Discussion Points

DEPARTMENT OF HEALTH AND SENIOR SERVICES – GENERAL

1. The FY 2009 recommended budget reduces the number of State employees through an Early Retirement Initiative (ERI) and layoffs. A department's ability to hire employees to fill these vacant positions will be limited. The impact these personnel actions will have on the department's programs and services is not clear.

- ***Questions:*** **How many department employees are eligible for the ERI or may be laid off, by division? To the extent that new employees cannot be hired, what services or programs would the department reduce or eliminate? How will the reductions affect the department's monitoring and oversight of contracts and its efforts to maximize federal reimbursements?**

  Answer: Based on the assumptions in the budget for the projected $135.9 million net ERI savings, 465 of Department staff will be eligible for participation. The savings assumes an overall 50% participation rate that varies by Department. The initial proposal is still under discussion and could be refined in the enabling legislation. Regardless, the Governor has stated that the backfills of participants will be limited to 10% on a Statewide basis. We are not able to ascertain which employees may decide to accept early retirement; therefore we are not able to fully access the impact at this time.

2.a. The Commissioner of Health and Senior Services serves as Chairman of the New Jersey Health Care Facilities Financing Authority (NJHCFFA). The authority provides low-cost financing to hospitals and other health care facilities.

According to NJHCFFA's 2006 annual report (the most current available), the authority had about $4.5 billion in mortgages and loans receivable. Among the hospitals that NJHCFFA has assisted are several that have financial problems, have closed, or may close, such as Barnert, Bayonne, Columbus, Jersey City Medical Center, Muhlenberg and Pascack Valley.

- ***Question:*** **What is the total amount of mortgages and loans receivable currently in arrears or in default status?**

  Answer: No bond holder has missed a payment for Barnert, Bayonne, Columbus, Jersey City Medical Center and Muhlenberg. Pascack Valley had $81.235 million in bonds that were in default. The winning bid in bankruptcy court was $45 million.

2.b. At the end of 2006, the NJHCFFA had over $1.2 billion in outstanding Revenue Bonds and Notes where interest rates are determined either weekly or by auction. In recent months such financing has been more difficult to secure and interest rates on such debt have significantly increased.

- ***Question:*** **On average, how much have interest rates increased on such debt? What is the added interest cost of such debt?**

  Answer: Due to the myriad of formulas used and weekly variation in interest rates, neither the aggregate or average numbers can be determined.

2.c. Costs associated with the New Jersey Commission on Rationalizing Health Care Resources were supported by the NJHFFA. Navigant Consulting was contracted to provide services to the commission.

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- ***Question:*** **What was the final cost of the Navigant Consulting contract? How many billable hours did Navigant provide?**

  Answer: The total cost to NJHCFFA for the Commission on Rationalizing New Jersey's Health Care Resources was $705,064. The contract was performance based.

3. The New Jersey Building Authority is responsible for the construction of a new 275,000 sq. ft. laboratory for use by the Department of Health and Senior Services and other State agencies. Estimated construction costs have increased from about $139 million to over $156 million. Construction has still not been initiated.

- ***Questions:*** **As the cost for construction materials have significantly increased, is the $156 million estimate still valid? Are sufficient funds available to complete the project?**

  Answer: The $156 million estimate is still valid. Sufficient funds are available through New Jersey State Building Authority (NJSBA) bonding to complete this project. The site has been cleared and excavation for drainage piping has been initiated.

4. The FY 2009 recommended budget for the Departments of Children and Families and Human Services includes budget language to strengthen the prohibition of grantees to expend their State grants on lobbying activities.

- ***Question:*** **Why is no similar language recommended in the Department of Health and Senior Services budget?**

  Answer: Specific language is not necessary for the Department of Health and Senior Services, since we follow federal OMB circular letters: ***A-87 Cost Principles for State and Local Governments; A-21 for Educational Institutions; and A-122 Cost Principles for Nonprofit Organization***. These circular letters clearly state that lobbying activities are prohibited if the grantee is receiving federal or state funds from the Department.

HEALTH SERVICES

5. The federal Food and Drug Administration (FDA) has requested state assistance with respect to food safety inspections due a reduction in federal food and safety inspection staff.

- ***Questions:*** **Is the department assisting the FDA in this matter? If so, what additional costs are being borne by the State that are not being reimbursed by the federal government? Are these unreimbursed costs being recovered through inspection fees or absorbed by general State funds?**

  Answer: Yes, the Department has assisted the FDA in this area. The FDA is now expanding their workforce in this area. The actual work and the amount of staff hours vary from year to year so it cannot be quantified, but the assistance provided to the FDA benefits the health of NJ residents.

6.a. The FY 2008 appropriations act assumed $6.0 million in revenues from cost sharing by parents involved in the Early Intervention Program (EIP). Available data indicate that about $4.6 million in revenues, or about $1.4 million less than anticipated, will be collected.

Also, during budget hearings, legislators expressed concern that the co-pay increase would force families out of the program.

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- ***Questions:*** **Are sufficient funds available to cover this potential $1.4 million shortfall in co-pay revenues? How many families have discontinued services as a result of the co-pay increase? Is this number greater or lower than the department had anticipated?**

  Answer: Yes, sufficient funds are available to cover a potential shortfall in co-pay revenues. The SFY 2008 budget forecast anticipated a shortfall in collections as a result of the delays in approval to implement the revised co-pay until August 2007. However, the forecast for overall costs was less than expected for the shortfall is covered.

  The Department is monitoring the effect of the family cost participation (FCP) on families and their services. A monthly report is prepared documenting the number of families withdrawing from the NJEIS due to the family cost share or under suspension due to an outstanding cost share balance over 60 days. Based on past history with family cost participation changes, the number of families withdrawing from the NJEIS is about what was anticipated. For the period of August 2007-February 2008:

  - 80 families (1.4%) withdrew the referral of the child to NJEIS (70 families did not disclose income information and 4 were above 875% federal poverty level (FPL).
  - 168 families withdrew from receiving early intervention services under an Individualized Family Service Plan (IFSP). 67 of the children were aging out within three months of withdrawal. (52 families did not disclose their family income or chose full fee and 42 families were above 875% FPL).

6.b. The FY 2009 recommended budget estimates $7.0 million in EIP co-payments.

- ***Question:*** **Based on FY 2008 co-pay revenues, what is the basis for the $1.0 million increase in co-pay revenues?**

  Answer: The current projected forecast for SFY 2009 family cost participation revenue $6,309,464 based on anticipated monthly collections. The family cost participation revenue will continue to be monitored as the early intervention population changes. However, as caseload increases, so will cost share revenue.

6.c. The FY 2009 recommended budget estimates $15.0 million in federal Medicaid reimbursements to support EIP. Available Medicaid data indicate that about $17.0 million in federal Medicaid reimbursement will be realized in FY 2008.

- ***Question:*** **What is the basis for the $15.0 million Medicaid reimbursement estimate?**

  Answer: The budget authority was established at $17.0 million to allow for the potential Medicaid collections when data clean-up and waivers were approved for agencies to catch-up on back claiming. Maintaining the budget authority at this higher amount eliminates the need to request additional increases should the fund recovery exceed projections. The SFY 2009 budget estimate of $15.0 million is the current forecast projection based on SFY 2008 monthly claiming, fund recovery and anticipated growth.

7. Pursuant to P.L.2005, c.237, Federally Qualified Health Centers (FQHCs) receive $40 million annually from the 0.53% assessment on hospital revenues. (These funds are classified as Other Funds.) In addition, $5.5 million in General Funds are appropriated to FQHCs for other program activities.

As discussed in a Background Paper, p. xx, transferring $1.0 million to the Division of Medical Assistance and Health Services to facilitate a one-time adjustment to the Medicaid reimbursement rates for

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FQHCs would generate an additional $1.0 million in federal Medicaid reimbursement, subject to federal approval.

- ***Question:*** **Should $1.0 million be transferred to the Medicaid program to increase FQHC Medicaid reimbursement and generate an additional $1.0 million in federal revenues for FQHCs?**

  Answer: The State FY 2009 recommended budget has allocated $40 million from the 0.53% assessment on hospital revenues for cost-based reimbursement to FQHCs for uninsured patients. This initiative would require a long-term commitment from the state to raise Medicaid rates.

8. The FY 2009 budget recommends $1,250,000 for the Tourette Syndrome Association of New Jersey.

According to the association's contract with the department, the Executive Director is compensated over $107,000 in State funds. This compensation level exceeds what the State compensates the chief executive officers of the State developmental centers and psychiatric hospitals. Also, compared to agencies that receive considerably more grant funds, the Tourette Syndrome Executive Director is compensated more than Executive Directors of other agencies.

- ***Question:*** **As the Governor's recommended budget would limit contract agency compensation for its chief executive officers, will compensation the Executive Director of the Tourette Syndrome Association receives from the State grant be reduced, or otherwise limited?**

  Answer: We generally support limiting contract agency compensation packages for chief executive officers making them more closely aligned with similar state compensation levels. However, when that comparison is made other factors need to be considered. This consideration should include paid holidays; vacation; sick; pension and health benefits as part of the compensation comparison.

9. In an effort to reduce black infant mortality rates, the department awarded contracts to seven new agencies, in addition to the Black Infant Mortality Reduction and Resource Center. The new programs were to focus on outreach, community education and awareness, professional education and support services.

- ***Questions:*** **Which agencies were awarded funds and how much funding did each of these agencies receive? Are these agencies meeting program objectives with respect to outreach, professional education, etc.? If not, are funds being recaptured and contracts being modified or terminated?**

  Answer: The seven agencies awarded funds for the New Jersey Black Infant Mortality Project:

Northern New Jersey Maternal and Child Health Consortium	$150,000
Central New Jersey Maternal and Child Health Consortium	$155,000
Hudson Perinatal Consortium	$130,000
Regional Perinatal Consortium of Monmouth & Ocean Counties	$130,000
Newark Department of Health and Human Services	$ 75,000
Southern Jersey Family Medical Centers, Inc.	$175,000
Isaiah House	$150,000

The Black Infant Mortality Reduction Resource Center at the Northern NJ MCHC was also awarded $150,000.

Each of the seven funded agencies has specific objectives and strategies that they are responsible for implementing to achieve the goal of black infant mortality reduction. Agencies report progress on meeting

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objectives on a quarterly basis. Six of the seven agencies are meeting identified objectives and found to be in compliance with grant programmatic requirements, based on monitoring reports. One agency is receiving technical support from State staff to comply with the requirements and if after this grant period (June 2008) has not made sufficient progress the grant will be terminated

10.a. The department indicated that in FY 2008 the $4.5 million appropriated for Postpartum programs would be focused on treatment and support services.

- ***Questions:*** **How much is being expended on treatment and support services? How many women have received treatment and support services to date?**

  Answer: $2,490,000 is awarded through health service grants to the regional Maternal and Child Health Consortia, the Pediatric Council on Research and Education, the Family Health Line, and the Department of Human Services, Division of Mental Health Services. All of these funds are expended on treatment and/or support services. Funding is used to sponsor 28 Support Groups throughout the state, the call center for 24/7 information and referral, access to direct mental health treatment services through community mental health centers. Each of the consortia is also tailoring additional services to address the women in their area. Of the total amount, $500,000 is dedicated to printed and video education material, technical support for collecting data and individual assistance in implementing the screening legislation to obstetric practices.

  Numbers served:
  - The call center receives about 100 calls per month.
  - There are approximately 400 unduplicated persons being treated by the community mental health centers.
  - There are approximately 162 women each week attending support groups, for a total of over 8,000 encounters per year.

10.b. During Summer 2007, newspaper articles raised questions about the effectiveness of the $2.5 million being expended on Postpartum Education. The department indicated that treatment and support services, rather than education, would be the focus of program expenditures. Yet the FY 2009 recommended appropriation again recommends $2.5 million for Postpartum Education.

- ***Question:*** **Should the recommended appropriations for Postpartum Education and Postpartum Screening be adjusted to reflect the shift from education to treatment and support services?**

  Answer: Not at this time. While the focus this year has been to expand treatment options and services, education and outreach should remain a part of the appropriation. New women are pregnant every year and require outreach and education. The education includes both the professional community and consumers. New providers are also requesting assistance to institute their screening protocols. However, with the growing number of women in need of support or treatment services we may recommend in the future that the outreach and education appropriation be reduced and the screening and treatment budget be increased.

11. The Mobile Health Van Pilot Program is not continued in FY 2009. During FY 2008, the department awarded three grants to implement the program. As of this writing, the entire FY 2008 appropriation of $0.9 million has been expended/encumbered.

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- ***Questions:*** **As funding for the pilot programs is terminated in FY 2009, how much, if any, of the $0.9 million awarded to three agencies in FY 2008 can be recouped? Will the department allow the three agencies to retain any encumbered funds to enable the pilot program to continue in FY 2009?**

  Answer: The agencies selected from a competitive grant review process met individually with the Office of Primary Care Grants Management Officer wherein their submitted budgets were carefully reviewed and negotiated. Since the grant and budget period for this mobile health center project is only from January 1, 2008 to June 30, 2008, the process of granting a Notice of Grant Award (NOGA) was accelerated and most of the Grantees received their NOGA in early February, 2008. Because agencies will be purchasing mobile units and/or supporting salaries of key personnel to effectively operate an existing mobile unit, all of the $900,000 has been obligated and is expected to be expended by the termination of the grant. Therefore, none of the $900,000 can be recouped.

12. In addition to a proposed $5.2 million reduction in grant funding to the Cancer Institute of New Jersey, to $20.0 million, proposed budget language, D-168, would limit the expenditures to "infrastructure necessary to support cancer research, prevention and treatment."

- ***Question:*** **As virtually everything the institute does can be considered as "infrastructure necessary to support cancer research, prevention and treatment," how will the department enforce this requirement?**

  Answer: We share the same concern that no funds be expended except to support CINJ's infrastructure necessary to support cancer research, prevention and treatment. We will review CINJ's budget submission to ensure that the proposed expenditures directly related to the support of cancer research, prevention and treatment, and we will not allow any line item details that do not adhere to the legislative intent of the grant award.

13. A $15.0 million appropriation is recommended for the Hospital Asset Transformation Program – Debt Service. In addition to the $15.0 million appropriation, proposed budget language appropriates "such additional sums as required." This language means that any amount in additional funds may be appropriated without formal legislative approval.

In April 2007, the New Jersey Health Care Facility Financing Authority (NJHCFFA) issued $45 million in bonds related to St. Mary's Hospital (Passaic), in part related to the purchase of PBI Regional Medical Center.

- ***Questions:*** **Is any of the $15.0 million for debt service related to the St. Mary's Hospital bonds? How much is related to other projects? At this time, will additional appropriations be required? If so, how much in additional appropriations may be required?**

  Answer: The $15 million represents the amount needed to cover debt service for hospitals using the Hospital Asset Transformation program. This amount represents an estimate of debt service expenses the state expects to incur during SFY 2009 and therefore no additional appropriations are required at this time.

HEALTH PLANNING AND EVALUATION

14. There has been a significant increase in the number of medical clinics located in retail environments such as Wal-Mart, CVS, Walgreen, etc.

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- ***Questions:*** **Are these clinics licensed or monitored by the department? If not, are standards needed with respect to: medical personnel qualifications; square footage requirements; medical record keeping and retention of medical records; etc.?**

  Answer: Such clinics are not regulated by the DHSS, since they are considered the "private practice of medicine" and, thus, beyond the statutory and regulatory authority of DHSS.

15. The recommended appropriation to Implement Patient Safety Act program is reduced by $0.2 million, to $0.4 million. The reduction is to be offset by $0.2 million in Medicaid reimbursements. Thus, Medicaid reimbursements would represent 33% of program costs.

- ***Question:*** **As the overall percentage of Medicaid patients affected by the Patient Safety Act program does not represent 33% of total health care patients, what is the basis for the determination that $0.2 million in federal Medicaid revenues can be obtained?**

  Answer: The Department is working with the Division of Medical Assistance and Health Services to explore possible venues for increasing the federal share of Medicaid funding for programs such as the Patient Safety Act Program which provides services to all consumers of medical care in health care facilities including the Medicaid eligible. The UB data indicates that approximately 12-15% of inpatient hospital claims are Medicaid eligible; this is only one component of the patient safety program. When you factor in the expansion of this program to specialized hospitals, long term care facilities and ambulatory settings this percentage greatly increases.

  In addition to the $600,000 provided by the act, there are general departmental central costs and interdepartmental costs (such as fringe benefits) that are also reimbursable by Medicaid.

16.a. Current regulations, N.J.A.C. 10:52-11.1 et seq., require the department to audit the charity care reported by hospitals. In FY 2007 and FY 2008, over 640 audits were completed or undertaken.

- ***Questions:*** **As a result of these audits, were any charity care payments recouped? If so, how much was recouped?**

  Answer: FY 2007 audits are still in progress with the 4th quarter audit underway now to be completed mid-June 2008. The audit process does not "recoup" payments, since it is completed before the subsidy is allocated. The audit results (adjustments) reduce the "value" of documented charity care which can used for any future subsidy allocation. These are "accounting adjustments" which get reallocated to hospitals in future charity care allotments.

16.b. Proposed budget language conditions a hospital's receipt of Charity Care on the department's ability to "review, examine and/or audit any and all financial information" of hospitals.

- ***Question:*** **As the department has considerable direct and indirect authority to obtain needed information on hospital finances, what specific problems in obtaining financial information does the proposed language attempt to address?**

  Answer: This language is needed to investigate hospital finances in greater and more timely detail than financial reports reveal and to audit all financial records and activities as needed to ensure public money is properly accounted for and efficiently invested, including the use of outside consulting or management companies.

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16.c In an attempt to reduce Charity Care and expedite enrollment of uninsured persons into Medicaid/NJ FamilyCare, State law requires county welfare agencies to out-station personnel at hospitals designated by the Commissioner of Health and Senior Services to accept and process applications for Medicaid/NJ FamilyCare by uninsured persons who utilize hospitals.

As indicated in a Background Paper (p.xx), five counties do not out-station personnel at hospitals in their respective counties. Also, the assignment of personnel to hospitals by county welfare agencies appears unrelated to the amount of charity care a hospital provides.

- *Questions:* **For purposes of out-stationing county welfare agency employees, have all hospitals that receive charity care been "designated" by the commissioner? If so, why have five counties not out-stationed personnel to hospitals in their county? How can the Departments of Health and Senior Services and Human Services ensure better compliance by the counties as to the number of personnel out-stationed at specific hospitals?**

  Answer: All hospitals have been designated for the purpose of out-stationing county welfare agency employees. At this time we are working with the Department of Human Services to ascertain which counties have or have not assigned employees to their respective hospitals. Hospitals have a financial incentive to enroll individuals in Medicaid. DHSS, in conjunction with DHS is exploring a variety of ways to automatically enroll charity care clients into Medicaid wherever and whenever possible.

16.d. The FY 2009 recommended budget reduces the overall amount of Charity Care to be distributed to hospitals from about $715 million to $573.0 million and revises the formula by which Charity Care is distributed.

According to the New Jersey Hospital Association, the change in the distribution formula will result in 37 hospitals receiving less Charity Care in amounts between $35,000 and $28.1 million. Another 26 hospitals would lose between $143,000 and $5.4 million in Charity Care, or receive no Charity Care.

Many of the hospitals that will see their Charity Care reduced or eliminated entirely have financed projects through the New Jersey Health Care Facility Financing Authority (NJHCFFA) The Charity Care reductions could jeopardize repayments to the authority.

- *Questions:* **Will the reduction or elimination of Charity Care funding to the 63 hospitals affect the hospitals ability to repay NJHCFFA?**

  Answer: The ability of any given hospital to meet its obligations will depend on its ability to manage its total business and resources. For most of the hospitals that received significant cuts in funding, Charity care only accounts for 8% to less than 2% of their business. A few hospitals are known to have serious financial problems and may need assistance from the healthcare stabilization fund based on their critical safety net role in their community.

SENIOR SERVICES

17.a. The Adult Family Care (AFC) program is a component of the department's Enhanced Community Options (ECO) Medicaid waiver. The waiver provides various community services as alternatives to nursing home care. AFC is the smallest component of the waiver serving about 30 clients (December 2007) at an estimated cost of about $350,000 (State).

- *Question:* **Should AFC be eliminated and incorporated within other programs of the ECO waiver?**

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Answer: Adult Family Care (AFC) should not be eliminated. Even though it is a small program, it is valuable and has prevented/delayed institutionalization for over 243 individuals since its inception as a Medicaid Waiver service in 1996. At a Medicaid reimbursement rate of $50 a day, AFC is one of the most cost-effective 24/7 long-term care services available as it meets the needs of those individuals who benefit from a one-on-one relationship with a caregiver.

When the Department's Medicaid waivers are consolidated into one Global Options for Long Term Care (GO) Waiver, expected 7/1/08, AFC will become a service option within the GO services. AFC and AL will then be the only community services that can offer care 24/7; definitely a plus and a reason, in addition to the others listed above, to retain the program.

17.b. The department contracts with Public Partnerships, LLC, for various third party services in the community programs it administers, such as: Caregiver Assistance Program, Adult Family Care, Assisted Living Program, Assisted Living Residence, etc. The department granted Public Partnerships an extension until April 30, 2007 to develop a performance measurement report and a co-payments report.

- ***Questions:*** **Are these reports functional and operating to the department's specifications? If not, have any financial penalties been imposed on the contractor?**

  Answer: The Department received its first performance report on May 1, 2007 and has continued to receive performance reports monthly. The Monthly Report of Performance Measures shows in detail the percentage of each task completed whether it is issuance of Participant Employed Provider (PEP) payments within the four-day timeframe or the updating of training manuals. Public Partnerships LLC (PPL) clearly explains the method in which each task was performed and the findings pertaining to the task. It also analyzes the task to date and indicates any trends detected. For example, noting that claim discrepancies between provider invoices and data submitted by care managers is decreasing by 10% each month is very helpful to the Division.

  Lastly, PPL's Monthly Report of Performance Measures explains any actions that were taken to correct specific tasks that month, ranging from length of processing time and submission of bills and invoices to the updating of manuals and instructions. If there were no corrective measures taken that month, PPL uses this area of the report to suggest improvements that the State or PPL might need moving forward.

18.a. Final federal rules were adopted in February 2008 concerning "health care related taxes" in the Medicaid program. Such rules may affect the State's nursing home assessment program (N.J.S.A.26:2H-95 et seq.) and the $136.0 million the assessment generates.

- ***Questions:*** **Will this rule reduce the State's nursing home assessment revenues? If so, by how much?**

  Answer: We do not think this will impact New Jersey. CMS has already approved the New Jersey State Plan Amendment and Waiver Application regarding the nursing home provider assessment. In several places in the preamble of the final rules, CMS states that it is not aware of any state tax programs that would have been permissible under the original version of the hold harmless rules, but would not be permissible under the new interpretations.

18.b. The FY 2007 appropriations act assumed savings of $15.0 million by increasing the look back period for Nursing Home eligibility, from three to five years, as mandated by the federal Deficit Reduction Act. The department indicated that savings will be realized in FY 2009.

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A report by the federal General Accountability Office indicated that minimal Medicaid savings were achieved by existing look back programs, as few people actually transfer assets to obtain Medicaid eligibility.

- ***Question:*** **Does the department still anticipate $15 million in savings in FY 2009?**

  Answer: This initiative was built into the Department's base budget for nursing homes two years ago. Based on reduced projected nursing home forecasts, the Department assumes that these new federal asset transfer rules are working.

18.c. During FY 2006, Myers and Stauffer, LLC, conducted between 100 to 140 focused nursing homes audits. The department was to review these focused audits to determine whether they were cost effective.

- ***Questions:*** **Were focused audits cost effective? What savings were achieved by such audits?**

  Answer: Myers and Stauffer are scheduled to complete 106 focus audits for SFY 2006. They have completed 105. 1 is open, 50 are closed and 54 have been recalculated. The 54 recalculated audits resulted in an overpayment of $1,135,958 at a cost of $206,177.50. In the past, for every dollar spent on auditing, the yield is a $2.00 return. For Myers and Stauffer, the return is about $3.00. For the first stage of focus audits, for every dollar spent on focus audits, there is a $5.50 return.

18.d. In FY 2007, the department expected to complete about 170 nursing home recalculations. In FY 2008, 140 rate recalculations were to be completed.

- ***Questions:*** **What accounts for the reduction in the number of rate recalculations between FY 2007 – FY 2008? How many rate recalculations will be completed in FY 2009? What recoveries are expected to be realized as a result of these rate recalculations in FY 2008 and FY 2009?**

  ***Answer*:** The nursing home rate setting unit has experienced a drastic reduction in staff in the last two years. In November 2005 the Ratesetting Unit had 25 filled positions: a director, 3 clericals, and 21 analysts. The director of the unit retired in January, 2008. There are now 2 clericals and 7 analytical staff. The remaining staff needed to focus their attention on calculating the new FY'08 rates for each of the facilities. The Department requested an exemption from the hiring freeze for this unit. A new director has been recruited, and we are in the process of hiring 6 new analysts. Once new staff are on board and trained, we will again be able to devote staff time to recalculating rates as a result of audit findings. The budget proposal that eliminates rebasing of nursing home rates will also free up staff time for rate recalculations.

19. Recommended appropriations for Medical Day Care Services include $6.0 million in savings to be realized by reimbursing all providers at the average rate for a free standing facility, regardless of whether the provider is based in a hospital or nursing home.

- ***Questions:*** **Have any hospitals indicated that they may discontinue their participation in the Medical Day Care Services program if this reimbursement change is adopted? Is sufficient capacity available to handle the termination of any hospital based Medical Day Care Services program?**

  Answer: Only 1% of Medical Day Care services are provided at hospital based facilities. 95% of Medical Day care services are provided through freestanding facilities, and the remaining 4% are provided through nursing home based facilities. The budget initiative freezes the rates at the freestanding rate. We have not heard from hospital based facilities, but there is sufficient capacity available from freestanding facilities.

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20.a. Savings of $7.0 million are expected to be realized by increasing the PAAD co-payment from $5.00 per prescription to $6.00 per prescription for generic drugs and to $7.00 per prescription for brand name drugs. A number of medications used by PAAD recipients have no generic equivalent, e.g., Lipitor, Zyprexa, etc.

- ***Question:*** **Will PAAD recipients be required to pay a $7.00 co-pay for brand name drugs that have no generic equivalent?**

  Answer: Brand name drugs are generally the most expensive medications covered by PAAD. Beneficiaries will pay a $7.00 copay for all brand name drugs including those with no generic equivalent, unless the beneficiary is eligible for the Medicare Part D Low Income Subsidy (LIS) program. The population on PAAD with the lowest income and assets will pay a lower copay under Medicare Part D. Approximately 26,147 PAAD beneficiaries with income below 100% FPL and low assets will pay $3.10 for brand name drugs. Another 18,060 beneficiaries with income below 135% FPL and low assets will pay $5.60 for brand name medications.

20.b. An additional $1.1 million in PAAD savings are anticipated by increasing the rebate for generic drugs from 11% to 15.1%. Several years ago the State attempted to increase such rebates, but withdrew the proposal due to objections from pharmaceutical manufacturers.

- ***Question:*** **As the State's previous effort to increase the rebate paid on generic drugs by pharmaceutical manufacturers was not successful, what has changed to suggest that it will be successful at increasing the rebate on generic drugs in FY 2009?**

  Answer: This is an austere budget year and the sacrifice must be shared. We cannot expect PAAD beneficiaries to pay higher copays, pharmacists to have a reduction in reimbursement rates, and not require higher rebate payments from drug manufacturers. Prior to Medicare Part D implementation in January 2006, the PAAD program received rebates from drug manufacturers in excess of $150 million. Now that PAAD pays as a secondary payer to Medicare Part D for over 90% of the PAAD beneficiaries, the drug manufacturers pay the rebates to the Medicare Part D plans, rather than PAAD. PAAD currently receives rebates of approximately $13 million. The rebates paid to Medicare Part D plans are generally substantially lower than rebates required for PAAD and Medicaid. Consequently, we are now looking to the drug manufacturers to contribute more to fund PAAD benefits.

20.c. Savings of $4.8 million are anticipated through the cooperative purchasing of prescription drugs with other programs, presumably the Medicaid and State Health Benefits Programs. Several years ago the State attempted a similar concept by becoming a prudent purchaser of drugs in conjunction with other State programs. The effort was not successful.

- ***Question:*** **As the State's previous effort at cooperative purchasing of prescription drugs was not successful, how will the effort this year ensure success in reducing PAAD drug costs?**

  Answer: New Jersey has been approached by representatives from the States of New York and Pennsylvania regarding pooling the combined purchasing power of all state prescription expenditures from all three states when negotiating better rebates from drug manufacturers. National AARP representatives are also working on this initiative and have engaged outside consultants to work with representatives from the three states. The estimated aggregate annual buy of the three states of $11 billion is roughly 40% of the total prescription spending in the three states which will provide substantial negotiating power.

20.d. The dispensing fee pharmacists will receive is reduced from $3.73 - $4.07 per prescription to $3.73 to $3.99 per prescription. The $0.08 reduction is due to a change in the determination of how a pharmacy is

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entitled to an "impact allowance." At present, a pharmacy is eligible for an impact allowance if its Medicaid/NJFamilyCare/PAAD volume is greater than 50% of total claims. The amount this change may save is not identified.

- ***Question:*** **What will the revised criteria for determining the impact allowance be? How much will this change save?**

  Answer: The impact from eliminating the $.08 dispensing fee add-on will be minimal for PAAD and Senior Gold. If Medicare Part D pays as the primary payer, PAAD/Senior Gold does not pay a dispensing fee. As a result of the successful coordination with Medicare Part D, it is estimated that PAAD is primary payer on only 785,277 claims annually. The total estimated impact for PAAD would be only about $62,822 annually. Additionally there would be approximately 149,723 claims annually for Senior Gold that would have an impact of $11,977. For the minimal amount of claims affected, it makes sense that the dispensing fee for claims paid as primary under PAAD/Senior Gold follow the Medicaid dispensing fee logic in the Unisys claims processing system. It would not be cost effective to set up a different dispensing fee methodology for so few claims. Therefore, PAAD /Senior Gold dispensing fee will follow the Medicaid criteria.

20.e FY 2009 PAAD enrollment estimate for the elderly component is 144,700. The current number of elderly PAAD recipients is 139,400, or about 5,300 below the FY 2009 estimate.

- ***Question:*** **In view of the current number of elderly PAAD recipients enrolled in the program, can the FY 2009 enrollment estimate be reduced?**

  Answer: Effective March 12, 2008 there are 167,709 total PAAD beneficiaries of which 29,012 are disabled and 138,697 are aged. The FY 2009 enrollment estimates are 144,730 elderly and 27,841 disabled. These numbers change each week. Therefore, based on current enrollment, the number of anticipated aged beneficiaries is 6,033 higher than actual FY'08, but the number of anticipated disabled beneficiaries is 1,171 lower than actual FY'08

21. Savings of $3.4 million in the Senior Gold Discount Program are anticipated by requiring recipients to enroll in the federal Medicare Part D program. At present such enrollment is voluntary.

- ***Question:*** **Of the approximately 22,200 Senior Gold recipients, how many are currently not enrolled in the federal Medicare Part D program?**

  ***Answer*:** Currently, there are 21,770 Senior Gold beneficiaries and 15,208 (70%) are enrolled in Medicare Part D plans. 6,562 Senior Gold beneficiaries are currently not enrolled.

22. The recommended appropriation for the Office of the Public Guardian assumes $1.1 million in Other Funds, an increase of approximately $0.2 million over FY 2008. The increase may be related to an increase in the fees charged by the office for its services.

- ***Questions:*** **What is the increase in Other Funds attributable to? If it is attributable to an increases in fees, will it be necessary to adopt regulations to change the fees, and if so, when will proposed rules be published in the New Jersey Register?**

  Answer: The increase in other funds in attributable to the increase in the number of wards associated under the care of the Public Guardian.