for?

Answer:

It is anticipated that contract awards will be made in August and programs will have up to

4 months to begin delivering services, which would be in December 2017. Funding is provided by SAMHSA's State Targeted Response to the Opioid Crisis grants to the states and is included in the DMHAS Federal Funds appropriations.

- In the FY 2018 Budget Message, the Governor discussed a \$12 million appropriation for 200 beds to allow 18 and 19 year old individuals to receive in-patient substance abuse treatment under the Department of Children & Families (DCF). How much of the \$12 million appropriation announced to treat 18 and 19 years for substance abuse disorders is new funding and how much is being reallocated from the department to DCF? Is the \$12 million all State funds or is there a federal match? Is the role of DCF in treating 18 and 19 year old individuals for substance abuse limited to in-patient treatment? Are there plans to transition all substance abuse treatment for 18 and 19 years olds to DCF? Are there plans to transition any or all substance abuse treatment of individuals up to age 21 to DCF? Following the in-patient treatment in DCF-licensed facilities, the individuals will likely need continued outpatient treatment and supports in the community. Will those services be arranged and administered by the department or DCF? Do the departments have a system in place to make sure there are no gaps when transitioning individuals for treatment?

Answer:

New state and federal funds are being added to the DCF budget to support this expansion. Contractual modification and licensing waivers have already been made to allow underutilized providers to begin to serve the expanded population. Additionally, CSOC is working to procure additional inpatient services. Currently, there are 249 residential substance use beds providing co-occurring services at varying intensities. The current utilization for these beds is approximately 70% but we expect that to increase substantially as older youth are permitted to attend the programs. Outpatient care will be coordinated through DHS's IME for 18 -19 year old individuals.

- In the Governor's January 2017 State of the State Address, he announced the launch of a 24-hour a day, seven-day a week help line, 1-844-REACHNJ, that will remove information barriers and significantly improve access to substance abuse treatment. Where specifically in the FY 2018 Recommended Budget is funding for the 1-844-REACHNJ hotline?

Answer:

REACHNJ costs are funded through the DMHAS Addictions State Grants-in-Aid appropriation.

- In the FY 2016 budget, a program operated by Rutgers University Behavioral Health Care (RUBHC) with the department as an "Interim Managing Entity" was funded to coordinate and administer certain aspects of the State's addiction treatment system. One of the functions of the IME was to create a 24-hour call line to simplify the process of

finding available treatment. Is the 1-844-REACHNJ hotline meant to supplant the 24 hour hotline operated by Rutgers University Behavioral Health Care? How do the REACHNJ hotline, IME hotline, 211, and other substance abuse hotlines work together to make sure that individuals in need of services are not bounced around? Is there any coordination between the hotlines?

Answer:

ReachNJ, run by NJ 2-1-1, was not designed to supplant the IME. ReachNJ coordinates with other social service agencies, recovery supports, and hotlines including the IME. ReachNJ provides substance use disorder (SUD) information and referrals to all callers, including those with private insurance, those in need of financial assistance, children and young adults. Through this process, ReachNJ refers callers to agencies near their home and/or connects callers with the most appropriate call center. ReachNJ transfers adult callers who are Medicaid enrollees or are in need of financial assistance for their care, to the IME. The call is made through a warm transfer on a designated phone line. The IME completes a full screen, both clinical and fiscal, and uses this information to make a referral to an SUD treatment agency with the funding and capacity to meet the caller's needs. The IME holds Affiliation Agreements with all of SUD treatment providers who receive state funding, federal funding and/or Medicaid. These agreements allow for coordination between the provider and the IME to increase caller engagement in care.

ReachNJ refers eligible young people (19 and younger) to the Department of Children and Families (DCF) addiction referral source, PerformCare. As with the IME, ReachNJ works closely with PerformCare to assure seamless transitions for callers.

- The FY 2017 Budget appropriated \$3 million, \$1.5 million from the State and \$1.5 million from federal funds, to support the State's three Medicaid Accountable Care Organizations (ACOs), located in Camden, Trenton, and Newark. The FY 2018 budget recommends a decrease of \$1.5 million reflected in the line item Services Other Than Personal (page D- 182). Why is DHS proposing to eliminate funding Medicaid ACOs? Are the ACOs funded elsewhere in the FY 2018 Budget? How will the funding elimination impact existing ACOs?

Answer:

This funding has been included in the Final FY18 Appropriations Act.

- It has been reported that county boards of social services have been limiting or reducing the amount of Temporary Rental Assistance (TRA) provided while demand for this assistance is increasing. What is the Department doing to ensure that no family falls is denied services in which they are entitled?

Answer:

The Department's Division of Family Development continues to provide oversight of all welfare programs administered by the county welfare agencies (CWA). Anyone determined eligible for

Emergency Assistance (EA) is processed and enrolled. All county welfare agencies receive training on the administration of EA.

- When domestic violence is the cause of an individual's homelessness, how is that individual categorized? Is that individual still eligible for assistance or have they been deemed to "cause their own homelessness and are therefore ineligible for TRA?

Answer:

Individuals who leave or flee their living situation due to domestic violence may be provided a Family Violence Option (FVO) Emergency Assistance (EA) waiver, and categorized as experiencing family violence. This FVO categorization waives the client's EA time limits requirement for up to six months. The need for continuing the FVO waiver is re-assessed every six months. Individuals who leave or flee their living situation due to domestic violence are not deemed to have caused their own homelessness. The Department's Division of Family Development works with the county welfare agencies (CWA) to ensure domestic violence risk is assessed; and based on assessment outcomes the CWA will find the safest place for the family to reside.

- Providers who will be delivering services under the Community Support Services (CSS) program have projected losses ranging from 10% to nearly 40% when they "plugged" the new rates into their current budgets. These projected losses include new "back-office", compliance and audit costs incurred in FFS and third-party reimbursement arrangements. What is the department's plan to address the insufficiencies in the rates for these services, particularly as providers are unable to sustain operations?
- In the pending CSS program there is no mechanism to reimburse providers for the costs related to engagement and in-reach to State Hospitals for the service recipients assigned to them by DMHAS. Best practices in community mental health stress the importance of engagement and relationship building between service provider and consumer to support a successful service relationship. DMHAS staff has stated that a rate for this service is pending for many months. When will the department establish and communicate an in-reach and engagement rate to providers?
- The current CSS rollout excludes persons with serious mental illness living in community settings from access to CSS in that there is no provision for enrolling anyone who is not already receiving supportive housing services at the time of program start-up, unless they have been assigned from a hospital. Thus, persons living on their own, with families, in boarding homes or rooming houses who need supportive housing services will have no access to them, risking unnecessary exacerbation of symptoms, and the need for costly inpatient and emergency services. Additionally, this will push the mental health system to revert to one where people need to seek State hospital care to access CSS. When will persons with serious mental illness who are not referred from State hospitals and other inpatient settings have access to CSS?

- An important foundation of mental health treatment provision is the completion of thorough assessment and an accurate, detailed recovery plan (also known as a treatment plan). This is the engine that powers the services. At present there is no provision in CSS to pay the provider agencies for the hours required of their licensed clinical staff to meet with the person served to conduct the assessment and develop the recovery plan. With the CSS start imminent, providers need to know the rate of reimbursement for the documents to be able to hire the staff required to complete them. When will the Department establish and release the rates of reimbursement for the completion of these critical documents?

Answer:

For over the last two years, the DMHAS has worked closely with the CSS provider community, stakeholder groups, trade associations and with individual provider agencies to address concerns regarding the launch of CSS, financial forecasting, fee for services rates and budgetary issues. The DMHAS has met with providers in person, via conference calls and webinars to provide information, training and technical assistance. As with any new service, the DMHAS will work closely with providers to understand all aspects of the initiation of the service and proceed accordingly. The auditing of this service will be no more or less stringent than the auditing of other services.

DMHAS has finalized a flat rate for what is called “Pre-Admission” services for consumers who meet Community Support Services (CSS) eligibility and are being assigned to a provider for discharge planning from a State Hospital. The flat rate of \$1,598.08 requires the provider to attend treatment plan meetings, discharge meetings, complete the necessary CSS preliminary rehabilitation needs assessment (PRNA), the preliminary individualized rehabilitation plan (PIRP), and assist in any housing search with the consumer. The Pre-Admission reimbursement is claimed once the consumer is successfully discharged to the provider in the community.

Community Support Services (CSS) is a Medicaid entitlement service. Consumers, who are Medicaid enrolled and meet medical necessity for CSS eligibility, can receive CSS services. The DMHAS, in consultation with its Olmstead Consultant and another national Consulting firm (Parker/Dennison) cautioned that the roll out of CSS should be done in a controlled manner so the fiscal impact can be measured and to assure sustainability.

With respect to billing, Community Support Services (CSS) is an unbundled service, DMHAS allows for the licensed clinical staff to bill up to three (3) hours for the completion of the Comprehensive Rehabilitation Needs Assessment (CRNA) and up to three (3) hours for the completion of the Individualized Rehabilitation Plan (IRP).

- In July 2016, the Office of Inspector General from the U.S. Department of Health and Human Services issued a report concluding that New Jersey did not adequately oversee its Medicaid NEMT program, showing serious issues with quality and administration of the program. Further, a recent audit of the Division of Medical Assistance and Health Services’ Transportation Broker Services Contract- Capitation Rates, by the Office of the State Auditor found that the State overpaid LogistiCare, the agency tasked with providing

NEMT services, \$20.8 million. Given these issues, what is the Department currently doing to ensure that there is more prudent management and oversight of the NEMT contract?

Answer:

The Division disagrees with the conclusion for the several reasons, including the fact that the current contract with the broker has no provision that requires the direct transportation costs to be at least 80% of the capitation payments. With that said, the broker has been voluntarily returning monthly capitation payments so that their direct costs as disclosed in their financial statements for their NJ operations are in the 80% range.

The next NEMT Contract RFP has added the following enhancements to increase management of the new contract.

- The 80% provision, not part of the current broker contract, has been included in the new broker RFP.
- Call Center personnel shall be available for all calls during regular business hours, Monday through Friday from 8:00 AM to 5:00 PM.
 - This was changed to keep the call center open an additional hour each day.
 - The Contractor is also required to have personnel on-call outside of regular business hours for urgent issues.
- In cases of “Will Call” pick-ups, the Contractor must arrive at the pick-up location within sixty (60) minutes of the beneficiary’s notification to the Contractor that the beneficiary is ready for the return pick-up.
 - The requirement in the current contract is ninety (90) minutes.
- The RFP requires that the Contractor’s primary site for NJ Operations is within a 30 minute drive of DMAHS’ location at Quakerbridge Plaza.
- The Contractor is required to provide (non-public) network providers with a live electronic system to track vehicles.
 - This functionality shall be in 90% of vehicles and shall be capable of collecting data.
 - The system shall be capable of utilizing electronic signatures to track beneficiaries getting in and out of the vehicle.
 - The contractor shall monitor the automated trip data and provide monthly reports to the State Contract Manager indicating “on-time” and “no show” performance tracking data.
- The Contractor shall re-credential network providers annually, meeting the same initial credentialing requirements excluding the NJ State background check, and with the exception of fingerprinting which must be done once every 5 years.

- What role should the Department play in supporting Accountable Care Organizations to facilitate their continued development for regional and community based models?

Answer:

As part of the legislation, Rutgers Center for State Health Policy is responsible for the evaluation of the 3-year demonstration project.