

**Senate Budget and Appropriations Committee Testimony**  
**New Jersey Department of Human Services**  
**Acting Commissioner Elizabeth Connolly**  
**May 5, 2015**

Thank you, Chairman Sarlo for the opportunity to share with you and other members of the Senate Budget & Appropriations Committee the Department of Human Services' initiatives for Fiscal Year 2016. I have been Acting Commissioner of the department for approximately two months, previously serving as its Chief of Staff for two years and in various other roles for the past 24 years. Since completing graduate school, I have dedicated my career to public service on behalf of the constituencies impacted by this department, so I'm incredibly honored to serve in this role.

I've brought with me today a number of members of the department's executive staff who I will introduce as questions are raised in their area of expertise. Each of them, along with the remainder of our executive management team - who are all listening as they work this morning - very capably oversee many of the services we'll discuss today. The department is the largest state agency, serving one in six New Jerseyans through 8 divisions and one Commission, and I'm hopeful you'll welcome the valuable expertise we contribute.

Before today's hearing, I was fortunate to speak or meet with most of you, to hear your thoughts on how the department is managing its resources and to obtain your insight on some of the initiatives we have underway. I also heard your interests and concerns, which helped shape my testimony today.

I'll start with some updates and then look ahead to our plans for the coming fiscal year:

As mandated by the Task Force for the Closure of State Developmental Centers, the department closed two facilities: North Jersey Developmental Center in Totowa at the close of Fiscal Year 2014, and Woodbridge Developmental Center six months later at the close of Calendar Year 2014. Census had decreased by over 2,000 individuals, or 56%, since the State last closed a developmental center in 1998. Over half of that reduction has occurred in the last five years, with a census decline of 38% since the end of Fiscal Year 2010.

Funding has also significantly shifted during this time – five years ago, one third of DDD’s budget was dedicated to institutional operations; in FY16, this figure will decline to 20%. The proposed Fiscal Year 2016 budget invests over \$90 million in community-based services for individuals with intellectual and developmental disabilities, including Olmstead placements, Waiting List reduction, and housing support. Additionally, Fiscal Year 2016 will mark the beginning of enrollment in the new Supports Program, which will provide an enhanced service package across the system for individuals living at home with their families.

Last July, the department launched Managed Long Term Services and Supports, or MLTSS, which moved participants in Global Options and other waiver programs into a new, integrated system of home-based care for older adults and people with disabilities. The goal is to provide community-based support and services that allow participants to age in place for as long as possible and to prevent premature or unnecessary admission to a nursing home. This represents a sea change in philosophy and practice. While the program is still in its infancy stage, we have already started to see more participants utilize the MLTSS program and are projecting approximately 21,000 participants in MLTSS in FY16, an increase of 64% compared to the current fiscal year.

Based on Governor Christie's decision to expand Medicaid, since January 2014, 400,000 previously uninsured low-income New Jerseyans were enrolled in NJ FamilyCare. These newly eligible NJ FamilyCare members now have access to primary and preventive care, including dental coverage, prescription drugs, hospitalization, and mental health and substance use disorder services. The cost of covering the expansion population is 100% federally funded through Fiscal Year 2016.

Many reports highlight low physician participation rates in NJ's Medicaid program. However, this is not the best measure of access to services. NJ has one of the highest numbers of physicians in the country, with a lower proportion of Medicaid recipients to the entire population. A better measure of access to services is appointment availability. A recent New England Journal of Medicine report found that New Jersey Medicaid clients' access to physicians, in terms of appointment availability, was above average. In addition, the latest US HHS Consumer Assessment of Healthcare Providers, included in NJ FamilyCare's most recent annual report, shows that consumer satisfaction is at its highest since 2010 for both children and adults. However, we do acknowledge that finding specialists to serve the Medicaid population is challenging and that the growing number of Medicaid recipients will place a burden on those physicians already accepting Medicaid. That's why the proposed Fiscal Year 2016 budget includes a rate increase for certain participating Medicaid physicians beginning in January 2016.

We also have advanced an expansion in behavioral health care services. This is a subject area of increasing importance for individuals and families in New Jersey and across the nation. In the Fiscal Year 2016 proposed budget, there is additional growth and sufficient funding for various initiatives, including Involuntary Outpatient Commitment, housing and wrap around services,

and addiction prevention and treatment. Critical to this expansion is a newly funded program announced by the Governor in this year's State of the State Address.

This summer, the Division of Mental Health and Addiction Services will be launching a 'single point of entry' for individuals with substance use disorders who are uninsured or on Medicaid. Rutgers' University Behavioral Health Care will serve as an Interim Managing Entity that will coordinate services and care for this population and their families. A 24-hour hotline with supervised, certified call center staff will be in place for individuals/families to call. Staff will perform a preliminary assessment of the caller's need and make appropriate referrals to addiction treatment service providers. The service provider will do more detailed needs assessments, develop and implement a plan of care, and carefully monitor treatment progress. As patient needs change, plans will be revised appropriately to ensure recovery.

Now, before I take your questions, I do want to address two initiatives that have generated many questions over the past several months: CASS, and the state's Home and Community Based Services Transition Plan.

CASS, which stands for Consolidated Assistance for Social Services, was an integrated eligibility determination system for county workers to use to determine eligibility for programs like Medicaid and SNAP. In 2007, the state contracted with HP to deliver CASS, a planned six-year project. At several points in the process, new business rules, such as those required by the Affordable Care Act, required operational and coding modifications to an information infrastructure that was already being built.

After continued delays and unsuccessful pilot launches, the State and HP mutually determined that the contract should be terminated. We have since hired a consultant to perform a functional

and technical assessment to determine the potential reuse of CASS deliverables and options for a path forward and that analysis is currently ongoing.

Regarding the Statewide Transition Plan, or STP, I'm sure you all are aware, the department recently submitted a revised version of its draft to the federal government. The Plan describes how Medicaid funding will be used to meet the needs of individuals receiving long term services and supports in their home or community rather than in an institutional setting.

By way of background, every state was required to submit a plan to show how it would comply with the federal CMS final rules on Home and Community Based Settings and Services. Staff from this department, which is charged with developing and implementing the STP on behalf of several state agencies and offices, prepared a draft and released it publicly back in January, followed by a thirty-day comment period.

Over 1,000 comments were received in the form of letters, emails, phone calls and testimony at the two public forums. The draft Plan produced strong emotional and operations-based support for, and opposition to, various provisions. The process successfully opened up an important dialogue that resulted in some very constructive and useful feedback, much of which was included in the revised Plan. After consulting with some consumers, their families and service providers, the department feels strongly that the Plan now fully and fairly represents the interests and concerns of the people most impacted.

Thank you. I welcome any questions you may have.