

DHS Commissioner Jennifer Velez
Testimony before Assembly Budget Committee
April 5, 2011– Medicaid 2 p.m.

Good afternoon Chairman Greenwald and other members of this committee. Thank you for the opportunity to testify before you today regarding proposed changes for Fiscal Year 12 regarding Medicaid in the Department of Human Services' budget. I am here today with members of our Department's senior staff, in particular Valerie Harr, the Medicaid Director, to address your questions on the state's Medicaid program. I have only brief remarks, which may be useful to provide some context to our discussion.

In March, Governor Christie presented his proposed Fiscal Year 2012 budget. In it, he said:

“We must reform Medicaid, a federal program simply running out of control...We must do [this], not only to fill the hole created by the loss of over a billion dollars of federal stimulus money since 2010, but because it is the right thing to do. Medicaid's growth [in relation to state budget] is out of control. We must manage it better.

As the single state agency responsible for Medicaid, the Department of Human Services has worked closely with the Governor, the Department of Health & Senior Services – and with impacted stakeholder groups to develop an outline for effective, long-term, cost containing changes to Medicaid. These changes are presented in the budget as both specific programmatic modifications and as a comprehensive plan for reform.

In our current program, there are some things that we do very well and should indeed be proud of, but in other areas, some states are ahead of us and our systems of care are fragmented. At present, our Medicaid division – in partnership with 2 other divisions (DDD, DDS) and 2 state partners (DHSS, DCF) - administers 8 waivers – all with distinct administrative and reporting requirements, which have contributed to federal and state silos and unnecessary administrative efforts. This fundamental policy of reducing the administrative burden to states was underscored in Secretary Sebelius' letter to all states this past February 3rd.

The vision is to have fully integrated, coordinated care for all of the eligible participants. There are a variety of ways to accomplish this and the specific initiatives we have proposed as well as a comprehensive demonstration will allow NJ to be innovative and have more control to design a program that best serves NJ residents needing the safety-net of the Medicaid program. The principle under which we're operating is that a comprehensive waiver will allow NJ to effectively consolidate all of its distinct waivers in order to provide flexibility with rational accountability to manage the programs more efficiently – and to maximize our opportunities to claim as much federal funding as possible. Implementing changes where possible and necessary will allow us to “bend the (proverbial) cost curve” without devolving to reductions in eligibility.

In addition to the comprehensive waiver, we have proposed several immediate adjustments to our Medicaid program based upon our experience and the results of our efforts of the past several years. We have been moving toward coordinated and managed care since the mid-1990s. And while we want to be innovative, we do not consider any major system shifts lightly. We are not proposing anything that has not been operational in other states. We need to implement significant changes, but we are not being rash.

We also value and understand there is no Medicaid program without medical providers and that for many, modern managed care represents a change. We are working particularly closely with the fee for service providers to help them with the changes and to help them learn about Medicaid managed care. The savings initiatives we have proposed are not so aggressive as to drive providers out of business or for clients to be denied care. These proposals are based on best practices and are about integrating care, providing a broader network of providers, providing everyone with a medical home and care coordination where needed and as appropriate.

The time to examine these issues is right. Not entirely because of the state's fiscal situation...not just because we are anticipating broad-scale changes in 2014 from the Affordable Care Act... but because NJ needs the flexibility and timely authority to make changes and adjustments to the program when they're needed to fit the needs of OUR state. The changes we are considering and finalizing are essential – and they don't all represent reductions in services as has been feared. We are actively exploring, for example, flexibility to increase the timeliness of federal match opportunities – particularly in the developmental disability world – all of which will inure to the benefit of those served by NJ's Medicaid program.

I'm happy to answer any questions. Thank you.