

Discussion Points

1. **New Commissioner:** With the change in gubernatorial administrations, Dr. Stephen Cha was nominated to serve as the next Commissioner of Human Services, with the Senate confirming his nomination on February 24, 2026.
 - **Questions:** Please lay out the priorities and goals of Commissioner Cha for the Department of Human Services. What operational changes does the Commissioner intend to introduce? Please describe in detail: a.) any new initiatives planned for the department in the upcoming fiscal year; and b.) any changes to the department's objectives, performance benchmarks, and priorities.

Core Priorities and Goals

1. Protect access to essential services

The Commissioner's top priority is ensuring that eligible residents do not lose benefits due to administrative barriers, particularly in light of federal Medicaid and SNAP changes. This includes:

- Preventing coverage loss driven by paperwork, eligibility churn, or system inefficiencies
- Maintaining continuity of care, food assistance, and behavioral health services
- Shielding residents from disruptions caused by federal policy changes

This is a time-sensitive mission given the latest projected losses of up to 304,000 NJ FamilyCare enrollees

2. Strengthen system fundamentals and affordability

A major goal is to improve the underlying infrastructure of DHS, especially:

- Data systems
- Eligibility and enrollment processes
- Interagency coordination

The Commissioner emphasizes that without stronger systems, the State risks making reactive decisions instead of targeted, sustainable reforms.

3. Enhance accountability and program integrity

Commissioner Cha prioritizes a more rigorous approach to oversight and fiscal responsibility, including:

- Preventing misuse of funds
- Expanding auditing and transparency
- Strengthening enforcement against bad actors
- Ensuring every dollar is used effectively, especially in a constrained fiscal environment

Importantly, the Commissioner frames program integrity as compatible with access, not restrictive.

4. Invest in vulnerable populations across the lifespan

The Department continues to prioritize:

- Children and early childhood development
- Individuals with disabilities
- Older adults

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- Low-income families

These investments are maintained in FY27 even under fiscal pressure.

5. Build a culture of continuous improvement and learning

A key philosophical shift is toward:

- Ongoing system evaluation
- Learning from adverse events
- Embedding accountability and quality improvement into operations

Operational Changes the Commissioner Intends to Introduce

1. Modernization of eligibility and data systems

- Upgrading systems to handle increased eligibility checks and work requirements
- Reducing administrative churn and wrongful disenrollment
- Improving real-time coordination across agencies and counties

2. Expanded intergovernmental coordination and optimizing partner performance

- Strengthening partnerships with counties, contracted vendors, and State agencies
- Investing in coordinated administration, especially for SNAP and Medicaid

3. Increased administrative capacity

- Funding in FY27 to ensure counties can manage the transition to higher workloads
- Preventing service delays due to staffing or funding gaps

4. Stronger enforcement and oversight mechanisms

- Referrals to oversight entities for serious violations
- Introduction of civil penalties and fines for Division of Developmental Disabilities providers
- Expanded auditing practices

5. Data-driven and transparent governance

- Using improved data systems to guide decision-making
- Increasing transparency in provider performance and system outcomes

New Initiatives for the Upcoming Fiscal Year

1. Disability Mortality and Abuse Prevention Advisory Committee

A major new initiative focused on:

- Reviewing cases involving abuse, neglect, exploitation, or death of individuals with intellectual and/or developmental disabilities
- Identifying systemic failures
- Recommending prevention and accountability improvements

This represents a shift toward formalized, systemic learning from critical incidents.

2. On-demand accessibility services pilot

- Real-time sign language interpretation and visual reader services

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- Eliminates long wait times for accessibility accommodations
- Improves workplace inclusion for state employees

3. Expansion of early childhood language access programs

- Growth of the Language Instruction Program for deaf and hard-of-hearing children
- Hiring additional specialists
- Increasing family support capacity

4. Investments to mitigate federal policy impacts

- \$10M+ for eligibility system modernization
- \$71M to support county SNAP administration
- Funding to offset federal Medicaid cost shifts

5. Continued implementation of opioid settlement investments

- Advancing recommendations from the Opioid Recovery and Remediation Advisory Council
- Deploying hundreds of millions in settlement funds

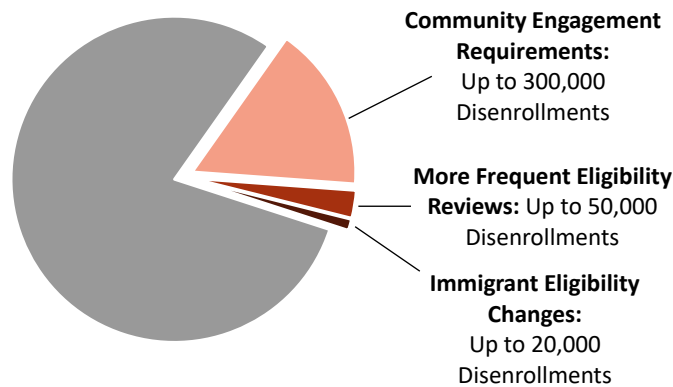
Division of Medical Assistance and Health Services (Medicaid/NJ FamilyCare)

2. **Impact of New Medicaid Eligibility Policies on Enrollment:** The 2025 federal budget reconciliation law, commonly known as the “One Big Beautiful Bill Act” (OBBBA), requires major changes to Medicaid eligibility rules during State Fiscal Year 2027. After OBBBA’s enactment in July 2025, the Division of Medical Assistance and Health Services estimated that enrollment in NJ FamilyCare — the State’s combination of Medicaid and the Children’s Health Insurance Program (CHIP) — may eventually decrease by up to 370,000 members once the new rules are fully implemented:

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New Medicaid Eligibility Policies:
Up to 370,000 NJ FamilyCare Members
Estimated to Be Disenrolled When Fully Implemented

Compared to 1.83 Million Average Monthly Enrollment In FY 2026:*



*FY 2026 average monthly enrollment as estimated in FY 2027 Governor's Budget

- Up to 300,000 members may be disenrolled for not *completing at least 80 hours per month of “community engagement”* — such as work, education, or volunteering — which is newly required for non-disabled, non-pregnant adults age 19 through 64 enrolled in the Affordable Care Act (ACA) Medicaid expansion. Certain groups are exempt, such as “medically frail” individuals and parents and caregivers of children age 13 and under. The State must initiate this requirement by December 31, 2026, though the federal government can grant up to a two-year extension for good-faith efforts to overcome implementation barriers.
- An additional 50,000 members may be disenrolled due to a required *increase in the frequency of eligibility redeterminations for ACA expansion enrollees* from once every 12 months to at least once every six months, beginning after December 31, 2026.
- Up to 20,000 members may be disenrolled after October 1, 2026 due to the *elimination of federal Medicaid eligibility for certain categories of lawfully present immigrants*, including refugees, asylees, victims of domestic violence, trafficking victims, and temporary humanitarian parolees.
- **Questions:** Have any of the division’s prior estimates changed regarding total NJ FamilyCare disenrollments under these policies? If so, please provide updated estimates for each of the groups above.
- For FY 2027, how many currently enrolled ACA Medicaid expansion adults are projected to be exempt from community engagement rules due to: i.) being parents/caregivers of children age 13 and under; ii.) medical frailty; iii.) meeting SNAP work requirements; or iv.) other reasons? Please disaggregate.

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- For FY 2027, how many non-exempt ACA Medicaid expansion adults are projected to have their compliance with community engagement rules verified: i.) automatically, based on income data or other data and requiring no actions by enrollees; or ii.) manually, where enrollees must submit attestations or other documentation? Please disaggregate.

DHS produced initial estimates on the impact of OBBBA eligibility provisions in July 2025 by scaling national estimates produced by the Congressional Budget Office to New Jersey's Medicaid membership. These estimates communicate the enormous stakes of these eligibility changes by demonstrating the very large potential enrollment decreases in New Jersey FamilyCare over the next several years. Substantial elements of the policies for community engagement / work requirements, more frequent eligibility renewals, and changes to non-citizen eligibility remain undefined by the federal government, which makes it challenging to refine enrollment estimates on a per-provision basis. However, best estimates now suggest that these three provisions will result in 165,000 - 330,000 fewer NJ FamilyCare members by SFY 2029. These estimates use [Urban Institute's analysis](#) of the impact of community engagement / work requirements and more frequent eligibility renewals, with minor adjustments and adding in estimates for enrollment changes due to changes non-citizen eligibility. DHS's estimates are uncertain and highly dependent upon pending federal guidance, timely access to additional data sources, and other factors, and are subject to change.

DHS is working intensively to leverage policy, systems, communications, and other tools to mitigate the potential impact of these eligibility changes. This work includes, wherever possible, granting or renewing coverage based on automated data checks to confirm compliance or exemption from work requirements. However, because this work is ongoing and individuals may fall into multiple compliance and exemption categories, we are not currently able to project the total number of individuals who will be compliant or exempt on a by-category basis using either automated or manual processes.

3. **NJ FamilyCare Enrollment Projections:** The FY 2027 Governor's Budget projects that NJ FamilyCare's average monthly enrollment will grow to 1.85 million members in FY 2027, or 1.1 percent above the revised FY 2026 estimate. This includes modest growth of roughly 6,600 enrollees (1.2 percent) in the State's Affordable Care Act "Medicaid expansion" for adults.

However, the federal "One Big Beautiful Bill Act" (OBBBA) requires several changes to NJ FamilyCare eligibility policies that were expected to significantly reduce enrollment among Medicaid expansion adults beginning in January 2027:

- The department previously projected that OBBBA's new Medicaid eligibility policies may reduce NJ FamilyCare enrollment by up to 370,000 members, as discussed above.
- Further, the Urban Institute [recently projected](#) that average monthly enrollment in New Jersey's Medicaid expansion would decrease by anywhere from 155,000 to 304,000 members between calendar years 2025 and 2028. The Urban Institute's projected decreases would result from OBBBA's community engagement requirements and more

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NJ FamilyCare Enrollment Estimates

Eligibility Category	FY26 Governor's Budget:	FY27 Governor's Budget:		FY27 Governor's Budget:	
	Original	Revised	FY 2026 Revised vs.	Estimated	FY 2027 Estimated vs.
	FY 2026	FY 2026	FY 2026	FY 2027	FY 2026
	Average Monthly Enrollment	Average Monthly Enrollment	Original (% change)	Average Monthly Enrollment	Revised (% change)
<i>Adults without disabilities (age 19-64)</i>					
ACA Medicaid expansion adults	541,164	545,091	0.7%	551,723	1.2%
Other Medicaid adults	145,720	134,658	-7.6%	136,042	1.0%
<i>Children without disabilities (age 0-18)</i>					
Medicaid children	698,611	671,590	-3.9%	678,203	1.0%
CHIP children	168,124	169,096	0.6%	171,387	1.4%
<i>Medicaid adults age 65+ and individuals with disabilities ("Aged, Blind, Disabled")</i>	313,958	308,511	-1.7%	311,950	1.1%
TOTAL	1,867,577	1,828,947	-2.1%	1,849,306	1.1%

Note: category averages may not sum to totals due to rounding within averages

frequent eligibility reviews alone, and the lower-end scenario of 155,000 fewer enrollees assumes that the State pursues “high mitigation” policies that would use extensive automatic data-matching and expansive definitions of exemption categories (such as “medical frailty”) to verify compliance and minimize disenrollments.

- Questions:** Given the department’s earlier projections of up to 370,000 fewer NJ FamilyCare enrollees due to OBBBA, and the Urban Institute’s projections of 155,000 to 304,000 fewer enrollees by calendar year 2028, why does the Governor’s Budget project enrollment of Medicaid expansion adults to grow modestly in FY 2027 (i.e., by 1.2 percent) when that group is most likely to be affected by OBBBA’s new eligibility policies?
- What explains the lower total enrollment currently projected in FY 2026 as compared to the original estimate in the FY 2026 Governor’s Budget? If FY 2027 enrollment is similarly overestimated for certain groups, can FY 2027 State appropriations be reduced?
- Within the FY 2027 Governor’s Budget, what are the specific enrollment changes in ACA Medicaid expansion adults and other Medicaid adults attributed to the following OBBBA provisions? For those two major eligibility categories, please separately quantify the net average monthly enrollment changes from FY 2026 to FY 2027 anticipated due to the:

 - New community engagement rules for expansion adults beginning in January 2027;
 - More frequent eligibility reviews for expansion adults beginning in January 2027;
 - New immigrant eligibility restrictions beginning in October 2026; and
 - Other provisions within OBBBA, if applicable (please specify).

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DHS remains deeply concerned about the likelihood of significant Medicaid coverage losses because of OBBBA. While we are working urgently to mitigate such losses, we continue to believe the impact on overall NJ FamilyCare enrollment is likely to be substantial.

That said, the effective dates of key eligibility provisions of the law mean that the most significant enrollment impacts will likely not be seen until FY 2028. The likely timeline of impacts for certain key provisions is detailed further below.

The new community engagement rules take effect in January 2027. However, because the eligibility redetermination process typically takes multiple months to complete, the earliest date an existing member is likely to lose coverage due to the community engagement requirements would be April 1, 2027. In many cases, this date may be even later, because the added complexity of the new eligibility requirements may mean that eligibility workers require additional time to reach an eligibility determination. Moreover, because eligibility redeterminations are spread roughly evenly across the year, only about 25% of affected members will have faced the potential risk of disenrollment due to community engagement by the end of FY 2027. On top of all of these factors, it remains possible (albeit far from certain) that the federal government may consider temporarily extending the effective date of this provision, based on New Jersey's good faith effort to comply with the law. If this occurs, initial impacts would be pushed further out. Considering all of these factors, significant unknowns, and in order to ensure there are sufficient budget resources for all eventualities, DHS has not projected loss of coverage due to community engagement in FY 2027.

With respect to OBBBA's requirement of more frequent (every six months) eligibility redeterminations, while the effective date of this provision is January 2027, recent federal guidance has clarified that states can choose to implement this provision prospectively. That is, the first members impacted by this provision will be those who are due for eligibility redetermination (or who newly apply for coverage) in January 2027. They will have their next eligibility redetermination scheduled for July 2027 (rather than January 2028, as would have been the case under the old rules). On a rolling basis, other members will prospectively switch to a six-month redetermination cadence over the course of 2027 as they come up for redetermination. Therefore, we do not expect to see any noticeable enrollment impacts of this provision until the beginning of FY 2028 (July 2027), when the first cohort of impacted enrollees will be subject to an eligibility redetermination earlier than they otherwise would have been.

OBBBA's restrictions on non-citizen eligibility for Medicaid has an earlier effective date than other major eligibility provisions: October 1, 2026. Moreover, unlike the other provisions discussed above, the impact of this change will largely be felt immediately – members with an affected immigration status will lose Medicaid eligibility, effective October 1, 2026. DHS has estimated the number of individuals impacted by this provision at approximately 11,000, which is reflected in the enrollment projections cited above. However, we underscore there is considerable uncertainty on this topic, and it is well within the realm of possibility that the true effect will be significantly greater.

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Lastly, we note that the revisions to FY 2026 eligibility projections included in the FY 2027 Governor's Budget simply reflect the most recent data available to DHS. In general, future Medicaid enrollment trends are always highly uncertain (depending on various hard-to-project economic and demographic factors). As such, it is reasonable to expect future fluctuations in enrollment (either up or down).

4. **Implementing New Medicaid Eligibility Policies:** The division has reported a range of preparations for the new Medicaid eligibility policies under the "One Big Beautiful Bill Act" (OBBBA). For instance, the New Jersey Innovation Authority is assisting the division with developing a new "Community Engagement Compliance Engine," which will interface with existing NJ FamilyCare eligibility systems and verify members' compliance with the new community engagement rules (i.e., completing at least 80 hours per month of work, education, or volunteering).

- **Questions:** Will the division, in collaboration with the county social service agencies and the State's Health Benefits Coordinator (Conduent), be able to implement these new Medicaid eligibility policies to the satisfaction of the federal government?
- Please describe the division's current plans for verifying NJ FamilyCare members' community engagement compliance or exemptions under the new eligibility policies. How will the "Compliance Engine" provide these verifications, using which data sources? What other processes and data sources will be used for these verifications? What is the current status of implementing these new processes?
- How will the division monitor its processes for verifying community engagement compliance to avoid enrolling or renewing ineligible individuals and making improper payments on their behalf?
- What are the most significant challenges to implementing OBBBA's new Medicaid eligibility policies, and how is the division addressing those? What concerns does the division have about meeting federal implementation deadlines and any potential non-compliance penalties? Is the division expecting to receive a federal extension for implementing the community engagement rules due to any significant challenges?

DHS is focused on timely implementation of changes to the Medicaid program as required by OBBBA. In implementing these changes, we seek to minimize coverage losses among members who remain eligible for Medicaid. Based on national research and our own data, we believe that the vast majority of NJ FamilyCare members will remain eligible for Medicaid after the introduction of work/community engagement requirements but will be at risk for disenrollment due to burdensome documentation and renewal requirements.

To implement community engagement requirements by January 1, 2027, as required by OBBBA, DHS is working to update IT systems, ensure eligibility staff readiness, improve member experience with NJ FamilyCare eligibility processes, and implement compliant State-level policy, among other areas of activity. The systems and member experience work includes

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a focus on improving automatic (also known as *ex parte*) verification of eligibility information and, where automatic verification is not possible, easing the process for members to communicate with NJ FamilyCare. In particular, we are seeking to expand the number of data sources to verify applicant and member income, which will assist both Expansion and non-Expansion members, as well as to integrate additional data sources to assist with documentation of exemption from or compliance with work requirements (e.g., educational enrollment, compliance with WorkFirst NJ/TANF work requirements).

DHS seeks to ensure that all changes that we make are consistent with federal statute, but timely implementation is challenged by the lack of federal guidance. We have provisionally made or must make many policy decisions in the coming weeks to ensure timely implementation of OBBBA eligibility requirements, but CMS has not yet completed associated federal rulemaking. Among other topics, we await federal guidance on application processing standards; definition of certain exemptions; and circumstances under which a state will be able to receive an extension of the January 1, 2027 implementation deadline. Absent this guidance, DHS is ensuring implementation flexibility where we can and documenting outstanding key policy decisions for CMS.

These challenges are magnified by the limited staff and vendor resources available to support implementation of eligibility changes. The extent of policy shocks under OBBBA are significantly straining the eligibility systems, policy, caseworker, contracting, and other capacity needed to comprehensively implement changes in the most public-friendly way.

5. **Costs of Implementing New Medicaid Eligibility Policies:** The “One Big Beautiful Bill Act” (OBBBA) appropriated \$200 million to support states’ implementation of the new Medicaid community engagement requirements, dividing \$100 million across all states equally and allocating \$100 million based on the size of states’ affected Medicaid populations. Federal law also provides matching funds for 50 to 90 percent of states’ Medicaid administrative costs, varying by cost category. However, in a [2025 survey](#) conducted by KFF and Health Management Associates, multiple states reported concerns about the potential costs of implementing OBBBA’s new Medicaid eligibility policies, including administrative costs for systems changes, staffing increases, and enrollee outreach.

The FY 2027 Governor’s Budget recommends \$10.5 million in State funding increases related to implementing OBBBA’s new Medicaid eligibility policies, including: \$5.0 million to engage the New Jersey Innovation Authority in OBBBA-related initiatives; \$3.0 million for additional vendor costs related to the new eligibility requirements; \$1.0 million for expanded professional services to comply with State and federal mandates; and \$1.5 million to increase county incentive payments for NJ FamilyCare eligibility determinations.

- **Questions:** What are the division’s total projected administrative costs during FY 2026 and FY 2027 for implementing OBBBA’s new eligibility policies? Please disaggregate these costs by fiscal year and funding source (e.g., State versus federal share) and provide a breakdown of major implementation activities and associated costs and, when applicable, the responsible vendor contracted to administer the activity.

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- **Please describe any new activities planned for FY 2026 and FY 2027 to advance each of the following goals and the total anticipated costs of such activities (with costs disaggregated by specified goal, fiscal year, and funding source). Please also indicate whether, and where, each activity is included within the total implementation costs estimated above:**
 - i.) Conducting outreach to NJ FamilyCare enrollees and applicants about the eligibility changes, including coordinating with managed care organizations, providers, regional health hubs, or other community organizations to inform enrollees about the new rules;**
 - ii.) Assisting NJ FamilyCare enrollees with finding employment or participating in other qualifying “community engagement,” including through interagency collaborations; and**
 - iii.) Assisting individuals disenrolled from NJ FamilyCare with identifying and accessing alternative sources of health coverage and care.**

Because DMAHS is still developing its full plan to implement the Medicaid provisions of OBBBA and because critical federal rulemaking and guidance related to OBBBA is still outstanding, at this stage it is not possible to give a full projection of total expected administrative costs associated with implementation. The FY 2027 funding requests cited above represent the State share of some of the investments that will be necessary. However, in addition to these new investments, a significant share of pre-existing DMAHS administrative funding has been or will be repurposed to support OBBBA implementation. This includes existing IT vendor contracts, existing funding for DMAHS’ Health Benefits Coordinator vendor, existing dollars for professional consulting services, existing funding distributed to County Social Service Agencies for eligibility work, and costs for existing State staff. In general, State appropriations that support OBBBA (whether new or existing) will be eligible for federal match, at a 50%, 75%, or 90% matching rate, depending on the nature of the activity. In addition to State appropriations, New Jersey has to date received \$4.7 million in federal grant funding authorized under OBBBA, which is intended to support State implementation. The New Jersey Innovation Authority has also provided in-kind resources during FY 2026 to support OBBBA implementation.

With respect to member engagement, DMAHS is planning extensive OBBBA-related outreach both directly to NJ FamilyCare members and through community-based organizations in the coming months. While some of this outreach may incidentally touch on connecting members with employment or with alternative sources of health insurance coverage, this is not expected to be the primary area of focus. DHS believes that the vast majority of members will remain eligible for NJ FamilyCare coverage under the new rules; the primary risk of disenrollment will be for members who struggle to comply with the extensive additional documentation/red tape now required by federal law. As such, the primary focus of our outreach will be on helping members navigate through that process and maintain their coverage.

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6. **NJ FamilyCare Eligibility System Capacity:** The division has identified eligibility system capacity as another challenge of implementing new Medicaid eligibility policies under the “One Big Beautiful Bill Act,” particularly for the community engagement rules and more frequent eligibility redeterminations. In January 2026, the division reported that some county social service agencies continued to lag in timely processing of NJ FamilyCare applications during 2025, and that the State’s Health Benefits Coordinator (Conduent) also lagged in application processing following an IT system transition in 2025.

The FY 2027 Governor’s Budget recommends State funding increases of \$1.5 million to increase county incentive payments for NJ FamilyCare eligibility determinations and \$3.0 million for vendor costs related to the new eligibility policies. According to a news report by the New Jersey Monitor, this \$3.0 million is intended to “improve the flow of work” with Conduent.

- **Questions:** What concerns does the division have about the capacity of the county agencies and Conduent to implement the new Medicaid eligibility policies? How is the division addressing any concerns through new forms of support, oversight, or training provided to the counties and Conduent in FY 2026 and FY 2027, and what are the projected State and federal costs of these new efforts in each fiscal year?
- What is the current processing backlog of NJ FamilyCare eligibility determinations for each county and Conduent? For each of those eligibility determining agencies, please report (and disaggregate) the current number of i.) delayed initial applications and ii.) delayed renewals.
- How are the counties’ increased incentive payments designed to support implementation of the new Medicaid eligibility policies? What are the total projected State and federal costs of these incentive payments in FY 2026 and FY 2027, respectively?

Implementing work/community engagement requirements and more frequent renewals, among other eligibility changes required by OBBBA, will substantially increase the volume and complexity of eligibility determinations made by Eligibility Determining Agencies (EDAs). DHS is working to ease this process through IT system improvements, integration of new automated data sources, and easier paths for members to self-report information, among other improvements, but the workload will still increase for County Social Service Agencies (CSSAs) and the Health Benefits Coordinator (HBC; NJ’s current vendor is Conduent). To help EDAs prepare for these changes, DHS has established a readiness process for counties and is negotiating contract updates with Conduent to improve current performance and readiness for OBBBA changes starting October 1, 2026. DHS has also reviewed county budgets to determine the ability for each county to staff its agency to ramp up capacity for the anticipated demand, and suggested changes where necessary. DHS is also seeking additional budgetary resources to support CSSA and HBC readiness, including an increase in county performance payments (\$1.5 million State, \$6 million gross) and funding to support HBC readiness (\$3 million State, \$12 million gross). We expect these resources will assist with increased staffing and improved eligibility determination processes, supporting timely processing for both Expansion and non-Expansion members.

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While we plan for eligibility changes starting this fall, DHS acknowledges that some EDAs struggle with timely processing. Conduent processes ~91% of new applications timely and ~58% of renewals within required timelines. Conduent's backlog of initial applications over 45 days of processing is currently ~1,200 and renewals over 45 days of processing is currently ~15,000. We expect Conduent to achieve timely processing standards well before the implementation of work/community engagement requirements and more frequent renewals as of January 1, 2027, and we continue to work with counties to provide enhanced support through technology such as increases in the *ex parte* rate for renewals and other processing improvements. While we are not yet able to publicly share CSSA performance, we expect to do so shortly and will be tracking comparable measures closely as part of the OBBBA readiness process. With the requested increase in CSSA performance incentives, total county incentives will increase from \$4 million State funding in SFY 2026 (\$16 million gross) to \$5.5 million in SFY 2027 (\$22 million gross). The use of the increased funding has not yet been determined, but it will be used to support improved county performance based upon the metrics being developed for analysis of each county's OBBBA readiness.

7. **Cover All Kids Enrollment and Costs:** The Cover All Kids Initiative, launched in FY 2022, aims to provide health coverage to the State's uninsured children. Phase I sought to enroll eligible children in NJ FamilyCare by removing barriers such as Children's Health Insurance Program (CHIP) premiums and the 90-day CHIP enrollment waiting period. In January 2023, Phase II expanded NJ FamilyCare coverage to children previously ineligible for the program due to immigration status. Phase I is funded by the State and federal government, while Phase II is entirely State-funded except for emergency hospital services receiving federal Medicaid reimbursement.

In its FY 2026 OLS Discussion Point responses, the department projected that Cover All Kids Phase II would enroll up to 47,000 children in FY 2026, with annual State costs of \$164.0 million and a managed care capitation rate of \$233 per-member per-month (excluding non-emergency transportation).

- **Questions:** By month since March 2025, please indicate the actual monthly enrollment and monthly cost of Cover All Kids Phase II to date. Overall, what is Phase II's projected average monthly enrollment for FY 2026 and FY 2027, disaggregated by fiscal year?
- What are the projected total costs of Cover All Kids Phase II for FY 2026 and FY 2027, disaggregated by fiscal year and funding source (i.e., State versus federal)? What is Phase II's anticipated managed care capitation rate in FY 2027?
- Considering the department's projection of significant federal Medicaid funding losses under the "One Big Beautiful Bill Act" (OBBBA), does the department have any plans to modify or eliminate any of the current policies implemented under the Cover All Kids initiative as a cost savings measure in FY 2027? If yes, please explain.
- What would be the State savings if CHIP premiums were reinstated (at FY 2021 levels) for children with household incomes above 200 percent of the federal poverty level? What

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would be the State savings if the 90-day CHIP waiting period were reinstated? Please provide a separate FY 2027 estimate for each scenario.

The table below shows monthly Cover All Kids Phase II enrollment and expenditures for March 2025 through March 2026. Expenditures include those paid from State appropriations and the Health Care Subsidy Fund and reflect fee-for-service payments, managed care, and transportation capitations, by month paid. Expenditures do not include costs associated with presumptive eligibility.

Month	CAK Phase II enrollment	Expenditures
March '25	46,555	\$11,378,709
April '25	47,355	\$14,850,528
May '25	47,377	\$13,923,771
June '25	46,492	\$14,153,032
July '25	45,312	\$14,934,185
August '25	44,243	\$13,541,380
September '25	42,976	\$12,695,990
October '25	42,530	\$13,274,454
November '25	42,511	\$12,635,960
December '25	42,074	\$13,663,694
January '26	40,946	\$12,643,079
February '26	39,337	\$12,817,149
March '26	38,625	\$12,616,246

FY2026 average enrollment is estimated to be 39,300 and FY2027 average enrollment is expected to be similar, at 39,200. FY2027 managed care capitation rates for Cover All Kids Phase II are projected to be \$280.62 per member per month. Estimated FY2027 expenditures for Cover All Kids Phase II population is expected to be \$132 million for capitation payments. Non-capitation FFS payments are estimated to be an additional \$37 million. FY2026 Cover All Kids Phase II expenditures across all agencies, and inclusive of capitation and presumptive eligibility payments, are estimated to be \$163 million. There is no federal match claimed for FY2026 and FY2027 expenditures.

The Governor’s budget proposal does not recommend modifications or elimination of coverage implemented under the Cover All Kids initiative for FY2027. These policies were implemented to improve access to preventive and primary care and support better health outcomes for children.

The Department has not modeled the financial impacts of reinstating CHIP premiums or a waiting period.

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8. **Cover All Kids Managed Care Contract:** In September 2025, new federal guidance indicated that, effective in 2027, states can no longer use Medicaid and CHIP managed care contracts to cover state-only-funded services for individuals ineligible for Medicaid and CHIP due to immigration status. Instead, if such individuals are covered under managed care plans, they must be covered by managed care contracts and payments that are “separate and distinct” from any Medicaid and CHIP managed care contracts.

The division has indicated that this new federal guidance also limits the State’s ability to cover, within any separate Cover All Kids Phase II managed care contract, certain emergency hospital services that qualify for federal Medicaid reimbursement. However, the new federal guidance does allow such emergency services to be covered under fee-for-service delivery systems (i.e., outside of managed care).

The FY 2027 Governor’s Budget proposes an \$11.0 million increase in State appropriations for “Cover All Kids Phase 2 - Lost Emergency Services 50% FMAP.”

- **Questions:** How does the division anticipate transitioning Cover All Kids Phase II enrollees outside of NJ FamilyCare’s standard managed care contract to comply with the recent federal guidance? What steps have been taken thus far, or are planned in FY 2027, to implement this transition?
- **Would the \$11 million State increase offset the loss of federal Medicaid funding for all applicable Cover All Kids Phase II services that previously qualified for federal “emergency Medicaid” reimbursement, or only a portion thereof? Please explain.**
- **What would be the net State savings or costs of shifting all Cover All Kids Phase II services to fee-for-service delivery, including any State savings due to restored federal “emergency Medicaid” funding? Why is the division not pursuing that strategy?**

DHS has closely reviewed the September 2025 federal guidance and is considering its options for how to respond. This includes both alternatives under which the Cover All Kids population would continue to receive coverage through managed care and alternatives that involve fee-for-service coverage. We note that, per the terms of the guidance, we believe the first managed care contract period where this guidance will be enforced will be July 2027 – June 2028. We expect to provide more detailed information on this topic well in advance of this time period. At this point, we do not have any cost estimates for the impacts of these alternatives – we expect any such impacts will be built into the Governor’s Budget proposal for FY 2028.

9. **Medicaid State-Directed Payments:** "State-directed payments" are arrangements where state Medicaid programs direct their contracting Medicaid managed care organizations to pay health care providers according to specific rates or methods, which typically increase providers' reimbursement rates above their base payments received from the managed care organizations.

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The "One Big Beautiful Bill Act" (OBBBA) prohibits Affordable Care Act Medicaid expansion states like New Jersey from establishing new Medicaid state-directed payments where total payment rates for a given service category (i.e., base payments plus state-directed payments) exceed 100 percent of comparable Medicare payment rates. For managed care rating periods beginning on or after January 1, 2028, these states must also reduce any existing state-directed payments that exceed Medicare rates by 10 percentage points annually until reaching the Medicare rate levels.

Federal guidance allows state-directed payments submitted for federal approval before OBBBA's July 4, 2025 enactment to be temporarily "grandfathered" and remain above Medicare payment rates until the phase-down period beginning on January 1, 2028. The guidance also prevents states from increasing the total dollar amounts of the "grandfathered" state-directed payments after receiving federal approval; however, states may choose to *decrease* those amounts at any time.

- **Questions:** Please provide a list of New Jersey's federally approved Medicaid state-directed payment programs for State Fiscal Year 2026 where total payment rates exceed 100 percent of the comparable Medicare rates. For each of these payment programs, please also indicate the program's:
 - i.) Targeted class of health care services (e.g., inpatient hospital services);
 - ii.) Federally approved total payment level (including base payments and state-directed payments), disaggregated by targeted service class (as applicable) and expressed as an estimated percentage of the comparable Medicare rate; and
 - iii.) Total dollar amount, disaggregated by estimated federal and non-federal shares.

- Does the FY 2027 Governor's Budget assume any State savings from reducing state-directed payments prior to the required phase-down after January 1, 2028? If so, which state-directed payments will be decreased in FY 2027, and by what total dollar amounts (State and federal)?

Program	Service Categories	SFY26 State Directed Payments	Federal share	Non-Federal share	Expenditures as % of Medicare Benchmark
Medicaid Access to Physician Services (MAPS) Program - General	Physician Services	\$472,781,615	\$319,692,883	\$153,088,732	189%
Outpatient Hospital Supplemental Directed Payment Program	Outpatient Hospital	\$574,278,276	\$364,838,989	\$209,439,287	233%
MAPS - AtlantiCare	Physician Services	\$50,611,881	\$31,379,366	\$19,232,515	189%
Quality Improvement Program (QIP-NJ)	Inpatient & Outpatient Hospital	\$210,000,000	\$126,000,000	\$84,000,000	240%

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New Jersey County Option Hospital Fee Program	Inpatient & Outpatient Hospital	\$4,078,612,204	\$2,771,640,368	\$1,306,971,836	226%
Notes:					
1) As of 4/20/26, 6 of the 14 Counties in the County Option programs were approved by CMS for SFY26.					
2) State Directed payment amounts do not include the base amount, only the supplemental payment. - this is the supplemental amount reported in the preprint and capped by CMS.					

The FY 2027 Governor’s Budget does not assume any State savings from reducing State-directed payments prior to the required phase-down before 1/1/28.

10. **Medicaid Provider Tax Changes in FY 2026:** The State uses revenues from provider taxes to fund NJ FamilyCare and other health activities, thereby drawing down federal Medicaid matching funds on reimbursable expenditures. New Jersey previously enacted several changes to existing Medicaid provider taxes in State Fiscal Year 2026 (see the chart below). However, the “One Big Beautiful Bill Act” (OBBBA) prohibits states from establishing any new or increased Medicaid provider taxes beyond taxes that were enacted and imposed as of July 4, 2025.

According to federal guidance, provider taxes will be considered “enacted and imposed” if, as of July 4, 2025, a state or locality had: i.) completed the entire legislative process needed to authorize or increase a provider tax; ii.) begun actively collecting tax revenue (including on a delayed schedule consistent with routine practices); and iii.) obtained any required federal waivers of requirements that the taxes be broad-based and uniform.

It is unclear whether the State has received full federal approval for all of the provider tax changes below and if they were all deemed “enacted and imposed” as of July 4, 2025. As of January 2026, the division indicated that federal approvals for the Nursing Home Provider Assessment and the County Option Hospital Fee Program’s local provider taxes were still pending.

Further, the FY 2027 Governor’s Budget proposes a \$50.0 million increase in State appropriations attributed to “Nursing Home Provider Tax – Increased Revenue not Implemented.” This effectively offsets \$50.0 million in State savings assumed in the FY 2026 Appropriations Act due to increased federal revenue generated by the Nursing Home Provider Assessment modifications below — suggesting that federal approval for those changes was not received.

Modified Provider Tax and Authorizing Legislation	Authorized Modification
Nursing Home Provider Assessment (FY 2026 Appropriations Act; approved June 30, 2025)	Increased tax to equal the full statutorily authorized rate (six percent of nursing homes’ aggregate amount of annual revenues) as of FY 2026.
County Option Hospital Fee Program (P.L.2024, c.47; approved July 22, 2024, with later local approvals for FY 2026 fees)	Expanded the eligibility criteria for participating counties and increased the cap on counties’ hospital fees from 2.5

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	percent to 5.0 percent of hospitals’ total net patient revenues.
Ambulatory Care Facility Assessment <i>(P.L.2025, c.70; approved June 30, 2025)</i>	Aligned tax with Medicaid regulations, expanded class of assessed facilities, removed per-facility maximum assessment cap, and reduced tax from 2.95 percent to 2.5 percent of the provider’s gross receipts as of FY 2026.

- **Questions:** Please explain the reason(s) for any federal disapproval of the State’s Nursing Home Provider Assessment modifications or any other factors driving the \$50.0 million State funding increase in FY 2027 for “revenue not implemented.” What percentage of each nursing home’s aggregate annual revenue will be assessed under the Nursing Home Provider Assessment for FY 2026 and FY 2027, respectively?
- Has the State received full federal approvals for all other Medicaid provider tax changes above? If not, please identify the affected taxes and explain i.) whether approval is still pending or why the changes were denied and ii.) whether the Governor’s Budget assumes those changes will be approved and implemented in FY 2027.
- For each provider tax above, please display the FY 2026 gross revenue (i.e., non-federal revenue and federal Medicaid funds) that was originally assumed within the FY 2026 Appropriations Act as compared to the revenue currently projected for FY 2026 and FY 2027, respectively, within the FY 2027 Governor’s Budget. Please also disaggregate each revenue projection by non-federal versus federal funds.
- Absent federal approval for each of the provider tax changes above, which categories of Medicaid providers and services have been affected by any FY 2026 shortfalls in anticipated federal revenue? If applicable, how much additional State funding will be allocated in FY 2026 to support any affected providers and services?

A summary of the current status of each of the three provider taxes referenced in the question:

Nursing Home Provider Assessment: Because the Home Provider Assessment included in the final FY 2026 budget exempts certain providers from paying the assessment, the State was required to request CMS approval for a waiver of the general federal requirement that provider taxes be uniform and broad-based. The State submitted such a waiver request to CMS in September 2025 and has yet to receive a formal response. However, according to CMS guidance that was issued on November 14, 2025, any such tax increase requiring a waiver would have needed approval by July 4, 2025. As a result, the State does not expect CMS approval of the waiver request and as such, does not expect to be able to implement the tax increase.

Had it been implemented, the increased Home Provider Assessment was projected to generate approximately \$140 million in new FY 2026 revenue. Of this amount, \$50 million was earmarked to support general Medicaid operations, whereas the remaining \$90 million would

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have been paired with \$90 million in federal matching funds dedicated to provider rate increases. In light of the likely non-approval of the tax, the provider rate increases have not been implemented. The \$50 million adjustment in the FY 2027 proposed budget is intended to offset the lost State Medicaid operating funds.

New Jersey County Option Hospital Fee Program Increase: On March 19, New Jersey received CMS approval for 6 of the 14 counties participating in the County Option program.

The increase in the County Option provider tax limit from 2.5% to 5.0% at the time of the FY 2026 enacted budget was expected to double county assessments from \$570 million in FY 2025 to \$1.3 billion in FY 2026. Participating counties can retain 9% of the assessment; the remaining \$1.2 billion is used to gain federal matching funds for increased payments to the hospitals.

The State had deferred implementation of the FY 2026 program until we received federal approvals. (Payments to hospitals in the 6 counties that have been approved began in April.) If federal approval for the remaining counties were to be denied, the counties and hospitals participating in the program would lose a significant funding source, including approximately \$1.3 billion in net benefits to hospitals and \$72 million for counties.

Ambulatory Care Facility Assessment: Following the FY 2026 changes outlined in the question, New Jersey entered discussions with CMS around this change; as of this writing, the discussions are ongoing.

Gross revenue collected for the ACF assessment is approximately \$75 million per year. Receiving CMS approval will save the State that amount. Historically, CMS has reduced the federal funding to the Medicaid program by an amount equivalent to the ACF assessment collections due to the impermissible tax. Without approval, the State will maintain status quo.

11. **Medicaid Provider Tax Limits:** The “One Big Beautiful Bill Act” (OBBBA) lowers future federal limits on Medicaid provider tax rates in New Jersey and other states with Affordable Care Act Medicaid expansions. Beginning on October 1, 2027, the limit will decrease by 0.5 percentage points annually, from the current 6.0 percent to 3.5 percent of providers’ net patient revenues by Federal Fiscal Year 2032 (beginning October 1, 2031).

These lower limits will effectively reduce the amount of provider tax revenue available to fund NJ FamilyCare and generate federal Medicaid reimbursements. The division has projected major fiscal impacts when these limits are fully implemented, such as:

- Up to \$400 million annually in lost federal Medicaid funds generated by the State’s health maintenance organization (HMO) premiums assessment, which supports general NJ FamilyCare expenditures.

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- Roughly \$800 million annually in lost federal Medicaid funds generated by provider taxes in the County Option Hospital Fee Program, which allows eligible counties to enact a tax on local hospitals and redirect the revenues and federal Medicaid matching funds back to their hospitals in the form of supplemental payments.

The lower federal limits will apply to Medicaid-reimbursable State and local taxes on all providers except for nursing facilities and intermediate care facilities.

- **Questions:** Please identify all of New Jersey's Medicaid provider taxes that will eventually require reduced assessment rates under these new federal limits.
- For each tax identified above, please also indicate the Executive's current estimates for: i.) reductions in federal and non-federal Medicaid revenues (disaggregated) during State Fiscal Years 2028 and 2029, respectively; and ii.) total annual reductions in federal and non-federal Medicaid revenues (disaggregated) when the provider tax limits are fully implemented after October 1, 2031.
- How will these new provider tax limits affect NJ FamilyCare providers' reimbursement rates? What steps is the department taking in FY 2026 and FY 2027 to prepare for these federal limits and mitigate their impacts on providers — such as hospitals receiving supplemental payments through the County Option program?
- How will the department collaborate with the Department of Health to assist any hospitals at risk of financial distress due to reduced NJ FamilyCare reimbursements under these new limits? What criteria or methods will be used to identify such hospitals? Does the department anticipate the need for increased State funding in FY 2028 and future years to offset the loss of provider tax revenue and associated federal funds under these limits? Please explain.

Based on our initial analysis, we believe there are two programs that will be impacted by the new provider tax restrictions included in OBBBA:

HMO Assessment: The current 6% HMO assessment must be reduced by 0.5% annually beginning in FY 2028 until it reaches 3.5% in FY 2032. The net loss of annual federal funding will be approximately \$82 million for each 0.5% reduction. The total federal revenue loss from FY 2026 funding levels will reach \$410 million per year in FY 2032. This revenue currently supports general Medicaid benefit and operating expenses; the State will need to replace this revenue source and/or implement cost reductions in response.

County Option Fee Program: The 5% County Option Fee program limit will be reduced by 0.5% annually beginning in SFY28 until it reaches 2.5% in SFY2032. Hospitals are projected to lose approximately \$265 million per year in federal funding for each 0.5% reduction. The total federal reduction from the FY 2026 funding level will be approximately \$1.3 billion in FY 2032. Additionally, the county tax revenue generated from this program will decrease by \$13 million per year starting in FY 2028, for a total annual loss of \$65 million from the FY 2026 level by FY 2032. (These numbers assume full approval of the program for all 14 counties)

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in FY 2026 and future years)..) We note that these estimates only reflect reductions that are required specifically by the *provider tax* provisions of OBBBA. The County Option program (which is financed by a provider tax but distributes provider payments through a State-directed payment) will also be impacted by the provisions of OBBBA that restrict State-directed payments, likely resulting in significant additional reductions to hospital payments.

DOH identifies hospital financial distress in accordance with P.L.2008, c.58 (C.26:2H-5.1a). Based on the scale of the impacts, the State cannot readily backfill the reductions, but will work across State agencies and health care sector stakeholders to mitigate impacts to health care access and affordability.

12. **Managed Care Cost Drivers:** Payments to managed care organizations drive a large portion of NJ FamilyCare’s annual costs. These organizations provide most health care services to NJ FamilyCare members in exchange for a per-member, per-month “capitation payment” from the State. Most NJ FamilyCare members are enrolled in the “acute care” managed care program, which provides services to individuals who do not have long-term care needs requiring a nursing facility level-of-care, whereas members with such long-term care needs are typically enrolled in the Managed Long Term Services and Supports (MLTSS) managed care program.

In September 2025, the State’s actuary projected the following per-member per-month costs, by service category, when finalizing capitation rates for all NJ FamilyCare members in the “acute care” and MLTSS managed care programs, respectively, for the period of July 2025 to June 2026:

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NJ FAMILYCARE: "ACUTE CARE" MANAGED CARE PROGRAM	
Service Category	July 2025-June 2026: Projected Per-Member Per-Month Cost (as of September 2025)
Inpatient Hospital	\$92.04
Emergency	\$19.90
Outpatient Facility	\$31.33
Physician	\$71.97
Pharmacy	\$120.33
Supplies	\$12.95
Lab & X-Ray	\$23.55
Transportation	\$2.63
Dental	\$22.81
Behavioral Health	\$24.80
Other Acute Services	\$39.71
Personal Care	\$14.36
Self-Direction	\$19.53
Medical Day Care	\$6.90
Nursing Facility and Hospice	\$6.52
Private Duty Nursing	\$9.57
Other Long-Term Services and Supports	\$1.18
TOTAL BENEFIT COSTS (above)	\$520.10
TOTAL NON-BENEFIT COSTS <i>(MCOs' administrative costs, HMO premium-based assessments, underwriting gain/profit)</i>	\$83.27
TOTAL CAPITATION RATE	\$603.37

NJ FAMILYCARE: MANAGED LONG TERM SERVICES & SUPPORTS	
Service Category	July 2025-June 2026: Projected Per-Member Per-Month Cost (as of September 2025)
ACUTE BENEFIT COSTS	
Inpatient Hospital	\$249.34
Emergency	\$11.81
Outpatient Facility	\$55.85
Physician	\$88.92
Pharmacy	\$181.48
Supplies	\$63.98
Lab & X-Ray	\$25.66
Transportation	\$15.66
Dental	\$12.96
Behavioral Health	\$18.86
Other Acute Services	\$35.79
LONG TERM SERVICES & SUPPORTS BENEFIT COSTS	
Personal Care	\$823.00
Self-Direction	\$526.19
Medical Day Care	\$304.90
Nursing Facility	\$2,700.30
Hospice	\$114.38
Private Duty Nursing	\$109.93
Home- and Community-Based Services (Non-Assisted Living)	\$118.88
Assisted Living	\$169.73
Home Health	\$3.83
TOTAL BENEFIT COSTS (Acute + Long Term Services & Supports)	\$5,631.48
TOTAL NON-BENEFIT COSTS <i>(MCOs' administrative costs, HMO premium-based assessments, underwriting gain/profit)</i>	\$939.11
TOTAL CAPITATION RATE	\$6,570.59

- **Questions:** What are the total costs of NJ FamilyCare’s “acute care” and MLTSS managed care programs, respectively, for FY 2026 and FY 2027, as assumed in the FY 2027 Governor’s Budget? Please separately disaggregate each program’s costs by funding source: State; federal; other (please specify).
- To show how specific service categories contribute to these programs’ capitation rates, please separately disaggregate the “acute care” and MLTSS managed care programs’ total projected FY 2027 per-member per-month costs by the same underlying service categories shown in the tables above (i.e., when applying the anticipated FY 2027 capitation rate to all rate cells and member months across the fiscal year).

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- **Within the data provided above, what are the *five* service categories with the *largest* projected FY 2027 cost growth (relative to FY 2026) in the “acute care” managed care program and the MLTSS program, respectively? Please also explain the primary drivers of cost growth in the five service categories identified for each managed care program.**
- **For each managed care program, what steps is the division planning to take in FY 2027 to control the primary drivers of cost growth identified above?**

The total managed care costs for acute care during FY 2026 are projected to be \$12.2 billion, with the State contributing approximately \$4.2 billion. These costs are projected to increase during FY 2027 to \$12.8 billion with the State contributing approximately \$4.4 billion.

The total costs for the MLTSS program (net of patient liability) during FY 2026 are projected to be \$5.6 billion with the State contributing approximately \$2.8 billion. The total costs for the MLTSS program are projected to increase during FY 2027 to \$5.7 billion with the State contributing approximately \$2.9 billion.

For the Acute Care program, the five service categories with the largest projected per member per month (PMPM) cost growth in FY 2027 compared to FY 2026 are as follows: Other Acute Services (including Applied Behavior Analysis), Inpatient Hospital, Self-Directed Personal Care Assistance services, Outpatient Hospital, and Pharmacy. The primary drivers of the per-member per-month (PMPM) cost growth for each of these services are as follows:

- **Other Acute Services:** Increases in the number of children with autism spectrum disorder utilizing applied behavior analysis therapy.
- **Inpatient Hospital & Outpatient Hospital:** Higher hospital utilization across all populations and higher negotiated rates between hospitals and MCOs.
- **Self-Direction:** Increases in the proportion of members utilizing self-directed personal care assistance services.
- **Pharmacy:** Increases in prescription drug prices and growing market share of expensive brand and specialty products.

For the MLTSS program, the PMPM costs are projected to decrease in FY 2027 due to a higher portion of home- and community-based services (HCBS) members enrolled in the program compared to FY 2026, and a corresponding reduction in the proportion of members residing in institutions. HCBS members are much lower cost than institutional members, so this results in a reduction to the average PMPM cost across the program. That said, the five service categories with the largest projected PMPM cost growth in FY 2027 compared to FY 2026 are as follows: Inpatient Hospital, Personal Care, HCBS, Physician, and Outpatient Hospital. The primary drivers of the cost growth for each of these services are as follows:

- **Inpatient Hospital, Outpatient Hospital, & Physician:** Projected increases in the portion of Medicaid-only (i.e. not also enrolled in Medicare) members enrolled in the program compared to the proportion of dually eligible (enrolled in both Medicare and Medicaid) members. MCOs are primarily responsible for the costs for these services for Medicaid-only members, but only partially responsible for them for dual members – therefore, an increase in the proportion of Medicaid-only members drives cost increases. Similar to

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acute care, there are also underlying provider rate increases and projected increases in utilization for these services as well.

- Personal Care: Increases in the proportion of HCBS (non-institutional) members, who are eligible to utilize these services.
- HCBS: As described above, this is primarily due to an increase in the portion of HCBS (non-institutional) members projected to be enrolled in FY 2027.

13. **Evaluation of Managed Care Contracts:** The Governor’s Transition Action Team for “Affordable Healthcare” recommended that, within the first few months of the administration, the department review its contracts with NJ FamilyCare’s managed care organizations to “ensure they are providing the best possible care to New Jersey residents and high value to the State and taxpayers.” The Transition Action Team also recommended evaluating these contracts through “cost containment and quality of care lenses.”

- **Questions:** Has the department initiated any related reviews of NJ FamilyCare’s managed care contracts? If so, what opportunities for improving quality of care and reducing costs were identified, and how will those be pursued in FY 2027? If reviews are still pending, please describe any plans and timeframes for completing them.

The Division of Medical Assistance and Health Services (DMAHS) comprehensively reviews the NJ Medicaid Managed Care Organization (MCO) contracts on an ongoing basis. These reviews are led by DMAHS subject matter experts (SMEs) and leadership, and function as a core regulatory and fiscal control mechanism, ensuring that the NJ MCO’s contractual obligations continuously align with evolving federal requirements, State requirements and priorities, and program integrity objectives.

The outcome of these reviews is the issuance of biannual contract amendments that operationalize both mandated regulatory changes and targeted performance enhancements identified through oversight activities, stakeholder engagement, and data-driven analysis. These amendments are strategically designed to strengthen cost containment and elevate quality of care by embedding enforceable standards related to access, utilization, and outcomes within the NJ Medicaid Program.

Recent examples include:

- A 2023 contract amendment which tightened adult network adequacy requirements to align with regulatory pediatric network adequacy requirements ensuring sufficient provider availability and geographic accessibility for all Medicaid members statewide. MCOs continue to be measured based on these enhanced requirements or be subject to financial sanctions.
- A January 2026 contract amendment requiring MCOs to increase the percentage of pediatric members receiving preventative dental services each year through FFY 2030 or be subject to financial sanctions.
- A January 2026 contract amendment that allows DMAHS to withhold ~~MCO~~ future capitation payments if the MCO fails to provide one or more of the medically necessary covered contracted services.

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This iterative contract review framework and biannual issuance of amendments enable DMAHS to drive improved MCO performance, clarify language, close identified gaps, systemically advance quality, efficiency, and accountability within the NJ Medicaid program.

In addition to the Division's contract review process, DMAHS conducts a structured, biannual Managed Care Performance Accountability Review (360° Review) of each contracted MCO, designed to rigorously assess performance, including clinical quality, network adequacy, program integrity, finance, and member experience. MCO and Division executive leadership and SMEs address reoccurring issues, concerning findings, identified weaknesses, mixed performance indicators, demonstrated strengths, and expectations for performance improvement, emphasizing actionable strategies tied to cost efficiency and care quality outcomes. The 360° Review process culminates in required documented corrective action plans and improvement strategies from the MCOs. This governance model ensures disciplined oversight, promotes transparency, and drives measurable improvements in both fiscal stewardship and the delivery of high-quality care to Medicaid beneficiaries.

14. **Nursing Home Any Willing Provider Requirement:** Prior to FY 2026, the department had proposed transitioning from its previous "Any Willing Provider" policy, which required Medicaid managed care organization (MCO) networks to include any nursing facility agreeing with the MCOs' contract terms and conditions, to an "Any Willing *Qualified* Provider" policy.

Under that new policy, MCOs would have contracted with all nursing facilities agreeing to their terms and conditions except if, in two of the three most recent calendar years, a facility was: 1.) included on federal Centers for Medicare and Medicaid Services (CMS) Special Focus Facilities Lists for low- performing nursing homes; 2.) cited for certain deficiencies by the federal or State governments; or 3.) given a one-star CMS rating for at least nine of the prior twelve quarters. MCOs could have chosen whether to contract with a facility that did not meet these requirements, and current residents of non-compliant facilities would not have been required to relocate.

Provisions adopted in the FY 2026 Appropriations Act required the department to reinstate an Any Willing Provider policy during the current fiscal year, thereby preventing the implementation of the proposed Any Willing *Qualified* Provider policy. The FY 2027 Governor's Budget recommends deleting the FY 2026 appropriations language that required the Any Willing Provider policy.

- **Questions:** Absent the proposed Any Willing *Qualified* Provider policy, did the department implement any other policies in FY 2026 to support MCOs in ensuring high standards of care within contracted nursing home facilities? What was the impact on quality of care in nursing homes due to the continuation of the Any Willing Provider policy?
- Please quantify, and explain, any State fiscal impacts of continuing the Any Willing Provider policy in FY 2026, such as marginal increases in managed care medical costs due to higher rates of injuries or illnesses among residents of "non-qualified" nursing homes.

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- **If the Any Willing Qualified Provider policy had taken effect in FY 2026, how many licensed nursing homes would have met the “qualified provider” definition, out of how many total possible facilities? Please list all of the facilities that would not have qualified, as well as the number of Medicaid enrollees currently residing at each of those facilities.**
- **Does the department intend to implement an Any Willing Qualified Provider policy in FY 2027? If so, will the parameters of the policy be identical to those proposed in FY 2026 or will new guidelines be proposed? Please explain.**

The Department remains committed to ensuring high-quality care in nursing facilities while maintaining access to a comprehensive provider network. Had the Any Willing Qualified Provider (AWQP) policy been implemented, approximately 343 of the State’s roughly 360 licensed nursing facilities—representing approximately 95% of providers, would have met the qualified provider standards. The remaining 17 facilities (less than 5%) would not have met the criteria. As proposed, MCOs would have retained discretion to contract with these 17 facilities to ensure continuity of care and no residents would have been required to relocate if the MCO elected to end a contract with a facility. The policy would have applied only to new admissions.

This analysis reflects that the AWQP policy was designed as a targeted quality improvement tool focused on a small group of persistently underperforming facilities while preserving broad access to care for Medicaid beneficiaries. Given that this policy was not implemented, its precise impact cannot be quantified; however it is reasonable to assume it would have had a net positive impact. Collectively, these few facilities received more than \$160 million of Medicaid revenue in FY25, with average annual Medicaid revenues of about \$9.4 million per facility. The volume of taxpayer dollars directed to facilities with chronic quality issues underscores concerns also raised by the State Comptroller about whether current standards sufficiently ensure high-quality nursing facility care. While AWQP did not require MCOs to remove non-qualified facilities from their networks, it would have established a framework for the Department to meaningfully address persistent quality failures and to strengthen expectations for facilities with repeated federal and State health and safety violations.

The FY 2027 Governor’s Budget removes one-time FY 2026 budget language, restoring the Department’s historic discretion and regulatory flexibility. The Department does not plan to reintroduce AWQP provisions in the July 2026 MCO contract amendments. However, ensuring program integrity, optimizing the use of State dollars to deliver quality care to members, ensuring continued access, and providing system stability remain imperatives. Any new framework in the future would incorporate quality criteria and implementation parameters based on updated data and stakeholder input.

The table below lists the nursing facilities that would not have qualified under AWQP had it been implemented in FY 2026. We note that if the same policy were implemented in FY 2027, the list of impacted facilities may not be exactly the same. Underlying the disqualifying criteria listed in the table below, these non-qualified facilities demonstrated serious and repeated quality and safety deficiencies, including failures to prevent abuse and neglect; inadequate medication documentation; failure to provide required modified diets; failure to respond to

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residents expressing suicidal ideation; insufficient monitoring of behavioral challenges contributing to at least one resident death; and staffing lapses, including an incident in which a nurse was found asleep during their shift, leaving staff unsupervised. Of the 17 facilities deemed not qualified last May, seven currently have a 1-star overall CMS rating, another five hold 2-star ratings, and two are now on CMS’ Special Focus Facility candidate list, underscoring ongoing quality concerns.

Facility Name	Total Revenue (FY25)	Medicaid Revenue (FY25)	Medicaid Residents (May 2025)	Disqualifying Criteria (2 of 3 most recently completed calendar years)	Current Overall CMS Star Rating
Accelerate Skilled Nursing and Rehab Piscataway	9,028,314	3,355,966	76	2 G Level or Higher Violations	2
Avant Rehabilitation and Care Center	12,697,667	9,407,057	226	SFF list; 2 G Level or Higher Violations	4
Cambridge Rehab and Healthcare Center	20,818,234	7,648,735	167	One Star in 9 of 12 Previous Quarters	3
Complete Care at Chestnut Hills	9,526,411	7,092,583	163	One Star in 9 of 12 Previous Quarters	2
Complete Care at Shorrock	19,723,134	9,993,886	180	SFF List	3
Cranford Park Care	9,266,764	4,683,207	27	SFF List	1
Foothill Acres Rehab and Nursing	22,124,437	8,859,870	153	SFF List	3
Hamilton Grove Healthcare and Rehabilitation	25,710,758	12,101,554	204	SFF List	1
Little Brook Nursing and Convalescent Home	4,174,331	2,177,755	26	SFF List; One Star in 9 of 12 Previous Quarters	1
Llanfair House Care and Rehab Center	11,232,684	8,174,487	119	SFF List	2
Merwick Care and Rehab Center	21,062,053	11,837,447	172	SFF List	1
New Vista Nursing and Rehab Center	27,758,506	22,999,635	348	SFF List	2
Palace Nursing and Rehab	17,900,425	13,733,161	208	SFF List; One Star in 9 of	1

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				1 Previous Quarters	
Premier Cadbury of Cherry Hill	13,963,158	6,242,249	118	SFF List	1
Runnells Center for Rehab and Healthcare	30,807,325	22,077,999	278	One Star in 9 of 12 Previous Quarters	5
Silver Healthcare Center	3,173,566	2,305,427	157	SFF List	2
Troy Hills Center	12,576,074	7,546,556	121	SFF List	1

15. **Behavioral Health Integration:** For decades, the State has contracted with managed care organizations to deliver and reimburse physical health services for most NJ FamilyCare members. However, until January 2025, most members’ behavioral health services — including mental health and substance use disorder services — were delivered outside of managed care and reimbursed directly by the State on a fee-for-service basis.

During FY 2025, the State began shifting additional NJ FamilyCare members’ behavioral health services from fee-for-service arrangements into managed care contracts, with goals of increasing enrollees’ access to services, better integrating behavioral and physical health services, and improving care coordination. The department anticipates the following timeline for this initiative:

- *Phase I* (effective January 1, 2025): shifted certain outpatient behavioral health services into managed care
- *Phase II* (TBD; originally January 2026, but delayed): shift residential services and opioid treatment programs into managed care
- *Phase III* (TBD): shift additional behavioral health services into managed care

In response to behavioral health providers’ concerns, the State extended certain Phase I “transition flexibilities” that were originally intended to expire 90 days after January 1, 2025. These flexibilities required managed care plans to automatically approve providers’ prior authorization requests and pay out-of-network providers at existing Medicaid fee-for-service rates for error-free claims submitted with any required prior authorization requests. As of January 2026, the division had ended these flexibilities for Aetna (on November 1, 2025) and planned to end the flexibilities for the other four managed care organizations upon completion of final readiness reviews.

- **Questions:** What key performance outcomes is the department tracking for the behavioral health integration initiative, and what do those data indicate about whether the initiative is achieving its goals? Since Phase I began in January 2025, has this initiative experienced any notable implementation challenges or areas where performance outcomes have been below expectations? If so, please explain.
- What specific provider concerns were the extended Phase I “transition flexibilities” intended to address? Did extending the transition flexibilities beyond their original 90-

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day timeframe result in any increases to NJ FamilyCare's managed care costs for FY 2025 or FY 2026? If so, please quantify any increased managed care costs by fiscal year and disaggregate by funding source (e.g., State versus federal share).

- Why was Phase II implementation delayed past the original target date of January 2026, and when does the division currently expect to launch Phase II?
- For NJ FamilyCare members whose behavioral health services were shifted to managed care in Phase I, how does post-January 1, 2025 average per-member, per-month spending compare to prior fee-for-service spending for the same population and services (including administrative and other non-benefit costs)? To date, has behavioral health integration increased or decreased NJ FamilyCare's overall costs?

During the transition period, the Department closely monitored key performance metrics, including continuity of care for members; behavioral health (BH) care management enrollment; claims denial rates and underlying causes; the timeliness and accuracy of provider payments; network development efforts; and prior authorization outcomes. MCO performance in certain areas—particularly claims denials—fell short of targets, prompting an extension of the transition period. As a result, MCOs were required to maintain policy flexibilities and continue engaging providers through education and resources until specified performance thresholds were met to achieve integration goals of increased access, improved health outcomes, and enhanced care coordination. As of May 1, 2026, three of the five MCOs have met these thresholds and have been permitted to lift their transition-period policies.

The extended transition period overlapped with the timeframe originally intended for Phase II planning and stakeholder engagement, as MCO performance improvements took longer than anticipated. However, lessons learned from Phase I are expected to support a more efficient Phase II implementation. Phase II implementation is now targeted to begin in January 2027.

The transition to managed care was not expected to significantly increase or reduce overall Medicaid expenditures on behavioral health, and evidence to date has been consistent with this hypothesis. We note that the number of members receiving psychotherapy services has modestly increased (by about 10%) since Phase I behavioral health services were fully carved in – however, it is unclear whether this change is attributable to the transition to managed care, or other unrelated factors.

16. **Rural Health Transformation Funding:** The Department of Human Services is the designated lead agency for the State's initial \$147.3 million federal Rural Health Transformation Program grant under the "One Big Beautiful Bill Act" (OBBBA). The department collaborated with the New Jersey Department of Health to develop and submit the initial federal funding application, and the two departments are jointly managing the implementation of funded initiatives.

The federal government required the State's program application to be based on five budget periods with hypothetical awards of \$200.0 million per year. Under the previous administration, the Department of Human Services posted an ["excerpt"](#) of the State's submitted application in

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early December 2025. The State’s complete application was subsequently obtained and published by [KFF Health News](#), and that document included additional details regarding anticipated funding allocations and disaggregated costs, implementation plans and timelines, outcomes and metrics to be tracked, and other information, such as policy commitments factored into application scoring.

Based on the State’s complete application, the State budgeted the following amounts across five major Rural Health Transformation initiatives and core administrative costs:

**Federal Rural Health Transformation (RHT) Funds:
New Jersey's Original Budgeting, By Major Initiative and Federal Fiscal Year**

RHT INITIATIVE	PERIOD 1 (FFY 2026)	PERIOD 2 (FFY 2027)	PERIOD 3 (FFY 2028)	PERIOD 4 (FFY 2029)	PERIOD 5 (FFY 2030)	TOTAL
<i>Core RHT Administrative Costs</i>	\$1 million	\$1 million	\$1 million	\$1 million	\$1 million	\$5 million
<i>RHT1 (Workforce):</i> supports recruitment, training, and retention of clinical and non-clinical providers	\$47 million	\$43 million	\$42 million	\$39 million	\$33 million	\$204 million
<i>RHT2 (Infrastructure):</i> supports essential providers of behavioral health (Certified Community Behavioral Health Centers), primary care (Federally Qualified Health Centers), and emergency medical services (hospitals)	\$69 million	\$78 million	\$79 million	\$82 million	\$88 million	\$396 million
<i>RHT3 (Technology):</i> encourages regional partnerships to strengthen care delivery outside of "brick-and-mortar" settings, including telehealth, remote patient monitoring, and mobile care	\$32 million	\$27 million	\$27 million	\$27 million	\$27 million	\$140 million
<i>RHT4 (Prevention):</i> supports community-level efforts to promote preventive health	\$28 million	\$26 million	\$26 million	\$26 million	\$26 million	\$132 million
<i>RHT5 (Chronic Disease):</i> invests in evidence-based interventions and data integration efforts to improve chronic disease treatment	\$23 million	\$25 million	\$25 million	\$25 million	\$25 million	\$123 million
TOTAL	\$200 million	\$200 million	\$200 million	\$200 million	\$200 million	\$1.0 billion

Upon receiving a \$147.3 million award for the first budget period on December 29, 2025, the department was also required to re-budget and resubmit the State’s activities, with final federal approval to be provided by March 1, 2026.

- Questions:** Given the smaller first-year award of \$147.3 million, how has the department re-budgeted the anticipated Rural Health Transformation funds across the planned initiatives (e.g., RHT1, RHT2, etc.) and core administrative costs? Please update the table above to indicate those allocations. Please also explain whether the State’s re-budgeting involved proportional reductions to all RHT initiatives or a different approach.

Discussion Points (Cont'd)

- Of the funds anticipated to be received in each federal fiscal year, what amounts will the Department of Human Services and the Department of Health each be responsible for administering? Please disaggregate by federal fiscal year, department, and initiative.
- Does the department plan to publish the State’s complete Rural Health Transformation Program application? Does the department plan to publish the State’s other federal submissions required under the program, such as annual progress reports, data on subawards submitted pursuant to the Federal Funding Accountability and Transparency Act, or non-competing continuation applications for future budget periods? If the department does not plan to publicly release any of that information, please explain why.
- What amount of federal Rural Health Transformation funding does the State currently expect for the next budget period (i.e., Federal Fiscal Year 2027)? If that amount differs from the \$147.3 million for the first budget period, please explain what assumptions account for any differences.
- What legislative or regulatory actions will the State’s Rural Health Transformation initiatives require for implementation through Federal Fiscal Year 2030, including any State policy commitments factored into the federal funding awards? (Please list.) How much federal funding is at risk if the State fails to complete each of these actions?

In response to CMS awarding the State \$147.2 million for Budget Period 1, DHS and DOH rebalanced the application from the original amount of \$200 million. Rebalancing required CMS approval. New Jersey received partial CMS approval of our State’s rebalancing in February 2026, and full CMS approval in March 2026. Our approved, rebalanced funding for Budget Period 1 (with the Initiative-specific disaggregation by Department) is shown in the table below. Please note that we have used the RHT-specific performance period because RHT Budget Periods do not map precisely to the federal fiscal year.

NJ RHT Initiative	Budget Period 1	DHS	DOH
<i>NJ State’s Core RHT Administrative</i>	<i>\$0.6M</i>	-	-
RHT1 Workforce	\$35.9M	-	\$35.9M
RHT2 Infrastructure	\$61.4M	\$39.4M	\$22M
RHT3 Technology	\$9.9M	-	\$9.9M
RHT4 Prevention	\$26.6M	-	\$26.6M
RHT5 Chronic Disease	\$12.8M	-	\$12.8M
TOTAL	\$147.2M	\$39.4 M	\$107.2M

We did not rebalance by proportionally decreasing each row of funding uniformly. Instead, we assessed sub-initiatives for the subset that were most likely to be implemented efficiently during the abbreviated Budget Period 1. New Jersey’s Budget Period 1 is an abbreviated 7-month period (February-October 2026), as compared to the 12-month periods projected for the remaining years (October 31-October 30). It was important to take this rebalancing strategy

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because the success of our Budget Period 1 implementation will impact the availability of funds for subsequent years.

In the near future, DHS will launch a NJ Rural Health Transformation (NJ RHT) website to compile information on NJ RHT, including information about our initiatives, our progress with Budget Period 1, and future plans to meet NJ RHT's goals. We currently plan to use this website to publish any documents to comply with State and federal requirements. Guidance on future RHT submissions (such as progress reports, data, and non-competing continuation applications) is still being finalized by CMS; as such, we are not yet able to say what can be publicly released.

Final award levels for Budget Periods 2-5 are not currently available because CMS may adjust funding levels between Budget Periods. CMS has indicated that state-specific funding amounts for subsequent Budget Periods are subject to change depending on how New Jersey and other states implement RHT. Each state must submit a non-competing continuation application before the start of each new Budget Period. For Budget Period 2, we will submit an application assuming we will maintain the current funding level of \$147.2M funding into the next Budget Period.

In the application submitted in fall 2025 for activities starting in 2026, New Jersey did not make any definitive legislative or regulatory commitments, in light of the gubernatorial transition taking place during the application period. We acknowledge that certain CMS-generated publicly available summary documents imply otherwise: DHS is working to correct these errors.

Department-wide

17. **Consulting Costs:** In October 2025, the State awarded a \$7.5 million contract to Boston Consulting Group for assistance with implementing new Medicaid policies under the federal "One Big Beautiful Bill Act" (OBBBA). During his confirmation interview before the Senate Judiciary Committee in February 2026, the Commissioner of Human Services stated that this contract would support related improvements to NJ FamilyCare's eligibility and enrollment systems. Available information indicates that Boston Consulting Group's contract continues through June 30, 2026, with an optional six-month extension for additional planning and implementation support.

In recent years, the department has contracted with Boston Consulting Group and other consulting firms to support a range of initiatives, including but not limited to: designing and implementing Housing Supports and behavioral health integration under the NJ FamilyCare Comprehensive Demonstration; resuming NJ FamilyCare eligibility reviews after the COVID-19 public health emergency; developing the State's Home- and Community-Based Services spending plan under the American Rescue Plan Act; and reviewing the design and sustainability of the Pharmaceutical Assistance to the Aged and Disabled and Senior Gold programs.

- **Questions:** What are the currently projected State and federal costs, respectively, of Boston Consulting Group's OBBBA-related contract during FY 2026? Does the Governor's

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Budget anticipate extending this contract into FY 2027 — and, if so, with what budgeted costs in that year? (Please disaggregate by State versus federal share.)

- **What other projects or activities will Boston Consulting Group support under its OBBBA-related contract, beyond improving NJ FamilyCare’s eligibility and enrollment systems?**
- **Please list all of the department’s active and anticipated consulting contracts during FY 2026 and FY 2027. Please include: i.) the division(s) supported by each contract; ii.) the contracted vendor; iii.) a brief description of the contract’s scope; and iv.) total projected contract costs for FY 2026 and FY 2027, disaggregated by fiscal year, division, and funding source (e.g., State versus federal share).**

BCG has been contracted to track and support NJ DMAHS compliance with OBBBA’s many provisions. This includes project management and implementation support for some of the provisions requiring significant changes to systems and eligibility policies and procedures, in particular work requirements and changes to non-citizen eligibility. The timelines for implementation required by CMS necessitate this increased support to avoid loss of coverage for eligible individuals, compliance issues, and potential federal penalties. DMAHS envisions needing continued support throughout the coming fiscal year and has proposed funding for that support in the Governor’s budget. This funding qualifies for a federal funding match, with a significant portion eligible for enhanced match of up to 90% for the support that is focused on systems builds. Federal approval for that enhanced match rate is required and DMAHS has and will continue to seek as much enhanced match as is available. On the statewide, the M4010 blanket for professional business consulting services, BCG, McKinsey, and BerryDunn have been contracted to perform similar types of work.

Projected costs for BCG through the end of FY2026 total approximately \$14.15 million State + \$14.15 million federal + \$1.5 million from PAAD rebates; for McKinsey, \$1.1m State + \$4.1m federal; and for BerryDunn, \$570,000 State + \$5.1m federal. DHS cannot speculate on contracts it may award in FY2027, but notes that funding is included in the Governor’s budget for additional consulting costs related to HR1 implementation.

18. **Collaborations with New Jersey Innovation Authority:** The Governor proposes increasing State funding for the New Jersey Innovation Authority by \$13.3 million in FY 2027. According to the FY 2027 Budget in Brief, the recommended funding level would “support the Governor’s efforts to improve customer experience, reduce administrative burdens, and make government more responsive and accountable.” Further, the department’s proposed budget includes an additional \$5.0 million for engaging with the Innovation Authority to support the Division of Medical Assistance and Health Services with initiatives related to the “One Big Beautiful Bill Act” (OBBBA). The division has previously reported that the Innovation Authority is helping to develop a “Community Engagement Compliance Engine” to support new Medicaid eligibility policies under OBBBA.

- **Questions: Please describe all current and past collaborations between the New Jersey Innovation Authority and the Department of Human Services. What have been**

Discussion Points (Cont'd)

the objectives and outcomes of the joint projects? Please detail the associated impacts on departmental performance metrics, as well as expenditures and revenues.

<https://doula-assistant.nj.gov/form/welcome> In 2025, DHS worked with the New Jersey Innovation Authority (NJIA) to create and launch a [“New Jersey Doula Assistant” tool](#) that helps doulas fill out the initial paperwork to enable them to serve NJ FamilyCare families and receive Medicaid reimbursement for those services. Because doulas are a group of non-clinical, perinatal care providers that are not accustomed to working with health payers, this investment to streamline provider enrollment processes is intended to help grow the doula provider network available to our NJ FamilyCare individuals. The Doula Assistant work was done in close collaboration with NJ Maternal and Infant Health Innovation Authority, NJ Department of Health, and the prior Murphy Administration’s Office of the First Lady.

In addition, DHS began working with NJIA in late 2025 to develop and implement technology to assess compliance with community engagement requirements under HR1 that go into effect starting in January 2027.. This effort includes establishing a new, standalone Community Engagement Compliance Engine (CECE), which will intake information from available datasets and member submissions and output a determination of whether a member or applicant has complied with or is exempt from these requirements. CECE will interface with existing eligibility systems used by Eligibility Determining Agencies (EDAs). NJIA’s work to develop the CECE, as well as associated tools for eligibility workers and applicants/members, is critical to DHS implementing community engagement requirements in a timely, thoughtful manner.

- **What other collaborations is the department planning or implementing with the New Jersey Innovation Authority? What are the new initiatives’ goals and their anticipated impacts on the department’s revenues and expenditures? How are the new initiatives expected to improve the department’s performance and administrative efficacy? Please identify any metrics that will be used to assess the success or failure of the initiatives.**

At this time, the NJDHS’ priority for collaboration with NJIA is the ongoing efforts on the Community Engagement Compliance Engine for HR1 implementation. Any additional collaborations with the New Jersey Innovation Authority (NJIA) to modernize human services systems would aim to improve administrative efficacy, accelerate the adoption of innovative solutions, and support more efficient, data-driven, and user-centered service delivery.

19. **Coronavirus State Fiscal Recovery Fund:** The table below shows all allocations to the Department of Human Services from the State’s largely discretionary \$6.24 billion federal Coronavirus State Fiscal Recovery Fund grant under the American Rescue Plan Act of 2021. The federal grant had to be obligated by December 31, 2024 and must be expended by December 31, 2026. Any sum remaining unexpended after this date will revert to the federal government. States, however, may transfer unexpended previously obligated funds among programs that had received an allocation by December 31, 2024.

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Status of Coronavirus State Fiscal Recovery Fund Allocations to the Department of Human Services as of April 12, 2026			
PROGRAM	ALLOCATED	EXPENDED	BALANCE
Caregivers Hub Site and Community Grants	\$7,175,000	\$556,302	\$6,618,698
Mental Health First Aid	\$5,205,000	\$900,780	\$4,304,220
County Area Agencies on Aging	\$4,100,000	\$892,641	\$3,207,359
Potable Water New Lisbon/Hunterdon	\$2,400,000	\$372,154	\$2,027,846
Higher Education Peer Counseling	\$1,560,000	\$130,542	\$1,429,458
Excluded New Jerseyans Fund	\$57,300,000	\$56,761,160	\$538,840
Immigration Work Authorization Program	\$2,500,000	\$2,067,414	\$432,587
Centralized Advertising Budget	\$5,000,000	\$4,864,593	\$135,407
DHS Central Advertising For State Services & Programs	\$3,000,000	\$2,865,563	\$134,437
Direct Outreach for State Benefits	\$6,250,000	\$6,249,845	\$155
Child Care Workers Recruitment And Retention	\$30,000,000	\$30,000,000	\$0
Enrollment Based Payment Extension	\$48,000,000	\$48,000,000	\$0
TOTAL	\$172,490,000	\$153,660,993	\$18,829,007

- Questions:** By program, by what date does the department expect to fully disburse the remaining Coronavirus State Fiscal Recovery Fund balances? Please identify the programs for which the department anticipates surplus balances by the federal December 31, 2026 expenditure deadline relative to the allocations shown in the table above as well the reasons for the expected surplus balances. If applicable, please describe the plan for reallocating undisbursed amounts prior to the federal expenditure deadline.

The Department intends to fully expend nearly all of its SFRF allocations, most before September 2026. The Department will work with the Division of Disaster Recovery and Mitigation in the Department of Community Affairs and the Governor’s Disaster Recovery Office to ensure that any unspent funds are reallocated towards other eligible State needs and expended before the December 31, 2026 deadline.

Division of Family Development

20. **Child Care Subsidies:** The Child Care Subsidy Program assists lower-income families with paying for a portion of child care costs when they are working, participating in training programs, or enrolled in school. In May 2025, the former Commissioner of Human Services reported to the Legislative budget committees that the program would face a \$25 to \$30 million shortfall under its recommended FY 2026 \$563.8 million State appropriation, which was increased to \$565.8 million within the FY 2026 Appropriations Act. Accordingly, on August 1, 2025, the department stopped processing new applications, and increased family copayments, for the program.

Discussion Points (Cont'd)

In November 2025, the department announced that the program would reopen, due to normal attrition, to families with very low incomes, children with special needs, and experiencing homelessness. In its March 2026 “DHS in the Community” newsletter, the department stated that the Child Care Subsidy Program will open applications “for all eligible parents” under the \$581.8 million State appropriation proposed by the FY 2027 Governor’s Budget. The department later announced, on April 9, 2026, that the program had fully reopened to all eligible families.

The FY 2027 Governor’s Budget recommendation is a net increase of \$16 million over the program’s original FY 2026 State appropriation, but still \$7 to \$12 million less than what the former Commissioner indicated was necessary to eliminate the FY 2026 funding shortfall. There are no anticipated changes in program funding from other sources, and enrollment is expected to increase by 7.2 percent in FY 2027, to an average of 77,494 children per month.

The Governor’s Budget also recommends continuing two related appropriations language provisions: one, with minor changes, which permits the department to pause or terminate acceptance of program applications if insufficient funding is available; and one which provides the department with unlimited supplemental appropriation authority for the program.

- **Questions:** During FY 2026, how has the department mitigated any negative impacts of i.) eligible families excluded from the program due to paused application processing; and ii.) increased family copayments? By what amount did the increased copayments offset the estimated \$25 million to \$30 million funding shortfall in FY 2026?

On August 1, 2025, the Department closed the application process for the Child Care Assistance Program (CCAP) for most applicants, but continued to process applications for families receiving Temporary Assistance for Needy Families (TANF), Post Adoption childcare, and Child Protective Services cases.

In December 2025, siblings/new children of existing CCAP families were allowed to enroll in the program. In February 2026, applications for families in priority groups (lowest income, children with special needs/disabilities, homeless families) began to be accepted into the program.

On April 7, 2026, the CCAP application process re-opened for all eligible families. Applications will now be found online at MyNJHelps.gov.

The SFY27 proposed budget allocates \$582 million of State funding for child care assistance to ensure the full reopening of the Child Care Assistance Program application process to all eligible individuals. This includes an additional \$18 million. This will allow the program to serve up to 77,500 children.

Enrollment as of March 2026 is 66,000 children. The program was average 69-70K children per month prior to the shutdown of the application process.

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The increased copay revenue was implemented in August 2025 to reduce the original projected FY26 deficit down from over \$42 million. DHS estimated at the time that the additional copay savings would reduce that projected deficit by an additional \$12 million down to \$30 million.

- **Does the FY 2027 Governor's Budget assume changes to the program's eligibility requirements, provider rates, or any other policies? If yes, please explain.**

The SFY27 budget does not anticipate implementing any changes to program eligibility or provider rates. The Department will be conducting the federally required Market Rate Study this year. Findings will be published during the next calendar year. Currently, the provider rates are meeting at least 50% of the market rate, which is a requirement of the Child Care Development Block Grant.

- **Does the department expect that program applications may be limited at any time during FY 2027 due to a funding shortfall? If yes, how much additional funding is needed to ensure that the program remains open to all eligible applications throughout FY 2027?**

The Department does not anticipate limiting enrollment in the program based on current funding, what is proposed in SFY27 budget and current enrollment trends.

- **Would the department consider restructuring the program to reduce its overall cost and provide year-to-year stability by altering family income eligibility, family copayments, provider subsidies, or provider payment policies? Please explain why or why not, and which type(s) of restructuring are feasible.**

The Department regularly reviews its child care policies and will continue to do so to facilitate the reach of services to families in need of care. The Child Care Assistance Program is one part of the early childhood ecosystem. Any changes to CCAP or any other program, such as the State Preschool Program, Head Start, etc., impacts the ecosystem. The Department will continue to work with colleagues across State government to promote stability and growth of the early childhood system.

- **What amount of State savings could be achieved for the program if the department: implemented the maximum level of federally permissible copayments; decreased the provider subsidy rates to pre-pandemic levels; or reinstated attendance-based payments?**

Copayments are already reaching the maximum allowable level for some households. They are structured to promote fairness to all families where only the highest earners are paying the maximum, and those with lower incomes, only one child, or part-time children are paying lower amounts. Important to note is that federal regulations prohibit assessing a copayment for those families at or below 100% of the FPL.

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Decreasing the provider subsidy amount would put CCAP out of compliance with the federal provisions. Reinstating attendance-based payments would violate the current federal rule that states that payments will be based on enrollment rather than attendance, which is with the industry norm for private pay.

21. **Increased State and County SNAP Administrative Costs:** Currently, the federal government incurs 50 percent of Supplemental Nutrition Assistance Program (SNAP) administrative costs, and states and counties cover the remaining 50 percent. Under the federal “One Big Beautiful Bill Act” (OBBBA), the federal share of SNAP administrative costs will be reduced to 25 percent as of October 1, 2026, requiring New Jersey and its counties to pay 75 percent of these costs during the remainder of State FY 2027. The FY 2027 Governor’s Budget recommends an additional \$70.9 million in State funding to cover these new SNAP administrative costs during this transition year, of which \$61.0 million will be appropriated directly to counties.

- **Questions: How much of the recommended \$70.9 million in the FY 2027 Governor’s Budget will exclusively support additional administrative costs incurred by the State? What is the estimated annualized cost of the increased State and county shares, respectively, for SNAP administrative costs under OBBBA?**

Of the \$70.9 million recommended, \$9.87 million supports the additional administrative costs that will be incurred by the State. These costs include expenses for salaries of State employees, EBT costs, training related expenditures, and other support services for SNAP clients. The total annualized cost for both is currently estimated at \$94.5 million with State share being \$13.196 million and county share estimated at \$81.3 million.

- **How will the department oversee the counties’ use of the additional State funds for increased SNAP administrative costs in FY 2027? Of the \$61.0 million appropriated directly to counties in FY 2027, how much funding will each county receive? (Please disaggregate.) Will these amounts completely cover all increased SNAP administrative costs incurred by each county in FY 2027? If not, please indicate each county’s share of the increased costs.**

The Department will continue to monitor the County Social Services Agencies (CSSAs) through the SNAP Quality Control process and regular Management Evaluation reviews. Additionally, the Department has dedicated field staff representatives who provide compliance oversight and technical assistance to the County Social Service Agencies. CSSAs with identified concerns are placed on corrective action plans and are provided with additional technical support.

DHS has preliminary estimates of the amount each county will receive (see attached chart) that is tied to an allocation formula that is currently used to allocate other State SNAP funding. Since these OBBBA cost shifts go into effect October 1, 2026, DHS only requested 75% of the annual amount of funding needed. If the State were to continue absorbing the federal cost

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shift on behalf of counties in FY27, there is a total of \$23.5 million shortfall that will have to be addressed in the FY28 budget to account for the full year.

ATLANTIC	\$2,281,982
BERGEN	\$3,299,060
BURLINGTON	\$1,999,566
CAMDEN	\$5,868,842
CAPE MAY	\$614,553
CUMBERLAND	\$1,881,287
ESSEX	\$8,976,044
GLOUCESTER	\$1,335,918
HUDSON	\$7,148,892
HUNTERDON	\$314,654
MERCER	\$3,519,586
MIDDLESEX	\$4,308,655
MONMOUTH	\$2,399,029
MORRIS	\$1,573,743
OCEAN	\$3,085,775
PASSAIC	\$5,398,424
SALEM	\$618,876
SOMERSET	\$1,120,868
SUSSEX	\$347,377
UNION	\$4,279,815
WARREN	\$627,054
NJ TOTAL FOR FY26	\$61,000,000

- **Does the Executive plan to shift any additional SNAP administrative costs from the State to the counties in future fiscal years, and how is the department preparing counties for any such shifts?**

At this time, the Department is not planning to shift any additional SNAP administrative costs from the State to the counties. The State portion of SNAP administrative costs are used to perform critical and federally mandated functions related to evaluation, operations, program integrity, and other administrative functions. The role of the State has become ever increasing as we continue to adjust and modify policy in accordance with the SNAP changes dictated in OBBBA and other federal actions.

The Department has and will continue to prepare the counties for these shifts through clear communication, consistent operational and policy support, and via training that prioritizes program access, integrity, and compliance with federal rules.

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There are other provisions of OBBBA that could cause an increase in administrative costs to be borne by the State due to Payment Error Rates. DHS' Division of Family Development (DFD) is working closely in concert with the County Social Service Agencies (CSSAs) to avoid those increased costs and has [advocated for federal policy changes](#). Any changes to the amount of administrative funding to the CSSAs will be communicated with the CSSAs well in advance of any implementation.

22. **Increased State SNAP Benefit Costs:** Currently, Supplemental Nutrition Assistance Program (SNAP) benefits are fully federally funded. The federal "One Big Beautiful Bill Act" (OBBBA) requires states with SNAP payment error rates of at least six percent to cover between five and fifteen percent of SNAP benefit costs beginning on October 1, 2027 (during State FY 2028). In the first year of this requirement, states may use either their federal FY 2025 or federal FY 2026 payment error rate to determine their benefit cost-sharing levels. The new cost-sharing requirement is delayed for states with adjusted error rates of 20 percent or more in either of those years (after applying an OBBBA-specified multiplier of 1.5) until October 1, 2028 or October 1, 2029, respectively. The federal FY 2025 payment error rates will not be released until June 2026.

New Jersey's SNAP payment error rate peaked at 35.70 percent in federal FY 2023, which the department attributed to a federal policy change in Quality Control reviews that classified households as wholly ineligible for SNAP benefits when procedural deficiencies were identified. The State's payment error rate then declined to 14.33 percent in federal FY 2024.

- **Questions: To what factors does the department attribute the State's success in lowering the payment error rate between federal FY 2023 and federal FY 2024?**

In FFY 2023 and 2024, USDA made substantive changes to the FNS 310 Handbook, the federal manual that dictates how SNAP Quality Control (QC) reviews are conducted, resulting in an inflated payment error rate (PER) for New Jersey for those years. New Jersey submitted written objections to USDA on June 1, 2023, regarding those changes and their effect on the PER, outlining how they did not align with federal regulations and legislative intent. We requested that the USDA withhold publication of the PER, dismiss claims established against households based on erroneous QC findings, refund payments to households, and hold states harmless for any errors incurred due to this. However, no response was received from FNS.

In December of 2024, the USDA issued a QC policy memo with a retroactive policy reversal for FFY24. If that policy reversal had been applied to New Jersey's QC cases for FFY2023, our PER would have decreased from 35.70% to 4.91%. Although the policy reversal did apply retroactively to FFY2024, it was incorrectly applied, inflating our PER to 14.33% when it should have been 5.65%. The lowering of the PER is solely due to the USDA incorrectly applying the policy reversal to some but not all of the affected cases in FY2024.

The Department notes that the PER is a fundamentally flawed metric for the purposes proposed by HR1. See: [Governor Sherrill and Human Services Commissioner Cha Call for Elimination of Trump Administration's Flawed SNAP Cost Shifts](#).

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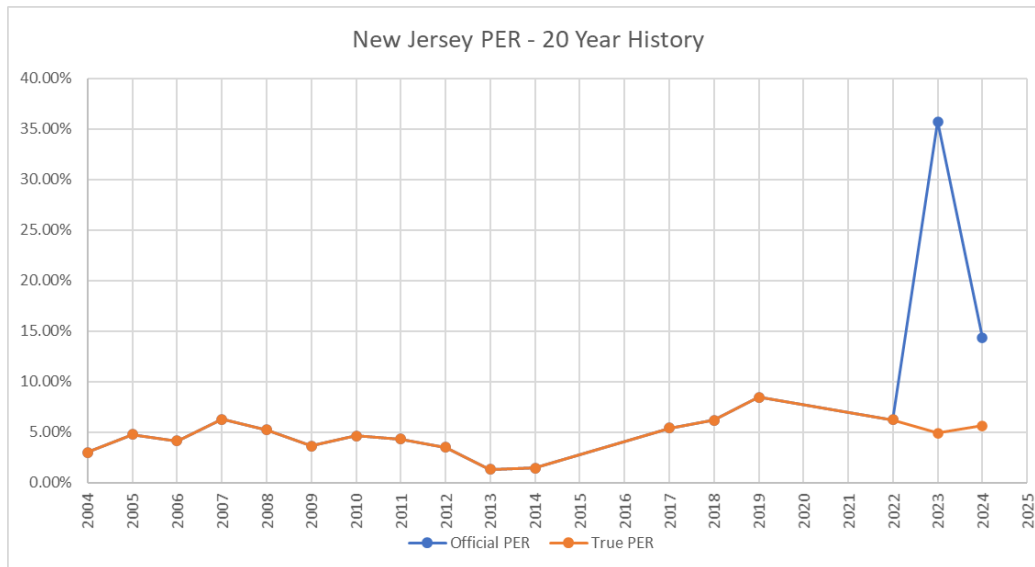


Figure: New Jersey payment error rates over time demonstrate the substantive impact of the 310 Handbook changes that implemented the inclusion of administrative errors in the PER. Under the revised December 2024 policy memo, NJ’s 2023 true PER would be 4.91% and the 2024 true PER would be 5.65%.

- What is the State’s estimated SNAP payment error rate in federal FY 2025? Does the department expect that the payment error rate will be reduced below six percent in federal FY 2025 or federal FY 2026? Why or why not? If not, what initiatives, at what additional State costs, would be needed to achieve this target?**

The PER for FY 2025 is estimated to close at just below 6%. The State-reported PER, before regression analysis, is 6.23%. We are in the process of attempting to calculate how regression will affect our official PER for FY 2025. However, the USDA has not completed their re-review of state QC findings by the required deadline of March 31, 2026, thereby delaying our analysis.

For FY 2026, New Jersey is currently at 2.60%, which is in alignment with the last quarter of FY 2025. Other policy changes associated with HR1 including ABAWD changes and Standard Utility Allowance (SUA) changes may negatively affect our PER for FY 2026 moving forward. Moreover, potential changes being proposed for the pending federal Farm Bill, such as removing the SNAP QC thresholds and elimination of Broad-Based Categorical Eligibility, may further inflate the PER.

Although the Department and county partners will continue to do our best to train over 4,000 county social services agencies’ employees on the new policies, the lack of clear and complete federal guidance has made it difficult or impossible for us to consistently implement HR1 optimally. Current PER reduction initiatives include: targeted management evaluation reviews; monthly communication and analysis of active errors with CSSA directors and other key county staff; creation of a corrective action dashboard; designating targeted counties to check in weekly, to meet monthly on corrective action initiatives, and to fulfill a county corrective

Discussion Points (Cont'd)

action plan; quarterly PER-focused meetings to review statistics, trends, and case scenarios; PER updates at Quality Control Liaison meetings; analysis and breakdown of federal Quality Control reports; re-review of all active errors by our Corrective Action team including a root cause analysis and trend identification; monthly Error Review Analysis meetings to discuss errors, trends, and corrective action jointly with multiple operational teams; and ad-hoc meetings with county staff to breakdown PER, analysis, and root causes.

We are in the development stage of other initiatives including: creation of a PER webinar based of the USDA's Keys to Payment Accuracy; creation of a training that compiles case scenarios from Quarterly PER meetings; creating a PER predictive model that can determine cases likely to be future payment errors at initial certification; and recreating the USDA regression analysis to fully understand how each error, incomplete, and disagree affects the official PER.

- **What role will county governments play in lowering the State's SNAP payment error rate? Are there any plans to incentivize county governments to help the State achieve a payment error rate under six percent, such as tying a portion of State support for counties' increased SNAP administrative costs to such efforts? Please explain.**

County Social Service Agencies (CSSAs) play a critical role in lowering the State's SNAP PER. They are the target of most of our analyses and trainings. Currently we are discussing options of how to distribute a potential cost shift to the CSSAs based on county-level PER and performance measures. Tying County performance to the State's support for increased SNAP administrative costs may be a consideration.

- **Would the department consider limiting SNAP eligibility, or terminating the \$95 SNAP minimum benefit program, to help cover any increased State share of SNAP benefit costs in future fiscal years? Please explain.**

The Governor's budget fully funds the \$95 SNAP minimum benefit for FY 2027. The Department cannot speculate on appropriations in future fiscal years.

Division of Aging Services

23. **Pharmaceutical Assistance Programs Trends:** The federal Inflation Reduction Act of 2022, enacted in August 2022, is intended to lower drug costs and stabilize prescription drug coverage premiums under the Medicare program. For example, the law capped Medicare out-of-pocket prescription drug costs at \$2,000 per beneficiary starting in 2025 and authorized Medicare negotiated drug pricing that was initiated in January 2026. Because Medicare-eligible Pharmaceutical Assistance to the Aged and Disabled (PAAD) and Senior Gold beneficiaries are required to enroll in a Medicare Part D Prescription Drug Plan — and because the PAAD and Senior Gold programs help pay for beneficiaries' Medicare Part D out-of-pocket cost-sharing — any reductions in Medicare drug costs should reduce PAAD and Senior Gold program expenditures.

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The FY 2027 Governor's Budget recommends reducing State grants-in-aid appropriations for PAAD by \$32.6 million (63 percent), to \$19.0 million. The State grants-in-aid appropriation for Senior Gold is recommended to decrease by \$0.5 million (15 percent), to \$3.0 million — which includes \$2.9 million in administrative costs. Notably, evaluation data show that both programs are now projected to spend significantly less in FY 2026 than what the FY 2026 Governor's Budget originally projected: \$30.7 million (53 percent) less for PAAD and \$483,000 (80 percent) less for Senior Gold.

Evaluation data from the FY 2027 Governor's Budget also show significant reductions in FY 2026 average costs per prescription and average prescriptions per member for drugs covered by the two programs as compared to the original FY 2026 projections. The Governor's Budget projects these trends to largely continue in FY 2027, with modest enrollment growth offsetting some effects of the lower costs and utilization on program expenditures.

Available information also indicates that Boston Consulting Group has been assisting the division with reviewing program design and funding sustainability for PAAD and Senior Gold. This effort includes comparing New Jersey's approach to peer states and developing recommendations to ensure the programs' fiscal sustainability while maintaining affordability and access for beneficiaries.

- **Questions:** What accounts for the significant decrease in PAAD and Senior Gold net annual costs between the Executive's original FY 2026 projection and the revised FY 2026 estimate? If similar factors continue affecting program trends, are FY 2027 program costs overestimated, and can State appropriations be further reduced?
- How has the federal Inflation Reduction Act of 2022 interacted with the PAAD and Senior Gold programs? Did the FY 2026 Governor's Budget fully anticipate how this federal law would affect expenditures for the two programs?
- When will Boston Consulting Group's review be completed? What specific changes in PAAD or Senior Gold have been implemented, or are anticipated, due to this review? What portions of the programs' lower net costs in FY 2026 — and recommended FY 2027 State appropriation decreases — are attributed to any initiatives or program changes resulting from this review? (If any, please identify the specific initiatives or changes.)
- What other initiatives, program changes, or specific trend factors are contributing to the lower net costs for PAAD and Senior Gold in FY 2026 and the recommended FY 2027 State appropriation decreases for the two programs?

The decrease in PAAD costs compared with original projections is driven by both the federal Inflation Reduction Act (IRA) and lower-than-expected Part D premium levels. PAAD prescription costs have fallen even as enrollment has grown. Three IRA changes explain most of this reduction:

- The \$2,000 annual out-of-pocket cap significantly reduced cost-sharing for high-cost Part D beneficiaries, lowering the share PAAD must cover.
- The redesign of the catastrophic phase shifted a greater portion of high-cost drug spending from PAAD to Medicare and Part D plans. Although these changes took

Discussion Points (Cont'd)

effect in January 2025, their impact became more evident during FY26 as cost and utilization patterns diverged from historical trends. This transition helps explain the variance between projected and actual spending.

- The expansion of the Low-Income Subsidy Program increased the number of beneficiaries receiving full federal assistance, reducing both utilization and cost-sharing paid by PAAD.

These shifts lowered both the volume of prescriptions billed to PAAD and the average cost per prescription, driving down expenditures in FY26 and into FY27.

In addition, original FY26 estimates assumed higher Part D premium growth than ultimately occurred. Earlier projections expected premiums to rise from \$15.40 in FY24 to \$22.44 in FY25 and remain around \$22.65 in FY26. Actual FY25 premiums were \$19.04, lower than projections, yielding an estimated \$5.5 million in FY26 savings. These lower premiums, combined with IRA-related changes, explain the FY26 underspending and the adjustments reflected in the revised FY26 estimate and FY27 projections. No further reductions to the published FY27 budget are anticipated at this time. The proposed FY27 budget also includes no programmatic or benefit changes to PAAD or Senior Gold.

The Division of Aging Services engaged the Boston Consulting Group to conduct a comprehensive review of the PAAD program, including its manufacturer rebate structure, in response to an increase in manufacturers ending their participation in recent years. The analysis is currently under review. Findings will be used to inform planning for FY28 and future fiscal years.

Division of Developmental Disabilities

24. **Community Programs Cost Containment:** The Division of Developmental Disabilities administers two Medicaid waiver programs, the Community Care Program (CCP) and the Supports Program, that provide home- and community-based services to clients based on their assessed needs and individualized budgets. The CCP primarily serves clients who live in State-licensed residential settings, while the Supports Program primarily serves clients living with family members or in their own homes. Individuals determined eligible for division services can enroll and begin receiving services in the Supports Program at any time, but the CCP provides more extensive individual services and supports and has a waiting list. The Executive anticipates that 4,306 individuals will be on the CCP priority waiting list in FY 2027.

The FY 2027 Governor's Budget projects total State and federal costs of \$3.106 billion for CCP and \$897 million for the Supports Program, which reflects a combined \$294 million increase from all sources when compared to revised FY 2026 expenditures. The two programs' projected rate of growth, however, is lower than in previous fiscal years. The combined average costs per client for CCP and the Supports Program are projected to increase by 2.4 percent between FY 2026 and FY 2027, compared to increases of 3.1 percent between FY 2025 and FY 2026 and 4.8 percent between FY 2024 and FY 2025.

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In its FY 2026 OLS Discussion Points responses, the department indicated that several cost containment measures would limit spending growth during FY 2026, but the department only specifically identified an initiative to reduce the number of individuals annually reached on the Priority Waiting List from 400 to 318.

- **Questions:** To date, what cost containment initiatives have been implemented for the Community Care Program and the Supports Program in FY 2026, including reductions in the number of individuals reached on the Priority Waiting List or any other initiatives?
- What additional cost containment initiatives are assumed within the FY 2027 Governor's Budget? What State and federal savings are assumed, respectively, for each of these initiatives? Does the department anticipate that growth in the average cost per client for both programs will continue to decline into FY 2028 due to these initiatives?
- Have any cost containment measures implemented in FY 2026, or planned for FY 2027, involved reducing services or benefits for enrollees in CCP or the Supports Program?
- How many people are currently on the Priority Waiting List and the General Waiting list for CCP services? In FY 2026 and anticipated in FY 2027, how many individuals on the Priority List will be reached to receive CCP services?

As of April 14, 2026, there are 3,542 individuals on the Priority Waiting List (PWL) and 1,970 individuals on the General Waiting List (GWL).

The FY26 budget established a new restriction on the number of new, non-emergent housing vouchers issued to eligible DDD consumers. The Division reduced the number of housing vouchers by 100, to 115 annually, which it projects will save \$1 million in FY26. The Division retains the ability to assign housing vouchers to persons who will be homeless within 30 days, consistent with the Division's regulations. The Division's FY26 trend was also adjusted to contain growth of enrollment on the Community Care Program (CCP). The FY26 budget would enable DDD to reach 318 individuals on the CCP priority waiting list (compared to 400 in the prior year). This is estimated to reduce spending by \$12.6 million (\$6.3 million State/\$6.3 million federal). There are no new cost containment initiatives proposed in the FY27 budget. However, the FY27 proposed budget continues the FY26 containment strategies described above.

DDD has not reduced or eliminated any waiver services in FY26 and has not proposed to do so in FY27. Please note that, pursuant to federal requirements, any reduction of benefits would be subject to individual appeals, which would detract or delay the realization of any savings if the State pursued savings through such means.

The Division maintains longstanding policies that function as cost-containment mechanisms across enrollment, rate setting, and budget assignment. These policies include, but are not limited to:

Discussion Points (Cont'd)

- Verifying that DDD applicants meet all eligibility requirements, including age criteria, documented intellectual or developmental disability, and the presence of three or more substantial functional limitations;
- Applying a Reasonable and Customary wage range within DDD's self-directed programs to ensure that wages for comparable work are funded consistently. For example, aligning compensation for self-directed workers with average wages of direct support professionals employed by provider agencies; and
- Assigning up-to budget amounts based on individually assessed needs, which establish spending caps for each consumer's services.

The primary drivers of growth in the average cost per client include enrollment growth, increases in client utilization of their individual budgets, and provider rate increases. There are no new DDD provider rate increases in the proposed FY27 budget, and the cost containment strategies implemented in FY26 are expected to aid in slowing the average cost per client growth.

25. **Oversight of Group Homes:** During May 2025, NorthJersey.com published a series of investigative articles, entitled *Hidden at Home*, regarding patterns of neglect, abuse, and deaths within New Jersey's group homes for individuals with developmental disabilities. In the wake of the series and the public conversations that followed, three new laws were enacted to strengthen oversight of developmental disability service providers:

- P.L.2025, c.280, authorizing the department to impose financial penalties on providers for instances of abuse, neglect (including "administrative neglect" for failing to protect clients' health and safety), exploitation, or other licensing violations, and establishing the Residential Facility Quality of Care Improvement Fund to collect and reallocate any penalty revenues to quality improvement and oversight activities (effective August 2026).
- P.L.2025, c.281, transferring responsibility for investigating alleged abuse or neglect of individuals with developmental disabilities who are ages 18-21 and receiving State-funded services from the Department of Human Services to the Department of Children and Families (effective February 2027).
- P.L.2025, c.282, which creates a temporary Disability Mortality and Abuse Prevention Advisory Committee to review cases of abuse, neglect, and exploitation of adults with developmental disabilities, evaluate the State's responses, and recommend improvements in preventing, investigating, and addressing such cases (effective April 2026).
- **Questions:** To date, what steps has the division taken to implement or prepare for each of these new statutory requirements?
- What additional steps is the division taking to prevent or address cases of abuse, neglect, or exploitation during FY 2026 and FY 2027?

Discussion Points (Cont'd)

- **During FY 2024, FY 2025, and FY 2026 (to date), how many substantiated cases of abuse, neglect, or exploitation occurred among adults with developmental disabilities receiving services from group homes or other community-based providers funded by the division? Please disaggregate by fiscal year.**
- **During FY 2024, FY 2025, and FY 2026 (to date), how many community-based service providers were investigated for allegations of abuse, neglect, or exploitation? Please disaggregate by fiscal year, and indicate how many of each year's investigations resulted in substantiated findings. For substantiated findings, please also provide summary data regarding the average fines and other penalties imposed on providers, by fiscal year.**

The Department appreciates the Legislature's efforts to strengthen the State's authority to hold providers accountable to standards that protect individuals with intellectual and developmental disabilities (IDD). Since enactment, the Department has taken concrete steps to implement the laws. A public call for letters of interest to serve on the Disability Mortality and Abuse Prevention Advisory Committee was completed, and appointments were made in April (see: New Jersey Human Services Announces Appointments to Disability Mortality and Abuse Prevention Advisory Committee). The Department is also preparing to procure an expert consultant to support the Advisory Committee's research and its review of mortality, abuse, and neglect cases. P.L.2025, c.280 takes effect six months after enactment, so no fines or penalties have yet been issued.

The Department aims to ensure that individuals with intellectual and developmental disabilities are safe, respected, and well supported. All direct service professionals (DSPs) serving DDD consumers, adults with intellectual and developmental disabilities, are subject to a comprehensive background check prior to employment which includes a federal and State criminal history background check via fingerprinting, a check against the Central Registry of Offenders Against Individuals with Developmental Disabilities, a check against the Child Abuse Registry, a national sex offender registry check, pre-employment drug testing, and random drug testing during employment. These requirements are overseen and tracked by the Office of Program Integrity and Accountability's (OPIA) Employment Controls and Compliance Unit (ECCU).

DDD also maintains rigorous training requirements to prevent abuse, neglect, and exploitation. DSPs must complete approximately 60 hours of training, which represents a recent doubling of the previous requirement, including coursework on life-threatening emergencies, incident reporting, medication administration, positive behavioral supports, prevention of abuse and neglect, crisis intervention, understanding and preventing life threatening health conditions, professionalism, working with families, safety protocols, trauma-informed care, dual diagnosis, and person-specific needs.

Beyond training, DDD provides a broad set of supports aimed at preventing abuse and neglect and improving quality. These include a 24-hour abuse and neglect reporting hotline; specialized Resource Teams for behavioral, medical, and swallowing needs; statewide health and safety initiatives; educational bulletins; crisis prevention and response services (START NJ); and tools such as walkaway-prevention resources and medical tracking sheets.

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Within the Department’s Office of Program Integrity and Accountability (OPIA), the Field Safety and Services Unit and Research and Prevention team conducts continuous oversight and systemic quality improvement. FSSU performs unannounced visits to licensed homes and apartments. Over 3,800 sites and nearly 17,000 individual assessments were conducted in 2025 to help ensure environments remain safe and free from abuse and neglect. The Research and Prevention team analyzes data and emerging trends, develops evidence-informed recommendations for providers, and issues educational materials on topics such as safe hiring practices, exploitation prevention, and transportation safety.

The Department maintains a zero-tolerance approach to abuse, neglect, and exploitation. All allegations are reviewed by OPIA’s Critical Incident Management Unit (CIMU) and categorized under [Administrative Order No. 2:05](#). Providers investigate lower-harm incidents under CIMU oversight, while more serious cases are referred to the DHS Office of Investigations. Findings are used to drive corrective actions, retraining, and policy improvements. When concerns indicate potential licensing violations, the Office of Licensing intervenes to take appropriate action. Referrals to other State entities are made when appropriate.

Substantiated Allegations of Abuse, Neglect and Exploitation (By Fiscal Year)

	FY24	FY25	FY26 (As of 4/15/2026)	Description
Abuse	534	592	257	Abuse includes substantiated allegations of abuse with major, moderate and minor injury, sexual abuse and verbal/ psychological abuse
Neglect	1,175	1,183	244	Neglect includes substantiated allegations of neglect with major, moderate and minor injury
Exploitation	47	37	19	Exploitation includes substantiated allegations of exploitation over \$100, under \$100, and personal exploitation

Count of DDD Provider Agencies Involved in Investigations of Abuse, Neglect & Exploitation (By fiscal year)

	FY24	FY25	FY26 (As of 4/15/26)
Total Number of DDD Provider Agencies	700	700	800
Number of provider agencies involved in abuse, neglect or exploitation investigations	238	237	208
Number of provider agencies with one or more substantiated allegation	104	150	71

Discussion Points (Cont'd)

Division of Mental Health and Addiction Services

26. **Opioid Settlement Funds:** The State and local governments expect to receive over \$1.1 billion in settlement payments from producers and distributors of opioid-based pharmaceuticals related to their alleged liability for the nationwide opioid epidemic. According to the State's 2025 Annual Opioid Abatement Report, the Opioid Recovery and Remediation Fund — which holds the State's share of these funds — had received \$200.9 million in abatement funds as of October 1, 2025, with \$119.3 million of these funds still unexpended.

The Division of Mental Health and Addiction Services directs the disbursement and allocation of these funds in consultation with the Opioid Recovery and Remediation Advisory Council. The division also coordinates with the State Comptroller and the Attorney General to monitor local governments' use of these funds. In June 2025, the Council released its inaugural Strategic Plan, a five-year roadmap that guides disbursement of these funds and emphasizes four key investment areas (housing, harm reduction, treatment, and coordinated wraparound services) along with a plan for monitoring and evaluating the use of funds.

In July 2025, the Office of the State Comptroller released a report concerning the Township of Irvington's mismanagement of over \$632,000 in opioid settlement funds and outlined several recommendations, including: clearly defining "evidence-based" and "evidence-informed" practices for local governments; providing regular training to counties and municipalities on opioid fund use; creating a formal process for local governments to seek advisory opinions on proposed fund uses; and providing additional guidance on the use of opioid funds to local governments through the Opioid Recovery and Remediation Advisory Council.

- **Questions:** To what extent is the State's own share of settlement funds supporting statewide initiatives versus activities focused on specific counties or regions? Please disaggregate the State's uses of its own funds by county or other geography (as appropriate) and fiscal year. How are the funds being used to support communities most affected by the overdose crisis and reduce racial disparities in overdose deaths?

The State's share of opioid settlement funds has been used predominantly to support statewide initiatives rather than county- or region-specific programs to date. In accordance with the terms of the settlements as well as the advice of the expert Advisory Council (including through the Advisory Council's specific recommendations and overall [New Jersey Opioid Recovery and Remediation Advisory Council Strategic Plan](#)), these investments focus on building broad, statewide infrastructure, including expanding harm reduction services (including to facilitate naloxone distribution), enhancing reach of treatment services (including increasing access to medication for opioid use disorder), providing coordinated wraparound supports, and providing supportive housing.

The approach is intended to ensure a consistent baseline of services across all regions while prioritizing populations most affected by the overdose crisis through expanded access, outreach, and service availability in high-need communities. At present, the primary exception to this statewide focus is the Housing Continuum Expansion program, which includes a targeted pilot initiative in Essex County to provide supportive housing for individuals with

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substance use disorders. Essex County was prioritized for the pilot as Essex County has had the most unintentional overdose deaths in recent years (see [Department of Health's New Jersey SUDORS Overdose Mortality Data Explorer](#)). More broadly, equity considerations are incorporated into statewide program design—such as prioritizing access in underserved areas and supporting culturally competent services—to help address racial disparities in overdose deaths, even though funding itself is not widely disaggregated or allocated by specific county or locality.

Note: Under the settlements, the State share of funds is roughly half and the other half flows directly to participating counties and localities. Details of how those jurisdictions have used their share of funds can be found here: <https://www.nj.gov/opioidfunds/important-documents/reports/>.

- **Beyond program spending identified on the NJ State-Level Opioid Settlement Dashboard, what additional programs, with anticipated funding amounts (by program), does the department anticipate supporting with the State's settlement funds in FY 2026 and FY 2027, respectively? Please also identify the State entity responsible for administering each additional program, where applicable.**

Due to the payment schedules of various settlements, interagency MOUs to move funding, and varying timeframes for grant awards to eligible entities for the specified activities, the Department does not maintain a breakdown the spending on the State fiscal year basis. The Department does track and report spending on the timeframes set in the settlements, and those annual reports issued each October 1 are available here: <https://www.nj.gov/opioidfunds/important-documents/reports/>.

Recommendations of the Opioid Recovery and Remediation Advisory Council adopted and funded starting in 2025:

Discussion Points (Cont'd)

Proposal Title	Annual Funding Level	Funding Duration	Proposal Total
Emergency Investments:			
Bridge Access to Community-Based Substance Use Treatment (SUD)	\$4,300,000	<1 Year	\$4,300,000
Maternal Wraparound Program (M-WRAP)	\$700,000	2.5 Years	\$700,000
Peers in SUD Residential Treatment Settings	\$1,300,000	1 Year	\$1,300,000
Recovery Management Check-Up	\$1,500,000	2.5 Years	\$3,500,000
New Programs:			
Capital Investments for SUD Treatment Providers	\$8,000,000	1 Year	\$8,000,000
Family and Community Support Group Capacity Grants	\$2,000,000 (Year 1) to \$5,000,000 (Year 3)	3 Years	\$12,000,000
Perinatal Centers of Excellence	\$1,614,570 (Year 1) \$4,614,570 (Year 2)	2 Years	\$6,229,140
Continuation and Expansion Programs:			
Harm Reduction Continuation and Service Expansion	~\$21,350,000 (Year 1) to ~\$22,65,000 (Year 5)	5.5 Years	\$118,681,215
Housing Continuum Expansion	\$3,500,000	3 Years	\$10,500,000
NJ Keeping Families Together (KFT) Expansion	\$1,620,000	3 Years	\$4,860,000
Bridge Access to Community-Based Substance Use Treatment (SUD)	\$15,000,000	1 Year	\$15,000,000
Strategic Planning and Evaluation:			
Monitoring and Evaluation of State-level Opioid Recovery and Remediation Fund Programs	\$1,000,000	3 Years	\$3,000,000
Study on State-level Administrative Barriers to Care	\$250,000	One-Time	\$250,000
Total Funding 2025	\$189,389,140		

Recommendations of the Opioid Recovery and Remediation Advisory Council adopted and funded starting in 2024:

Discussion Points (Cont'd)

Proposal Title	Annual Funding Level	Funding Duration	Proposal Total
Emergency Investments:			
Opioid Crisis Emergency Response (2023)	\$500,000	One-Time	\$500,000
Opioid Crisis Emergency Response (2024)	\$500,000	One-Time	\$500,000
New Programs:			
Rapid Referral Platform for Low Threshold Medication Access for Opioid Use Disorder	\$6,500,000	3 years	\$19,500,000
Housing Options for Individuals with Substance Use Disorder (SUD)	\$5,000,000 (Year 1) \$6,000,000 (Years 2-3)	3 years	\$17,000,000
Legal Services for Individuals with SUD	\$6,750,000	3 years	\$20,250,000
Continuation and Expansion Programs:			
Community Peer Recovery Centers Expansion	\$5,835,000	3 years	\$17,505,000
Harm Reduction Expansion Activities	\$12,000,000	2 years	\$24,000,000
Mobile Medication for Addiction Treatment (MAT) Expansion	\$4,525,000 (Year 1) \$2,250,000 (Years 2-3)	3 years	\$9,025,000
NJ Keeping Families Together (KFT) Expansion	\$2,700,000	3 years	\$8,100,000
Youth Substance Use Initiative Expansion	\$1,680,000	3 years	\$5,040,000
Strategic Planning and Evaluation:			
Opioid Recovery and Remediation Advisory Council Strategic Plan (2023)	\$291,800	One-Time	\$291,800
Total Funding 2024			\$121,711,800

Further details about each program is available in recommendation reports from the New Jersey Opioid Recovery and Remediation Advisory Council: <https://www.nj.gov/opioidfunds/>.

In FY26 and FY27, programs above are administered by the Department of Human Services, except:

- Harm Reduction Center (HRC) Continuation and Service Expansion
 - Lead agency: Department of Health
- Perinatal Care of Excellence
 - Lead agency: Department of Health
- Keeping Families Together (KFT) Expansion
 - Lead agency: Department of Children and Families

Discussion Points (Cont'd)

In addition to the above, the State is implementing the \$45 million dedicated across four hospital systems in accordance with the current Appropriations Act and the terms of the opioid settlement agreements.

- **To date, what steps have been taken to implement the Strategic Plan's monitoring and evaluation framework for the use of settlement funds? Please describe the grantee- and program-specific data collected from funding recipients, and indicate whether the data will appear on the State-Level Opioid Settlement Dashboard. If these data will not be available on the dashboard, please explain why.**

In fall 2025, the Advisory Council recommended and State adopted \$3 million over 3 years to support monitoring and evaluation. Building upon ongoing program-specific process and outcomes metrics and program oversight, funding this framework aims to help the State holistically consider the overall impact of settlement-funded projects in addressing the opioid crisis.

The Department has begun to operationalize the Advisory Council's Strategic Plan's monitoring and evaluation framework by building infrastructure for evaluation, collecting standardized data from grantees, and launching the State-level Opioid Settlement Dashboard.

State agencies collect data about program activity and output metrics from grantees, such as:

- Number of individuals served
- Number of harm reduction supplies distributed (e.g. naloxone, fentanyl/xylazine test strips, wound care kits, and hygiene kits)
- Number of training/education sessions
- Number of referrals to treatment
- Number of services provided/encounters
- Number of individuals linked to case management
- Number of individuals placed in permanent housing
- Number of recovery support meetings

Forthcoming updates to the State-level dashboard include adding initiative-specific data collected from grantees. The data is currently available in the State's annual report issued each October 1 here: [Reports](#).

- **Please describe any misuses of the State's own share of settlement funds identified by the department in FY 2026 through implementation of oversight measures.**

To date, there have been no identified cases of misuse of New Jersey's State-controlled share of opioid settlement funds.

- **Which of the State Comptroller's recommendations above has the department implemented? How does the department currently monitor local governments' use of settlement funds, and how does the department's monitoring role differ from the State Comptroller and the Attorney General? By fiscal year and locality, how many fund-**

Discussion Points (Cont'd)

mismanagement cases has the department investigated, how many instances of misuse have been identified, and what is the status of the settlement funds in each case?

The Department's current monitoring role is administrative and reporting-focused: it gathers expenditure and program data submitted by local governments, compiles this information, and makes it publicly available on the opioid settlement website. It does not conduct investigations into fund mismanagement, which distinguishes its roles from those of the State Comptroller and of the Attorney General.

27. **Opioid Recovery and Remediation Funds for Hospitals:** The FY 2026 Appropriations Act appropriated \$45 million from the Opioid Recovery and Remediation Fund to the department for the purpose of providing necessary care and treatment for victims of opioid-related health issues at four of the State's hospital systems: Hackensack Meridian Health (\$10 million), RWJBarnabas Health (\$15 million), Cooper University Health Care (\$15 million), and Atlantic Health System (\$5 million). The FY 2027 Governor's Budget does not recommend continuing this appropriation.

- **Questions: To date, and by amount, how much of the \$45 million FY 2026 appropriation has been distributed to each hospital system?**

As of April 2026, the funds are yet to be distributed.

- **Please describe each hospital system's anticipated use of these funds, including types of services provided and numbers of patients served. Does the FY 2027 Governor's Budget anticipate supporting these initiatives through other State funding?**

The Governor's FY27 budget does not propose continuing the below initiatives.

While final awards are pending, proposals shared by the hospitals included these program areas:

Atlantic Health System

- Atlantic's Opioid Patient Safety Initiative Expansion Program
 - This initiative expands the Opioid Patient Safety Initiative into a comprehensive, prevention-driven program aimed at reducing opioid exposure, improving safer pain management, strengthening behavioral health integration, and broadening harm-reduction services across its hospitals and outpatient settings. The expansion aims to scale clinician training, patient education, naloxone distribution, fentanyl testing, and data-driven prescribing oversight while embedding mental health and substance use services into primary care. The initiative is expected to reach over 155,000 additional patients annually, train 5,600 clinicians, and achieve major reductions in high-risk prescribing and opioid dosing, with immediate implementation readiness and long-term sustainability through integrated clinical operations and community partnerships.
- Other Activities

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- Public awareness campaign (collaboration with Partnership for a Drug-Free New Jersey)
- Peer recovery services (collaboration with Prevention is Key)
- AHS will engage an analytics consulting firm to assist in building the required tools, reports, dashboards, and other technical assets required to implement the Expansion Program.

Cooper University Health Care

- Center for Healing Housing Continuum Program
 - Cooper's Center for Healing proposes a Housing Continuum Program to expand safe, stable, and supportive housing for individuals with substance use disorders (SUDs) who are experiencing homelessness across Camden and Cape May Counties. The initiative combines emergency shelter access, Housing First-based long-term vouchers, and three new harm-reduction-focused sober living/supportive residences tailored to women, pregnant/parenting individuals, and patients in Cape May. Integrated with Cooper's extensive evidence-based addiction services, mobile teams, and care navigation infrastructure, the program aims to remove barriers to shelter entry, connect patients to treatment, and stabilize health outcomes. The proposal is expected to serve more than 565 individuals annually, offering emergency beds, housing vouchers for up to 40 families, and long-term supportive housing. Designed as a new initiative that builds on existing regional capacity, the program aligns with New Jersey's opioid settlement priorities and employs evidence-based models such as Housing First, recovery housing, and intensive case management to reduce overdose risk, improve treatment engagement, and decrease emergency utilization.
- Center for Healing/Harm Reduction Services program
 - Cooper's Center for Healing (CFH) proposes an expansion of harm reduction and toxicosurveillance services across Southern New Jersey through strengthened partnerships with Camden AHEC, Seeds of Hope, and the South Jersey AIDS Alliance. The initiative will increase access to overdose prevention education, naloxone, sterile-use supplies, HIV/HCV testing, and linkage to evidence-based SUD treatment within Camden and Cape May Counties—regions with high overdose burden and significant service gaps. The program also expands CFH's toxicosurveillance capacity to monitor the evolving drug supply and deliver real-time clinical guidance statewide. Building on CFH's nationally recognized, trauma-informed, evidence-based treatment model, the initiative is expected to reach 550+ unduplicated individuals annually, with additional system-wide impact via enhanced clinical responses informed by drug-supply surveillance. This proposal aligns with New Jersey's Harm Reduction and Overdose Prevention strategic priorities and will be implemented through community partnerships, low-barrier service delivery, and targeted analytics. CFH requests one year of settlement funding to launch the expanded partnerships and surveillance capacity, with sustainability pursued through state, federal, and private funding sources.

Discussion Points (Cont'd)

- Center for Healing – PATH (Providing Access to Treatment and Hope)
 - This initiative will support a new Camden drop-in center providing SUD treatment and wrap around services, expand inventory of SUD medications available and care of admitted patients at Cooper Camden Hospital, expand SUD treatment access in Cape May County, expand navigator support for patients with SUDs in Skilled Nursing Facilities, expand mobile SUD treatment and mental health services, integrate virtual nursing into the ED, integrate telemedicine into low barrier community sites, and expand integrated complex pain treatment and research.
- Center for Healing Whole-person Recovery Access Program (WRAP)
 - This initiative builds on CFH's existing, evidence-based addiction treatment system to address social barriers faced by patients with opioid and other substance use disorders - housing, transportation, food insecurity, stigma, re-entry challenges, rural access, and workforce shortages. CFH plans to work with Center for Family Services and Cape CARES as subrecipients to provide programming and staffing services at the new Camden drop-in center and to expand the existing navigation and drop-in center services offered in Cape May County.

Hackensack Meridian Health

- HMH Carrier Behavioral Health
 - This initiative outlines a comprehensive expansion of opioid use disorder (OUD) and co-occurring substance use and mental health (SUD/MH) services in Bergen County. The plan strengthens the full continuum of care—from crisis response to long-term recovery—by increasing access to treatment, enhancing coordination, and integrating mental health and physical health services.
 - Key components include expanding withdrawal management, residential treatment, and medication-assisted treatment (MAT/MOUD) services; enlarging the EmPATH (Emergency Psychiatric Assessment, Treatment and Healing) crisis unit for rapid stabilization; and deploying Peer Recovery Specialists and multidisciplinary teams across hospital emergency departments to engage individuals immediately following overdose or withdrawal.
 - To meet the needs of more than 16,000 OUD-related emergency department visits annually, the plan increases the availability of addiction psychiatrists and addiction medicine providers across emergency, primary care, and community settings, supported by telehealth and bridging clinics. Mental health care will be fully integrated using evidence-based therapies to address co-occurring conditions.
 - The initiative also extends support beyond clinical settings through post-discharge case management, naloxone distribution, training for healthcare and community members, partnerships with community coalitions, and assistance with transportation and housing. Enhanced internal training and expanded specialist support in call centers will further strengthen system-wide response. Collectively, these efforts aim to improve outcomes, reduce overdose risk, and

Discussion Points (Cont'd)

build lasting recovery pathways for individuals with OUD and co-occurring SUD/MH conditions.

RWJ Barnabas Health

- Harm Reduction Program
 - This program will increase the availability and distribution of naloxone care bags which will include naloxone kits, personal care and hygiene items, xylazine test strips, gloves, and a card listing Harm Reduction Centers throughout the state. Additionally, the program will work to install naloxone vending machines throughout the state and is expected to reach 5,000 unduplicated individuals annually.
- Office-Based Addiction Treatment (OBAT)
 - This program expands evidence-based care for opioid use disorder (OUD) and other substance use disorders within primary and ambulatory care settings. Referred through the Peer Recovery Program, patients gain streamlined access to telehealth, low-barrier MOUD initiation, and wound care. A coordinated team—an Addiction Physician, Recovery Coordinator, Program Manager, and Patient Navigators—provides medical treatment, MOUD management, and support for social drivers of health. Patient Navigators offer ongoing follow-up for seven weeks to ensure connection to needed services. OBAT ensures seamless continuity of care for patients who start MOUD in acute care, improving engagement, retention, and recovery outcomes. This program is expected to serve 780 unduplicated clients in the first year, 1,560 unduplicated new clients in the second year, and 3,900 unduplicated new clients in the third year.
- Peer Recovery Program (PRP)
 - This initiative provides 24/7 recovery support to patients with substance use disorders (SUD) in emergency departments and inpatient units, with additional weekday coverage in behavioral health units. Using certified Peer Recovery Specialists and Patient Navigators, the program offers screenings, assessments, warm handoffs to appropriate treatment, and ongoing recovery support. PRP aims to “open a window to recovery” by addressing opioid use disorder (OUD) and co-occurring SUD through person-centered, strength-based, non-clinical support. The program reduces stigma and isolation, helps patients build positive social networks, guides them through complex resources, and closes gaps in care. The initiative is expected to reach 2,567 unduplicated clients annually.
- Peer Recovery Program (PRP) – Maternal Health
 - This initiative will provide recovery support services for perinatal and postnatal patients who present with substance use disorder (SUD) in RWJBH birthing hospitals. The goal of the initiative is to implement evidence-based interventions that strengthen perinatal and postnatal support services for patients with SUD, connect patients with Maternal Health Recovery Specialists who are cross-trained as doulas, address social determinants of health (SDOH), and reduce deaths among perinatal and postpartum patients. The initiative is expected to reach 163 unduplicated clients annually.

Discussion Points (Cont'd)

- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
 - The SBIRT program, piloted in RWJBH Medical Group practices, screens all patients ages 12 and older for risky or unhealthy substance use and provides brief interventions, brief treatment, or referrals to the Peer Recovery Program as needed. Wellness Specialists offer hybrid in-person and virtual recovery support to high-risk individuals and train medical staff on SBIRT practices. The program addresses the lack of early identification of substance use risk in primary care. By increasing routine screenings, SBIRT reduces under-reporting and missed diagnoses, enables earlier intervention, and simplifies connections to appropriate treatment for individuals with or at risk for substance use disorders. This program is expected to reach 9,593 unduplicated clients annually.

- **How will the department monitor and evaluate the use of these funds?**

The State will monitor and evaluate the use of these funds in the same manner as it does for other opioid settlement-funded programs. This includes collecting quarterly and annual reports from the hospital systems, along with program-level information and output data such as services delivered, individuals served, and overall implementation status.

- **Will the applicable data regarding this \$45 million appropriation be included on the NJ State-Level Opioid Settlement Dashboard? If not, please explain why.**

Yes, it will be included on the dashboard and in the State's FY 2026 annual report.

28. **9-8-8 System:** The FY 2027 Governor's Budget recommends maintaining funding for the federally mandated 9-8-8 national suicide prevention hotline at \$28.8 million in FY 2027. The 9-8-8 hotline, first implemented in July 2022, is a part of a larger crisis care continuum being developed by the department. In May 2025, the former Commissioner of Human Services testified to the Legislative budget committees that, at full implementation, the 9-8-8 continuum of care would cost approximately \$67 million, with 81 percent of funding from State sources.

Currently, two of the three components of the 9-8-8 system are fully operational: the 9-8-8 contact centers, which receive calls, texts, and other messages from individuals in mental health crisis; and Mobile Crisis Outreach Response Teams (MCORTs) that coordinate with the 9-8-8 contact centers and respond to address non-life-threatening crises in all 21 counties. The Governor's Budget projects that contact centers will receive 169,052 contacts in FY 2027, unchanged from FY 2026 adjusted levels and 10,906 above the original FY 2026 estimate. In February 2026, the contact centers' in-State answer rate was 85 percent, which is below the 90 percent performance goal established by the national administrator.

The 9-8-8 system's third component is the State's Crisis Receiving and Stabilization Centers, which provide 24/7 short-term crisis stabilization services for individuals in mental health crises. In June

Discussion Points (Cont'd)

2024, the division awarded \$37 million to establish five centers serving all 21 counties. Tentative launch dates spanned from July 2025 through September 2025; however, federal funding disruptions delayed these opening targets. According to the department, expanding beyond these five centers would require \$6 million per new center.

- Questions:** What is the department’s current estimated annual cost of the 9-8-8 continuum of care, assuming full implementation and disaggregated by funding source (State, federal, other)?

SFY 2026 Funding							
Initiatives	State	9-8-8 Federal Territory Improvement	MHBG	BSCA	ARPA	SUPTR	Total
CRSCs	\$ 833,330		\$ 1,053,267	\$ 735,432	\$ 4,592,693	\$ 324,368	\$ 7,539,090
CDH	\$ 1,225,000				\$ 275,000		\$ 1,500,000
988 Call Centers	\$ 11,824,000	\$ 6,878,873			\$ 3,000,000		\$ 21,702,873
MCORT	\$ 16,000,000						\$ 16,000,000
CSC-CI			\$ 2,832,041	\$ 278,150	\$ 2,303,149		\$ 5,413,339
Total	\$ 29,882,330		\$ 3,885,308	\$ 1,013,582	\$ 10,170,842	\$ 324,368	\$ 52,155,302

- Please provide the anticipated funding level, in FY 2026 and FY 2027, respectively, for each component of the 9-8-8 system, disaggregated by funding source.**

SFY 2027 Funding									
Initiatives	State	9-8-8 Federal Territory Improvement	MHBG	BSCA	ARPA (ended 9/30/2025)	SUPTR	Total Available	Total Need	Deficit
CRSCs	\$ -		\$ 1,400,000	\$ -	\$ -	\$ 324,368	\$ 1,724,368	\$ 30,878,405	(\$29,154,037)
CDH	\$ 1,146,000				\$ -		\$ 1,146,000	\$ 3,560,182	(\$2,414,182)
988 Call Centers	\$ 11,824,000	\$ 1,950,000					\$ 13,774,000	\$ 13,774,000	\$0
MCORT	\$ 16,000,000						\$ 16,000,000	\$ 16,000,000	\$0
CSC-CI	\$ -		\$ 2,832,041	\$ -	\$ -		\$ 2,832,041	\$ 7,217,785	(\$4,385,745)
Total	\$ 28,970,000		\$ 4,232,041	\$ -	\$ -	\$ 324,368	\$ 35,476,409	\$ 71,430,372	(\$35,953,964)

- What methodology did the department use to estimate the number of contacts received by 9-8-8 contact centers in FY 2027? At what level of contacts would the 9-8-8 system require additional funding to meet demand?**

Data shows that NJ 9-8-8 is outpacing initial call projections.

During the planning phases of 9-8-8, NJ DMHAS utilized Vibrant’s New Jersey 9-8-8 State Volume and Workload Estimates to gauge projected volume and costs. According to the Growth Model with the baseline, diverted, and new volume sources, it was expected that New Jersey would see upwards of 52,000 calls in year 1 and 65,000-70,000 calls by year 5.

Year	Calls Routed	Chats/Texts Routed	Total Demand
1 (SFY23)	57,409	3,184	60,593
2 (SFY24)	77,378	12,508	89,886
3 (SFY25)	85,380	33,528	118,908

Discussion Points (Cont'd)

4 (SFY26) projection based on current data	123,865	58,200	182,065
5 (SFY27) projection based on current data	155,000	86,900	241,900

Though in-state answer rates have steadily improved, NJ has never been able to keep up with in-state demand to achieve the 90% in-state target set by Vibrant. For FY 26, the current overall average in-state answer rate (calls) is 83.6% and has steadily trended upward since launch.

Estimating the amount of funding to get to the 90% in-state answer rate for texts has not yet been finalized. The overall combined average for chats/texts is 66.4% with 3 of the 4 centers providing the service. To get to the targeted 90% in-state answer rate is more complicated since the Centers are responding at varying hours with varying staffing levels at varying budgeted rates of pay. To bring NJ closer to Vibrant 90% target, DMHAS 9-8-8 plans on including a funding request for an additional chat/text center in the upcoming federal 9-8-8 SAMHSA grant application.

- **Will the recommended level of FY 2027 funding for 9-8-8 contact centers help achieve an in-State answer rate of 90 percent and chat and text services at all centers? Please explain the department’s current and anticipated efforts to achieve these goals.**

No, the 90% in-state answer rate will not be achieved. Current efforts include: individual meetings with the Centers; meeting with Vibrant’s Work Force Management (WFM) Team to ensure the Centers’ staffing aligns with demand (impossible to fully achieve with current funding); and ongoing regular contact with the Centers to ensure operations are running smoothly according to Vibrant protocols.

Anticipated efforts to achieve the 90%: since NJ is in the final Y3 of the current federal grant, the Division will be responding to the NOFO for the next federal 9-8-8 grant. In the application for federal resources, to get to the 90% in-state answer rate, we plan to include requests for:

- 20% increases for Caring Contact & CONTACT of Mercer County to add staff;
 - Targeted RFP for additional chat/text services; specifically, to procure a new Center to pick up the unanswered contacts; and
 - RLI to target overnight hours (Rutgers and/or COMC); specifically, funds to either supplement Rutgers staffing or to expand COMC’s hours.
- **What are the number of dispatches and average response rates, by MCORT, in FY 2026 to date? Have any issues emerged during the first full year of implementing this 9-8-8 system component, and how has the department addressed these challenges?**

In FY2026 through 4/14/26, there have been 830 MCORTs dispatched and 808 face-to-face outreaches completed. Since launch on 3/3/25 through 4/14/26, there have been 1013 MCORT dispatches and 970 face-to-face outreaches completed. The disparity between MCORTs

Discussion Points (Cont'd)

dispatched and face-to-face outreaches completed is owing to various reasons: after agreeing to MCORT when speaking to the 9-8-8 Lifeline, caller changes his/her mind when MCORT calls to confirm; caller has an unforeseen scheduling issue (e.g. picking up daughter at school, family came to visit unexpectedly, etc.).

The primary issue that has emerged is that, overall, MCORT dispatches have been fewer than anticipated. The original calculation assumed two dispatches per MCORT Team per shift in all nine Regions, including overnight hours. However, because Crisis Counselors managing the Lifeline have been handling callers for many years even prior to the initiation of 9-8-8 (National Suicide and Crisis Lifeline/NSPL established in 2005), they are very adept at managing crises via phone support alone. Accordingly, as with any new program, the learning curve combined with feedback from a larger than anticipated percentage of callers that they are not always interested in a face-to-face outreach (preferring the anonymity aspect afforded by 9-8-8 phone, text, or chat support) despite the MCORT service being routinely offered, means it is taking time to get up to the levels of outreach anticipated. Callers are increasingly requesting MCORT when contacting 9-8-8, so the trend and expectations continue to evolve. To continue the upward trend, the following initiatives are underway:

- Pilot programs have been implemented whereby providers that operate Psychiatric Emergency Screening Services and MCORT can make referrals from Screening to MCORT for consumers who, upon triage by Screening, are assessed as not in need of evaluation for possible hospitalization. In these cases, MCORT is perfectly positioned to outreach to provide face-to-face support, linkage, and referral to ongoing community services. DMHAS has plans to expand this beyond the pilot program and anticipates this in combination with the already-increasing utilization via 9-8-8, will yield positive results.
 - DMHAS is in conversation with NJ Veterans Health Administration Suicide Prevention Team (NJVHASPT) to strategize how to dispatch MCORT to callers who utilize the “Press 1 option” and get transferred to the Veterans Crisis Line (VCL). Because VCL is not State-based, there is not currently a mechanism to facilitate caller access to MCORT once the VCL option has been exercised. DMHAS 9-8-8 is therefore working with NJVHASPT to develop a protocol to facilitate MCORT once NJVHASPT is involved in follow-up to callers handled by the VCL.
 - DMHAS 9-8-8 is strategizing on a process to facilitate MCORT dispatches to individuals who utilize chat and text contact, expanding MCORT from utilization by callers only.
 - Consideration for utilizing MCORT (9-8-8 continuum Pillar 2 = “Someone to respond”) in further collaboration with CRSCs (9-8-8 continuum Pillar 3 = “Somewhere to go”) to ensure follow-up and/or wrap-around supports for consumers served by CRSCs.
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- **What is the implementation status of Crisis Receiving and Stabilization Centers throughout the State? Which centers are open, and when will the rest open? Does the FY 2027 Governor’s Budget include sufficient State funding for this 9-8-8 system component to be fully operational, or is additional State funding needed due to federal funding disruptions or any other factors? How many centers are planned when the**

Discussion Points (Cont'd)

component is fully operational, and what non-funding factors might limit the State from achieving full capacity?

CRSCs are home-like, non-hospital centers that provide short-term (under 24 hours), community-based support for individuals experiencing suicidal, mental health, or substance use crises.

In June 2024, \$37 million in contracts were awarded to create new Crisis Receiving Stabilization Centers (CRSC) in Morris, Bergen, Essex, Monmouth, and Camden counties to provide services to people in need of immediate in-person crisis intervention and stabilization for behavioral health crises. Contracts of \$6.9 million each were awarded to Center for Family Services in Morris County, Care Plus NJ in Bergen County, Rutgers Health, UBHC in Essex County, Monmouth Medical Center in Monmouth County and Legacy Treatment Services in Camden County. Each award includes up to \$400,000 in one-time start-up funds for items such as medication refrigerators and furniture to create a safe and welcoming environment; and up to \$166,666 in capital funds for acquisition, construction, reconstruction, development, and leasehold improvements. This initiative is funded with State and federal funds. Unfortunately, over the past year, relevant federal funds were stopped for a period of time by federal SAMHSA, which delayed progress on this program.

As of 4/16/26, the centers are in the Certification stage and have not opened yet. The tentative start dates, pending certification for the CRSCS are as follows:

- RUBHC - Certification pending, awaiting revised go live date
- CarePlus - awaiting revised start date
- Center for Family Services - June 2026.
- Monmouth Medical Center - August 2026
- Legacy Treatment Services -July - September 2026.

Five centers were awarded and are planned to open in CY 2026. When fully operational, each center will have the capacity for 22 individuals at a time with a primary serious mental illness or substance use disorder who are experiencing acute psychiatric symptoms. One non-funding factor that may limit the state from achieving full capacity might be staffing issues. In order to be proactive, some of the CRSCs are adopting flexible work schedules to recruit and maintain staff.

We expect all funds to be fully encumbered by September 30, 2026, with total expenses incurred by December 31, 2026; therefore, we do not anticipate any underspending.

Division of Management and Budget

29. **Office of New Americans:** Established in FY 2021 under Executive Order No. 74 of 2019, the Office of New Americans supports immigrants and refugees in New Jersey through outreach, education, and two legal services programs — one for unaccompanied minors and immigrant youth, and one for individuals facing detention and deportation. The FY 2027 Governor's Budget maintains level funding for the office at adjusted FY 2026 levels, when disregarding \$8.2 million in

Discussion Points (Cont'd)

FY 2026 supplemental appropriations that proposed appropriations language would reauthorize in FY 2027.

Over the current fiscal year, United States Immigration and Customs Enforcement agents have engaged in significantly expanded enforcement of immigration law and removal operations of undocumented individuals throughout the country, characterized by higher arrest rates, increased detention numbers, and the development of new and expanded detention centers.

- Questions:** How have changes in federal immigration enforcement during FY 2026 affected the legal services offered by the office? Does the department have any concerns regarding the office’s and its vendors’ capacities to meet the demand for legal services at current funding levels?

Changes in federal immigration enforcement during FY 2026 have increased both the complexity of cases and the demand for legal services. More individuals are being held in detention for longer periods, fewer are being released on bond, and changing legal standards have made cases more complex. As a result, cases now require more time and filings.

Legal service providers strive to offer full representation, meaning an attorney handles a case from start to finish, including court appearances and applications for relief. However, given the significant rise in both case volume and complexity, providers do not have the capacity to offer this level of service to all who qualify. As a result, they are prioritizing detained individuals and, in some cases, providing more limited assistance—such as legal advice or help with filings—to reach more people.

At current funding levels, providers are maximizing available resources but cannot meet the full demand for services. Additional funding would help expand capacity and ensure more individuals receive comprehensive legal representation.

- From FY 2024 to FY 2026 (to date), how many individuals have been provided legal services funded by the office, disaggregated by type of service and fiscal year? How many individuals are projected to receive services in FY 2027, disaggregated by type of service?**

New Jersey’s Detention Deportation and Defense Initiative (DDDI) Program Data

	FY27	FY26	FY25	FY24
Budget	\$8.2 M	\$8.2 M	\$8.2 M	\$8.2 M
Clients	TBD	1,078 (Q1-Q2 only)	2,755	3,326

Kids In Need of Defense (KIND) Program Data

	FY27	FY26	FY25	FY24
Budget	\$5.3 M	\$5.35 M	\$6 M	\$7.5 M
Clients	TBD	287 (Q1-Q2 only)	1,530	2,166

Discussion Points (Cont'd)

We are unable to project how many individuals would receive services in FY 2027; however, given increased immigration enforcement and the growing complexity of cases, the need for legal services is expected to continue increasing.

- **Please describe any new initiatives implemented by the Office of New Americans in FY 2026, or planned in FY 2027, in response to expanded immigration enforcement activities in New Jersey or elsewhere in the country. What are the projected State costs of any new initiatives in FY 2026 and FY 2027, respectively?**

In response to increased immigration enforcement, the Office of New Americans has focused on ensuring individuals and families have access to clear, accurate information.

In FY 2026, ONA developed community preparedness resources, including Know Your Rights (KYR) materials and family preparedness information. These materials help individuals understand their rights and make informed decisions in the event of enforcement actions. See here: [Office of New Americans | Know Your Rights](#).

ONA is also launching an Immigration Legal Rapid Response Coordination and Training pilot to expand statewide capacity to support habeas petitions and other emergency immigration filings. This effort focuses on recruiting and training volunteer attorneys with federal court experience and coordinating their engagement with immigration legal service providers.

In partnership with the Community Foundation of New Jersey (CFNJ), ONA is supporting a statewide network of regional Community Support Hubs to coordinate local responses to federal immigration policies. These hubs—active across counties including Middlesex, Mercer, Essex, Hudson, and Bergen—focus on information sharing, referrals, KYR dissemination, family preparedness, and identifying emerging community needs.

Looking ahead, ONA will implement a train-the-trainer model to expand the reach of these materials, equip community partners to deliver KYR and family preparedness information directly within the communities they serve, and provide updated guidance on refugee re-vetting.

The Department works closely with sister agencies to provide subject matter expertise to inform implementation of [Executive Order No. 12](#) and [recently enacted laws](#) relating to protecting New Americans.