New Jersey Medicaid Eligibility Reform

The Solution is "Pending"

A report regarding the challenges facing New Jersey's
Long Term Care Medicaid application, determination & eligibility process.

Compiled by HCANJ with information provided by Genesis HealthCare, Senior Planning Services and with empirical and anecdotal information from the experiences of our 300 licensed assisted living, skilled nursing and special care nursing facilities throughout New Jersey.

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Executive Summary

Recent media attention has highlighted serious delays and mounting challenges with New Jersey's Medicaid application and eligibility determination process related to the processing of applications and surging due to Medicaid expansion, as well as the myriad of other programs administered by New Jersey's County Welfare Agencies (CWAs).

Regrettably, the recent news underscores a decades-long problem across beneficiary groups. For years, this seriously delayed and dysfunctional Medicaid application and eligibility process has prevented timely access to care and services for many New Jersey citizens. The extent of the problem goes way beyond just shortages in staffing. Rather, it involves systemic process and oversight failures that demand a comprehensive reform plan and immediate measures to better serve the needy in our state.

The purpose of this document is to highlight the challenges facing arguably the most complex, expensive (per person) and regulated group of beneficiaries; that being, those in the long term care (LTC) community served by special care nursing facilities (SCNFs), skilled nursing facilities (NFs) and assisted living facilities (through waiver services). By examining the experience of these patients and their providers, we will be able to identify and promote solutions to benefit all Medicaid and social welfare applicants whether they are seeking Medicaid, TANF, CHIPs, ACA or other services.

As providers of long term care know, the nursing facility Medicaid eligibility process is a system filled with delays, inefficiencies and inaccuracies which represent a real crisis for families and facilities. The CWA system adds a layer of bureaucracy and obstacles rather than true social service work for the applicant, families or facilities trying to access services and receiving clear Medicaid application and eligibility criteria and determinations. A quick Medicaid eligibility determination, according to state and federal guidelines, is possible. Yet, New Jersey takes an average of nearly three times the required 45 days.

The counties have been providing inconsistent instruction, misplacing parts or whole files, delaying and denying applications in situations that could have been easily resolved with little effort and a better process. Increased and appropriate state oversight and a better case management system will allow us to improve performance and meet the statutory requirements and institute contracts with the counties with vastly improved state protections.

The unique aspect of the LTC beneficiary community is that they often cannot handle their own affairs and are relying on family members, persons of authority (POAs) and/or the Office of the Public Guardian for assistance. That, combined with strict federal guidelines about asset transfers and income or exemption rules, makes delving into a lifetime to determine financial eligibility or spousal support for end of life care, challenging at best. Too often the counties delay or deny and the State does not have the knowledge or a system of metrics and sanctions to hold them accountable.

There is also a distinct inability for the providers in this market to cost shift or just not accept a Medicaid resident as would a doctor, dentist or other provider when faced with a patient having

no payer source. Combined with the demands of hospital and managed care referrals and the state regulations requiring 45% of skilled nursing facility residents and ten percent of assisted living residents to be Medicaid recipients, it makes denial of any resident unacceptable. Further, if the majority of facilities suddenly were selective, it would lead to legions of unserved patients remaining in more costly hospital beds or remaining uncared for at home.

With the transition to Managed Care, many Medicaid pending applicants will remain in a fee for service (FFS) status much longer than necessary, rather than quickly entering the managed care system. With shorter stays in long term care facilities becoming more common, this delay adversely impacts the time period where this care can be truly managed under the Managed Long Term Service and Supports (MLTSS) as intended.

Additionally, after a resident is admitted, this long-time Medicaid-pending or denied resident, who has often been provided care with no reimbursement to the provider, must then be kept and cared for unless a safe discharge to another facility is permitted. That becomes an expensive "Catch 22" when no one will accept the resident since no private or Medicaid payer source exists and the county and State refer the provider to each other.

Facilities are literally "floating" the state millions of dollars due to this systemic problem. And, these delays are quite unnecessary as over 90% of the applicants are eventually approved. This crisis, combined with the chronic underfunding of the reimbursement for this care, is the primary reason we need and are advocating strongly for an interim fix as enabled by the passage and Governor's approval of the *"Uncompensated Pending Medicaid Beneficiary Payment Relief Act."* Our actual reimbursement for nursing facility care are now $30 per patient day short of our cost detailed in recent studies and cost reports filed with the state. With the average approval time at nearly three times the requirement, providers have become "the bank for the state. "Sadly, these pending balances are nearly breaking many providers and have already created a crisis of cash flow low which may compromise their heavily regulated and quality- driven operations.

The reform of the entire system requires a task force with a tight timeline to facilitate better access to services and a vastly improved and efficient system for New Jersey taxpayers. By addressing the information technology needs of case management and the oversight of the counties, and by seeking creative solutions and immediate measures of relief, the State can work with stakeholders and readily address the challenges in this report.

Only then will we be able to come close to meeting the required 45-day time frame for Medicaid application and eligibility determinations across the state social welfare system and county welfare agencies.

Challenge #1: Twenty-One (21) Counties

New Jersey is blessed with twenty-one counties that together comprise a state of valued diversity. That being said, from a governance standpoint, the patchwork of inconsistent systems in the county social welfare agencies and the lack of consistent application standards, driven by and strictly overseen by the state, is the #1 challenge to Medicaid eligibility reform.

States that are successful in this arena have information and accountability structures far beyond New Jersey's and a propensity to help, not hinder; and approve an application. The challenges posed by our system are many. The question is whether the state has been able to exercise its authority over the counties or take action to sanction non-performers. It is instructive then to detail customer/applicant ***concerns and key questions*** that may lead to the right solutions for effective state oversight and monitoring.

Concern #1a: Seriously delayed or late approval of eligibility
As data will show later, New Jersey averages, in the best cases, are nearly three times the statutorily-required 45-day timeline for a determination.

Key Question #1a: Does the State require the counties to keep records and consistent reports of how long applications are pending, how many are denied and for what reasons? Are there clear benchmarks to review how they are doing regarding timely approvals?

Concern #1b: Claim of lost application

Key Question #1b: Does the State require a statewide number or coding system for applications and provide receipts to customers in the counties?

Concern #1c: Continued poor performance by a county

Key Question #1c: Is there a system of ranking the counties by case volume, approvals, denials, etc.? Can the state chart the high and low performing counties and then assist or sanction them accordingly?

Concern #1d: County claims no record of contact or receipt of vital information

Key Question #1d: Does the state require an applicant contact record of when an application is received or an applicant has called? Is there a receipt system for when the county requests additional documentation and when it is received?

Concern #1e: Inconsistent paperwork and application requirements
The applicant claims they were not told what to provide or the County claims the denial or delay is due to various missing information requirements being unfulfilled.

Key Question #1e: Does the state require counties to use a consistent informational guide for applicants and consistent application standards across counties?

Special Note: Managed care & insurance companies tried tactics decades ago of repeatedly denying claims for various reasons after each submission of requested information, rather than stating all errors at once. The state required them to follow ***"clean claim"*** procedures with time limits, rules and procedures meant to benefit the consumer and keep cases from having to be resubmitted repeatedly only to be denied again and again on a different technicality.

Challenge #2: A New Computer System - *sooner rather than later*

Concern #2a: Recognizing the need to modernize IT systems

Key Question #2a: Why has the State delayed improvement of our Medicaid application, eligibility and case management systems?

Background Info for #2a: The state has long sought to improve its Medicaid IT and case management system. Stakeholders have also made the appeal. On April 7, 2010, Paul Langevin, at the time the President of the Health Care Association of New Jersey, testified before the New Jersey Privatization Task Force regarding the shortfalls of the LTC Medicaid Eligibility process. He specifically advocated for simplifying the application process by instituting a web-based application system and centralizing the determination process to improve economy of scale, provide consistent policy application and to shorten the process. Over five years later, no improvements have been implemented and the problem has grown worse.

While limited staff and systemic process failures at county welfare agencies are, in part, responsible for the delays in approving Medicaid applications, the job is made more difficult because of the state's antiquated computer systems. The aforementioned oversight needed begins with a comprehensive eligibility and case management system.

Concern #2b: State action to improve and modernize IT systems

Key Question #2b: What action has been/is being taken to modernize the State's Medicaid application, eligibility and case management systems?

- Other states have found the right systems, solution and vendor. Have we called the states with similar systems and size to New Jersey and sought their advice?
- Can decisive action and immediate money that would have been used for the Consolidated Assistance Support System (CASS) be directed at this critical need to help us overcome this initial failure ASAP? Can we start that journey right now?

Background Info for #2b: The state properly sought to modernize its Medicaid application, eligibility and case management system by creating CASS. It was supposed to facilitate the application process by enabling county welfare agency computers to interface with State computers and federal data hubs.

Unfortunately, the State had to abandon this program just as the deluge of applications under Medicaid expansion started hitting county offices. Because New Jersey is one of only four states that still rely on abbreviated federal files that contain inaccurate information, including unverified incomes, county offices continue to spend unnecessary time tracking down the right information for applicants. Only through the modernization of the State computer system can counties access the electronic data available at the State and federal levels that is needed to expedite eligibility determinations.

Challenge #3: Break down the Jersey Barriers

One way to measure the efficiency of a system is to compare it to others. As such, we researched neighboring states' Medicaid eligibility systems and practices and found a few barriers specific to New Jersey. By breaking down these barriers we can bring immediate relief to the applicants and improve the Medicaid eligibility process consistent with the laws and our mission to serve our citizens.

Concern #3a: Painfully Misguided Spend-down Rule Implementation
No one is arguing that all states have regulations regarding when an applicant must be spent down to meet Medicaid's asset threshold, but…

Key Question#3a: Why is New Jersey the most stringent in its practices compared to other nearby states? In New Jersey, an applicant must be spent down by the first day of the month in which eligibility is being requested. Why is that?

Background Info #3a: In Connecticut, funds must be below the asset limit by the last day of the month in which the applicant needs eligibility. New York and Pennsylvania take an even more lenient approach. In both of these states, an applicant may qualify for retroactive coverage even if, at the time of the eligibility request date, there were funds that exceeded the asset limit, so long as the funds were used for nursing facility bills, medical bills or an irrevocable burial fund.

Why doesn't New Jersey do this? Why don't New Jersey social workers engage family members directly and use the sensible approach to apply such funds to their legal and obvious expenditures in qualified exempt asset categories rather than denying or delaying applications. The painful result is that shown in the following example:

Real World Impact for #3a: John is helping his elderly parent apply for Medicaid. He needs Medicaid to pay the nursing facility bill effective January 1st. Per Medicaid rules in New Jersey, the applicant can only qualify for benefits once below the asset threshold of $2,000.

In real-time it is not uncommon for people to not know every asset owned by their parent. This results in a scenario in which the applicant and/or representative erroneously believes they are eligible for benefits. Much to their dismay, they find out that there is another small account they never knew about resulting in ineligibility. This newfound resource may put them over $2,000 but leave them woefully short of the dollars needed to pay for their care.

This scenario is dramatically exacerbated by extremely slow county processing. John believed his mom would qualify for Medicaid beginning January 1, 2014. To his knowledge she has only $1,500 in resources. Suppose John is wrong and there is another small resource worth $600? In NJ, she will not qualify for Medicaid benefits effective January 1st because she is just $100 over the limit.

Additionally, because of extremely slow processing of Medicaid applications the case may not be addressed in timely fashion as required by state regulations. When the case is addressed at the county level, the additional resource may not be found until April. In this case, she will lose January, February, March and April (an average of at least $20K) since she was never properly spent down. Provided the resource is reduced below the $2,000 in April, this will then qualify the applicant for eligibility effective May 1st. That is four months lost due to strict resource "spend down" rules.

In New York and Pennsylvania, and the great majority of states, the very same situation would not be a problem at all. All the monies above the resource threshold would be allocated to medical expenses and Medicaid would cover expenses after that.

Concern #3b: Guardianship Challenges
Whenever a resident has no family or POA and requires a guardian it is very difficult to obtain Medicaid eligibility for this resident.

Key Question#3b: Why is this the case? We have an Office of Public Guardian (OPG) with a core mission to serve wards of the state and these recipients usually have few, if any, resources. What can we do to improve the process in these situations? Is the Office open to contact with providers in order to facilitate applications and advocate for residents with counties? They appear overburdened and challenged in their advocacy function.

Background Info for #3b: Technically, in New Jersey once a guardianship application is filed, the Medicaid application can also be filed. The application can remain open if an extension is requested by the applicant and approved by the county until all guardianship proceedings are completed. During the guardianship process, whatever assets exist are to be deemed as "inaccessible" and would not impede Medicaid eligibility. Should there be assets, the guardian will spend them down on behalf of the applicant. Coverage would be granted for the original Medicaid request date.

The reality is that many facilities are being told incorrectly by Medicaid to submit a Medicaid application only once the guardianship has been approved (resulting in lost eligibility periods). In other instances, applicants are being denied for not providing documentation or information that was inaccessible to them prior to and during guardianship proceedings. Through a fair hearing, the original eligibility request date is often not granted and most often results in undue hardship on the facility and newly-assigned guardian.

In New York, once an application for guardianship is filed, the person immediately qualifies for Medicaid. New York Medicaid will request a signed order proving that a guardianship is processing with a clause stating that, should there be assets, they are to be paid back to the state as compensation for monies expended by Medicaid. The big difference between New York and New Jersey is that in New York benefits are immediately granted. The experience in New York has been smooth and coverage is

more easily obtainable in contrast to NJ. How long must providers lose thousands of dollars in lapses in coverage for residents that are in need of guardianship and Medicaid? Additionally, the newly assigned guardians or the OPG lack the employee resources or incentives to process guardianships in a timely fashion or fight for retroactive coverage in fair hearings. Can't we do better?

Concern #3c: Unfair & Impractical Appeal Decisions
The most common reason for denials in New Jersey is "failure to provide documentation."

Key Question #3c: Who is at fault? Why does New Jersey so infrequently consider granting eligibility even if the documentation is provided prior to or at the appeal hearing? Why, after the appeal goes to an ALJ and eligibility is granted, does New Jersey, unlike any other state, so often overturn such a decision? In other states the ALJ is the final determining factor or well-supported in their deliberative review and decision.

Background Info for #3c: In practice in New Jersey, if an individual receives a denial for "failure to provide documentation" and sends in the documentation before the hearing date or brings the documentation to the hearing, the denial will most likely stand, despite the appeal. A new application is then required.

In Pennsylvania, when there is a denial because of "failure to provide documentation" and an appeal is requested, if the applicant sends in the documentation prior to or at the fair hearing, the case will be reopened and eligibility will be re-determined based on the new documents received for the original begin pay date requested. In contrast to other states, New Jersey is not likely to re-open cases, regardless if an applicant verifies eligibility upon an appeal and/or at a fair hearing. This can pose serious coverage gaps for applicants and facilities, resulting in huge financial loss.

Concern #3d: Penalties
New Jersey Medicaid will more often penalize clients for small cash transactions that other states will most likely overlook or come to understand and apply more fairly to the situation.

Key Question #3d: Why is New Jersey, without federal requirement, so apt to take this strict approach?

Background Info for #3d: Certain citizens, especially the needy, live cash-based lives and sometimes it is obvious that the cash funds spent were for basic living expenses. Still, without a paper trail, certain counties are more likely to penalize than to work through such instances.

Real World Impact for #3d: A couple that consistently spent approximately $1,300 each month using cash for daily living expenses. When the husband applied for Medicaid, the

couple was penalized for being unable to provide cash receipts for every single transaction. The penalty amounted to $70,000, which was paid by the spouse, who ended up becoming completely impoverished. It is reasonable to assume that $1,300 is a fair amount for a couple to spend monthly on basic household expenses and groceries.

Oftentimes, the applicant's representative absorbs significant amounts of financial losses for "gifting," that in actuality were not transfers for less than fair market value. Children, spouses and other family members will sometimes suffer trying to repay nursing facilities for the penalty periods in which the transactions, in reality, were for legitimate purchases and in accordance with Medicaid gifting regulation.

Concern #3e: Determining the right documentation

Key Question #3e: What is required? New Jersey counties have inconsistent and excessive documentation requirements and no consistent standard. Having a statewide standard for production of financial records, asset transfers, identification and other documents will improve the processing of all Medicaid and social welfare applications.

Background Info for #3e: In New Jersey, most counties will request five years' worth of financial records. Verification for transactions of $1,000 and over are also requested. Recently there have been requests for documentation for deposits as small as$150. A five-year look-back for blatant and unqualified asset transfers is the intent of the law, not a review of every transaction over five years of a senior citizen's life.

In Pennsylvania, most counties will request two years of financial records. In New York, most counties will request five years' worth of financial records and will only request verification of transactions that are $2,000 or more. In Connecticut, most counties will request two years' worth of financial records plus the previous December, and will only request verification of transactions that are $2,000 or more.

Real world impact for #3e: New Jersey counties are inconsistent and/or stringent in requesting documentation. Gathering documentation and requesting verifications can take a large toll on the applicant or caregiver. Failures in this area are to be blamed for many delays and denials leading to reapplications and lost benefits.

Concern #3f: Customer service & efficiency

Key Question #3f: How do we stack-up against neighboring states and our own requirements?

Background Info for #3f: HCANJ facility members have had the pleasure of working with many wonderful caseworkers who have guided residents through the difficult challenges of obtaining Medicaid eligibility and benefits. We understand that the sheer volume of Medicaid cases coming through the county can largely impact the general

operations time and availability to provide the customer service that stressed applicants are seeking. Since New Jersey has a very stringent approach with its Medicaid guidelines, this can sometimes pose challenges if applicants are unable to receive the customer service required to answer questions and alleviate their fears.

New Jersey's strict approach, the lack of resources and propensity to deny leaves us as one of the worst states for Medicaid eligibility approvals.

According to statute, the Medicaid eligibility determination process is supposed to take no more than 45 days. Below is a review of some recent statistics from families & facilities who have had applicants use a Medicaid Family Facilitator (company with Medicaid application and eligibility experts to collect data, apply and process):

- NJ eligibility determinations average - 122 days.
- NY eligibility determinations average - 96 days.
- PA eligibility determinations average - 55 days.
- CT eligibility determinations average - 44 days.

We learned recently of a case where an individual who has been in a fine nursing facility and paying privately for four years applied for Medicaid when assets were depleted. Even with individuals who have decades of state Medicaid application experience guiding the process it still took 60 days for this individual to be approved after experiencing many of the problems mentioned herein.

These long and often difficult waiting periods can cause huge losses for, not just the applicants, but many times the facilities as well. Rarely do families properly remit their share of the patient portion for care if the State denies eligibility or the process causes a gap in the eligibility period despite the fact that the facility provided the necessary care and, therefore, deserves full private-pay payment for that period of time.

Finally, and most importantly, the added stress to residents and their families is unfair and unwarranted. New Jersey can break down the barriers and do better.

Challenge #4: Hard cases & hardships made easy.

Even the most fortunate and supported families in our state often find the level of detail and complexity of the Medicaid application and eligibility process vexing and the requirements nearly impossible to meet. We must realize that the reality faced by the LTC provider community calls for a less restrictive and cumbersome process to deal with hardship cases, and circumstances when family members and/or persons of responsibility cannot or will not properly participate in the Medicaid process.

Concern #4a: Non-existent, non-compliant or otherwise challenged families not properly bearing their responsibility in the Medicaid application and eligibility process

Key Question #4a: Can we develop a solution to better address these cases and not further burden the county system?

Background Info for #4a: The need exists for facilities to receive a more efficient response to a "challenging" family case. Providers must be able to seek an additional level of social work or other remedy to assist with the toughest cases and in processing new applications coming into already backlogged counties.

Recently, Director Valerie Harr, Director of the Division of Medical Assistance and Health Services (DMAHS), had Xerox take over the enormous backlog of Medicaid redeterminations. In doing so, it is hoped that the backlog of Medicaid expansion applications can be addressed by others at the state and county level. Additionally, in April of 2014, Director Harr presented at the Medical Assistance Advisory Council (MACC) "an option in the state budget language to transition eligibility from counties to privatize or centralize eligibility for one or more counties but not before January 2015."

We applaud her leadership in both of these actions. We believe reforming and repairing the county system through benchmarks, metrics and sanctions is the best immediate approach. An assessment of a county- versus state-driven system is warranted.

As in the example with Medicaid recertification, we would recommend a private-public partnership to enable a new entity to take on the toughest cases and all new cases in backlogged counties, until such time they can get back on track and meet the standard.

Challenge #5: The reality from our members throughout New Jersey

From a small non-for-profit facility to the largest national multi-facility company operating in New Jersey and thirty four other states, the Medicaid pending challenges have a real and adverse impact.

The one facility non-for-profit experience –

- *"Our business office manager Jill has been relentless in her pursuit to receive these claims leaving countless messages and she is being regularly ignored.*"

- "This hat has turned into a monthly ritual where I need to ask our foundation for money to assist us in meeting our cash flow obligations. *I've never had to do it so much as this past year*.

- "I need to ask you to please call when you have some free time, perhaps just 5-10 minutes. Attached you'll find over $200,000.00 worth of receivables that are due from the state and we need this money. I am embarrassed to call the President of my Board monthly to ask for $40K here, $60K there while we're on a push to build a new facility."

The Genesis HealthCare Testimony –

- Genesis Healthcare, Inc. is the largest long term care operator in the nation with over 500 facilities serving over 60,000 residents in 34 states. In New Jersey they have over thirty five skilled nursing and two assisted living facilities and are the largest in the state as well. This gives them a unique perspective on the Medicaid pending challenges.

- They conducted considerable research and testified in favor of Assembly Bill #3928 "The Uncompensated Pending Medicaid Beneficiary Payment Relief Act." The biggest takeaway is shocking…Nationally for the year-end *2014 quarter, our national "Medicaid pending" accounts receivable for claims pending in excess of* ***over 90-days was $18.8 million***. ***Of this sum, New Jersey accounted for nearly a third of the total – a staggering $5.4 million.***

- That statement and other instructive and helpful information follows in the testimony reprinted below:

Statement of Walter Kielar
New Jersey Assembly Health and Senior Services Committee
March 2, 2015

Re: Support of AB 3928:

Mr. Chairman, Members of the Committee:

I am Walter Kielar, Senior Vice President for Operations for Genesis Healthcare, Inc. Genesis Healthcare operates post-acute skilled nursing and assisted living center in 34 states. In New Jersey, we operate 35 skilled nursing centers and two assisted living centers. I have operational

responsibilities for these New Jersey centers and for our 50+ centers in Pennsylvania. In addition to my role with Genesis Healthcare, I proudly serve on the Board of the Health Care Association of New Jersey.

This morning, I join with my colleagues urging the Committee to favorably report Assembly Bill 3928, the Uncompensated Pending Medicaid Beneficiary Payment Relief. We thank the sponsors for recognizing the fiscal burdens imposed on nursing home providers while they wait for government agencies to process Medicaid applications. We look forward to working with this committee and the bill sponsors in securing expeditious actions to make this legislation law.

I am not sure the public fully understands that nursing home providers in New Jersey are required to participate in the Medicaid program and to assume the full risk for the costs of care services for aged and disabled individuals while the bureaucracy processes eligibility applications for individuals deemed to be "Medicaid pending."

January 31, 2015 calculations affirm that we, Genesis Healthcare, are owed more than $9 million by the State of New Jersey for services that we have delivered to individuals whose Medicaid applications are pending. Upon approval of the pending applications, our centers expect to be reimbursed for these services; however, we should not have to wait the many months that it now takes to process these applications. The strain on our cash-flow impacts our daily operations. What this legislation will do is provide partial payment for care delivered when applications are delayed for more than 90 days. Since it is reimbursement that we will eventually receive, this legislation is revenue neutral to the State – it will not cost the state any more money as our receivable is currently a state payable. And if we do receive partial payment from someone later deemed ineligible, that amount would be deducted from our total Medicaid payment received from the State.

I want to emphasize three major points:

1. **New Jersey's performance in processing Medicaid pending applications is one of the worst in the nation:**

As indicated, Genesis Healthcare meets the post-acute care needs of over 60,000 patients a day through centers located in 34 states. The timely processing of Medicaid eligibility is an issue in a number of these states. In preparing our testimony, we looked at 2013 and 2014 company-wide data. It is reasonable to expect that it takes up to 60 days to work through the complexities of the eligibility determination process, and, therefore, the receivables that are most concerning are those in excess of that, especially those pending longer than 90-days.

Year-end 2014 quarter, our national "Medicaid pending" accounts receivable for claims pending in excess of over 90-days was $18.8 million. ***Of this sum, New Jersey accounted for over a quarter – a staggering $5.4 million.*** *Compared to Pennsylvania and Massachusetts, states where the Genesis delivery systems are comparable in scale, the over 90-days Medicaid pending in New Jersey is triple the amount owed to us in Pennsylvania and four times the amount owed to us in Massachusetts.*

Of note, the average processing of Medicaid pending applications in New Jersey is a third longer in New Jersey; the receivables in excess of one-year is nearly $1.3 million; accounting for nearly 50% of the aged receivables. This performance should be a cause for concern.

2. **This processing of Medicaid pending applications is an issue across all counties in the State where Genesis operates centers:**

Genesis Healthcare operates centers in 15 of the state's counties. The following table based on data tabulated January 31, 2015 performance, identifies those counties and the number of center and identifies by counties the percentage of Medicaid pending claims (dollars owed to Genesis Healthcare for delivered services) outstanding at over 90-days and the percentage claims (dollars owed to Genesis Healthcare for delivered services) outstanding longer than one year.

These data suggest that counties are struggling to keep pace with the applications process. It should be noted that for nursing home services virtually all of Medicaid pending claims are finally adjudicated in favor of the applicant. The bureaucratic process does not save the state money; but it forces providers to wait excruciating long periods of time to get reimbursed. We, the providers, are floating the receivable!

Table 1: Medicaid Pending Accounts Receivables – New Jersey Genesis by County
As of January 31, 2015 – % amounts over 60+ days/% amounts over 1 year *

County	# of Centers	$ amount pending as of 1/31/15	% over 90 days	% over 1 year
Bergen	3	$494,501	61.8%	21.0%
Burlington	3	$485,309	50.7%	6.0%
Camden	3	$2,314,059	69.9%	25.9%
Cape May	3	$425,163	59.3%	10.3%
Cumberland	1	$106,606	60.8%	6.5%
Essex	3	$1,203,999	55.8%	6.6%
Mercer	1	$298,182	67.5%	5.8%
Middlesex	3	$337,559	45.0%	3.0%
Monmouth	1	$523,650	65.8%	18.4%
Morris	3	$1,184,992	62.4%	10.3%
Ocean	2	$748,004	45.7%	10.5%
Somerset	1	$240,929	62.2%	6.1%
Sussex	1	$85,648	79.1%	20.4%
Union	2	$547,162	54.9%	11.8%
Warren	3	$435,324	40.9%	0.0%
Grand Total	**33**	**$9,431,089**	**59.7%**	**13.6%**

- $ data from 2 centers not available

3. New Jersey must streamline the Medicaid eligibility process for Medicaid purchased Long term care services.

Passage of AB 3928 is a step in the right direction. It acknowledges that today, nursing home providers are bearing all the costs of delivered services for individuals who are Medicaid pending without any certainty as to when they will be paid and if they will be paid. This legislation at least provides partial payment. It certain helps underscore the magnitude of the problem, and hopefully, it will prompt efforts to move forward with reforms. We strongly encourage additional steps for streamlining the cumbersome process, leveraging computer technology, and creating incentives such as those used in the private sector to incentivize performance. These are not new ideas; almost all were state promises made in the text of the waiver the state submitted, and CMS approved, for the

New Jersey's 1115 waiver to expand managed long term care. Absent streamlining the eligibility process, full implementation of managed long term care will fall short.

I, and my colleagues at Genesis Healthcare and my colleagues in the Health Care Association of New Jersey look forward to working with you in securing the passage of AB 3928. Moreover, we look forward to working with you in our continued efforts to assure that the most frail and vulnerable citizens of New Jersey are appropriately cared for with dignity and responsiveness in the most appropriate care settings.

Thank you.

Challenge #6: Moving forward on the road to reform

HCANJ staff, leaders and members look forward to working with the state and other stakeholders to discuss and implement the creative solutions herein and other ideas in order to permanently resolve the Medicaid Pending crisis impacting New Jersey's Medicaid and social welfare programs.