Discussion Points

DEPARTMENT OF HEALTH AND SENIOR SERVICES – GENERAL

1. According to Schedule 1, actual 2005 revenues from the HMO Covered Lives Assessment were $1.6 million, not the $2.6 million the FY 2005 appropriations act had anticipated.

- *Question:* **What accounts for the $1.0 million revenue shortfall?**

- **Answer**: This is a relatively new assessment and prior year budget estimates were in error. The FY 2007 budget reflects anticipated collections of $1.8 million which is in line with actual collections for this assessment.

HEALTH SERVICES

2. a. Available information indicates that in FY 2005 and FY 2006, the Office of Vital Statistics experienced a backlog in processing new applications, corrections and amendments to existing records and new birth certificates for adoptions.

- *Question:* **What steps has the office taken to reduce its backlog?**

- **Answer:** The Bureau of Vital Statistics and Registration has automated and streamlined many of the daily operations to provide a more efficient workflow. Additional office automation is ongoing and will continue to improve the capabilities and operations of the staff. Staff assignments have been restructured and man power reassigned to ensure critical operations are fully staffed on a daily basis. A one-time blanket of overtime has been authorized to eliminate the last remaining backlog by the close of FY 2006.

2. b. Evaluation data in the proposed budget indicate that the number of searches completed by the Office of Vital Statistics will be reduced by 20,000 in FY 2007, from 110,000 to 130,000. Additionally, the number of certified copies issued is also anticipated to decrease by 13,000, from 98,000 to 85,000.

- *Question:* **What accounts for the expected decrease in searches and certified copies issued in FY 2007?**

- **Answer:** During FY 2006 resources were allocated on addressing the backlog of applications received during FY 2005 and FY 2006, thus inflating the number of applications processed. By eliminating the backlog of processable applications the Bureau of Vital Statistics and Registration will focus on processing applications for the current year (FY 2007) only. The Bureau provided Local Registrars with data CD's of birth and marriage data and will continue to make progress in establishing a centralized web repository of vital records, enabling the local registrar's to issue a larger universe of records in a prompt efficient manner.

2. c. The Office of Vital Statistics provides exclusive rights to a vendor to process internet and facsimile applications for copies of vital records. A June 2004 State audit report recommended that a request for proposal (RFP) be issued for these services. In its response to the audit, the department stated that it had completed a RFP to choose a new vendor.

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- ***Question:*** **Has the department issued the RFP? Has another vendor been awarded a contract for these services?**

- **Answer:** The DHSS submitted the RFP to the Purchase Bureau in April, 2004. In January, 2005 we received the document back from the Purchase Bureau formatted on their template. In March, 2005 we received approval from OIT and resubmitted the RFP to the Purchase Bureau. In September, 2005 we received a substantially revised version of the RFP from the Purchase Bureau with their initial approval. Since that time it has been undergoing a series of refinements by DHSS management in response to subsequent reviews with questions by the Purchase Bureau. At this point we have responded to the most recent questions that the bidder from the Purchase Bureau sent on April 11, 2006. It is anticipated the RFP will be issued in early FY 2007.

3. In FY 2004, the Early Childhood Intervention Program implemented a monthly base cost share. The FY 2007 proposed budget assumes that there will be an increase in the cost share requirement from $10 per month to $30 per month for families at 350% federal poverty level (FPL) ($70,000 for a family of four). The FY 2006 and proposed FY 2007 budgets assume that the cost share will generate $3.5 million and $7 million, respectively.

- ***Question:*** **If the cost share is tripling, why are cost share revenues only doubling? What mechanism is in place to ensure that families pay their cost share? Have services been terminated to any families who have not met their cost sharing requirements?**

- **Answer:** Although it may appear that the cost share is tripling by the example used, it is not tripling for all families on the sliding fee scale. As the chart below indicates, the number of families in each tier decreases as the Federal Poverty Level (FPL) increases. Therefore, in order to increase the annual family cost participation (FCP) collections by $3,000,000 there is a need to increase rates to all families that are paying FCP. This is especially true for the base level, since it is the tier with the greatest number of families. Therefore, the base rate will need to triple from $10 to $30 per month. However, rates for families above the base will be progressive and vary in percentage increase along the scale.

  If the cost share base was set at $20 (or double the current rate) it would not be sufficient to generate the $3 million in additional revenue needed. Each year the federal poverty level increases without necessarily a concomitant increase in family income, resulting in fewer families participating in the cost share. Therefore, there was a need to increase the revenue across a declining number of cost share participating families.

  The chart below identifies the number of NJEIS families by Federal Poverty Level

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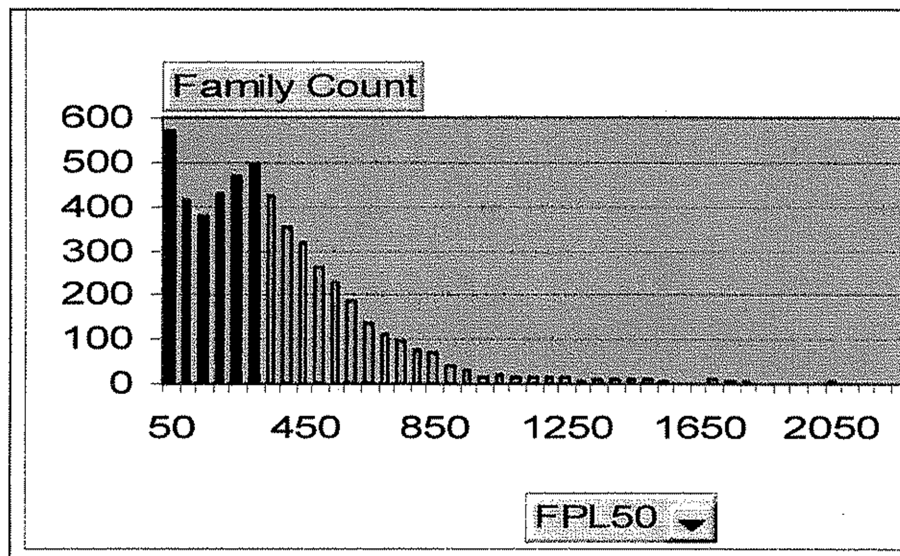

What mechanism is in place to ensure that families pay their cost share?

The New Jersey Early Intervention System (NJEIS) Family Cost Participation Policy and Procedures includes a failure to pay procedure. The current procedure is under review with the intent that timelines to implement termination of services for non-payment may be shortened. Current procedures for failure to pay follow:

- Each month, an Explanation of Benefit and, as appropriate, a billing statement is mailed to the family by Covansys, the Central Management Office (CMO) for NJEIS. The statement includes the total amount due. The family has thirty (30) days from the date of issuance of a Family Cost Participation Statement to pay their cost share payment.
- If the prior month's payment is not received prior to the generation of the current month's statement, the next billing statement mailed by the CMO includes a past due notice to the family.
- If payment is not received after another thirty (30) calendar days, a 60 day notice of non-payment is included on the family statement and mailed by the CMO
- At this point the NJEIS would send written notice to the family that if payment is not received in fourteen (14) calendar days, services will be suspended. The notice will include a date of suspension.
- A copy of the notice to the family will also be sent to the service coordinator and any EIP provider agency assigned to the family.
- The Service Coordinator is encouraged to contact the family to discuss the reason(s) for non-payment and, as appropriate, determine a need to review, and revise the IFSP and/or family cost participation Income Verification Form.
- If the service coordinator can not contact the family or determine a need to change the IFSP or if full payment of the family cost participation payment is not received, the EIP agency(s) providing services will be instructed to immediately suspend the direct IFSP services affected by the outstanding family cost share.
- Families would continue to receive the services provided at public expense that are not affected by a family cost share including: evaluation, assessment, IFSP development, service

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coordination, and procedural safeguards.

- If the family should satisfy the Family Cost Participation payment that is due after direct services have been suspended the NJEIS will reinstate the services at the family's request.
- Families are informed that there may be a delay between the suspension of services and reinstatement of the services. Make up services will not be provided for this disruption in services.
- To request reinstatement of services a written request must be sent to the state NJEIS office.

The NJEIS is currently exploring the feasibility of recovering unpaid family cost share through the Set-Off Individual Liability (SOIL) Program, which would entitle the NJEIS to hold an individual's tax refund, NJ Saver Rebate, and/or Homestead Rebate. The SOIL Program is authorized under N.J.S.A. 54:50-8 and 54:50-9.

Have services been terminated to any families who have not met their cost sharing requirements?

No, the NJEIS continues to catch up on service authorizations and claiming of services delivered by the EIP provider agencies back through SFY 2005. As a result there have been delays in family billing that has required leniency in implementation of the failure to pay procedures. Families cannot be billed until the EIP provider agency bills for services to ensure that families pay a monthly cost share or actual cost of services which ever is less. EIP agencies have been informed that they have until June 30, 2006 to resolve any outstanding issues related to billing for services. At that time there will be stricter adherence to a 90 day timely filing of claims on services provided to families. This will enable the system to be in "real time" billing. Currently 72% of families currently receiving services have paid some if not all of the payment due. The outstanding payment collection is $458,560.

4. a. The FY 2006 Appropriations Act provided a total of $26 million through both on-budget and off-budget sources for Federally Qualified Health Centers – Services to Family Care Clients (FQHCs), an increase of $5 million over the prior year. The increase was intended to provide services to an additional 30,000 State residents.

The Governor's FY 2007 budget recommends a total of $40 million for FQHCs through both on-budget and off-budget sources to expand the capacity of existing centers. The budget also increases funding for Family Planning Services by $2 million to support an additional 4,500 patients. Many of these family planning services are currently provided by FQHCs.

- **Question: Given that FQHCs received additional funding for expansion in FY 2006 and that the $5 million provided on-budget for FY 2007 is intended to expand services offered by FQHCs, can the $2 million increase for Family Planning Services be reduced?**

- **Answer:** No, family planning agencies provide comprehensive reproductive health care counseling and services to over 126,000 men and women, annually. Family planning agencies provide on-site accessibility to contraceptive pharmaceuticals at reduced costs. Family planning agencies also in accordance with federal title X regulations provide confidential services to adolescents (28 percent of family planning clients are under 21 years of age). Adolescent clients require skilled counseling and age-appropriate information.

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Family planning agencies facilitate successful counseling to minors on abstinence education and resistance to sexual coercion, peer pressure, violence, child abuse and domestic abuse. In comparison, FQHC services are usually limited to a gynecologic/obstetric physical examination.

Finally, it should be noted that 83 percent of clients served by family planning agencies are uninsured and predominately under 150 percent of the federal poverty level; providing just gynecological services for this population through FQHCs would exceed $18 million at the current rate of reimbursement. In SFY 2006, public support for family planning (federal and state grant funds) was approximately $14 million.

4. b. The Governor's Health and Senior Services Transition Policy Group issued a report which cited licensure requirements and other regulations governing community health centers that mirror, in many cases, those governing much larger health care facilities (e.g., hospitals). The report suggested that streamlining these requirements could reduce the operating costs of FQHCs.

- **Question: Has the department considered what specific regulatory requirements affecting FQHCs could be streamlined? If so, has the department begun work on streamlining the requirements?**

- **Answer:** Yes, The Department is exploring ways to streamline the initial licensure process. We are making progress with the most recent expansions five (5) new FQHC access points were licensed and operational within six months. We have been working with DCA to better coordinate this process for FQHCs. We are also exploring with them ways to simplify the process considerably for smaller FQHCs. We will continue our efforts to find additional ways to ease regulatory burdens for FQHCs.

4. c. Significant funding is provided to FQHCs by the department and the Medicaid program. Many FQHCs participate in the federal 340B Drug Program and are able to purchase drugs at discounted prices. It is not known whether the prices provided through the 340B program will be less than the price the State may pay for prescription drugs once bulk purchasing and federally mandated prescription drug reimbursement changes are adopted.

- ***Question:* Are federal 340B drug prices better than the prices the State will realize after bulk purchasing and federally mandated reimbursement changes are adopted? If not, should FQHCs be included in the State's bulk purchasing plan?**

- **Answer:** Currently, five (5) FQHCs participate in the 340B program, with an additional eight (8) under development. The 340B discounts range anywhere from 40% to 60% off retail for covered medications. The eligible entity (health centers, hospitals, family planning/planned parenthood organizations, etc.) get approved by the federal authority to acquire drugs from pharmaceutical companies at a discounted price. The center's clinicians prescribe the drug and, depending on the model selected for dispensing, the patients are able to purchase the drug at the specified pharmacy (or in-house pharmacy) for the discounted price.

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The discount through the 340B program is likely higher than what can be realized through bulk purchasing, however, we would be glad to include FQHCs in the bulk purchasing plan if the discounts are higher.

5. In FY 2006, the Legislature appropriated $2.5 million for Post Partum Screening, with level funding proposed for FY 2007. During last year's budget discussions, the department stated that this initiative would likely be implemented through the regional Maternal and Child Health Consortia, which would train clinicians to identify women with postpartum depression. Once these women were identified, they would be referred to a licensed mental health agency.
As of this writing, approximately $1 million from the account has been expended or is committed for this initiative in FY 2006.

- ***Question:* Have any clinicians been trained through the program? How many women have been referred for screening services? How many have received treatment? Are any indicators in place to test the effectiveness of this program?**

- **Answer:** In October 2005, the Department collaborated with the Maternal and Child Health Consortia to conduct Train the Trainer workshops for the Postpartum Mood Disorder (PPMD) Speaker Bureau. There were 148 professionals participating in the Train the Trainer workshops. These professionals have subsequently participated in the grand rounds, seminars and other educational venues conducted by the Maternal and Child Health Consortia.

  From November 2005 to April 20, 2006, a total of 4,464 clinicians (physicians, nurses, psychologists, social workers) have been trained through the PPMD initiative. General program evaluations are completed following each session.

  The Department's Family Health Line is a 24/7 hotline. As of April 19, 2006, there were a total of 853 PPMD calls received. Of this number, 626 were referred to University Behavioral Health Care (UBHC) for screening, assessment and treatment. The remaining 227 callers received mailed PPMD information.

  Based on available data from July 21, 2005 to February 28, 2006, a total of 672 Postpartum Mood Disorder (PPMD) related calls were received by the University of Medicine and Dentistry of New Jersey (UMDNJ) University Behavioral Healthcare (UBHC). Of this number, 399 callers received screening and assessment services. The remaining 273 callers had scheduled appointments and received treatment.

  In order to ascertain effectiveness of the initiative, questions specific to PPMD screening, referral and treatment are being added to the Pregnancy Risk Assessment Monitoring System (PRAMS) questionnaire.

6. In FY 2005 and FY 2006, the Legislature appropriated a total of $2 million to distribute 60,000 free home Lead Testing Kits for Expectant Mothers. Parents or guardians were to mail completed kits to a certified lab for analysis, and to bring children to a physician for lead screening if a home tested positive. Available information indicates that the program is not funded in the FY 2007 proposed budget because a surplus of kits will be available in FY 2007.

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- ***Question:*** **How many kits were distributed? How many were returned for analysis? How many children have had their blood lead levels tested as a result of the program? How many of those children had elevated blood lead levels? How many kits will be available for FY 2007?**

- **Answer**: As of April 19, 2006, a total of 11,630 kits have been shipped to providers. Of these kits 3,364 were distributed by providers. There were 895 kits returned and 217 of specimens tested positive for some lead detected and 104 had hazardous levels of lead detected. It is anticipated that an additional 8,000 kits will be distributed between April 2006 – June 2006. The majority of these kits were distributed to expectant mothers and testing of the home was done while the mother was still pregnant. Any children residing in the household would have their blood levels tested according to the established guideline, which is by the age of two.

  As of March 2006, the project has expanded the initiative and is distributing testing kits to families with children under three years of age living in the 18 highest risk cities.

  The projected number of kits available for distribution in FY 2007 is 35,000.

7. The FY 2005 Appropriations Act included language which authorized the department to provide no-cost loans and grants to the Coriell Institute for Medical Research for the establishment of a Statewide Allogenic Cord Blood Bank. Available information indicates that approximately $2.5 million was provided. Language in the FY 2006 Appropriations Act carried forward unexpended FY 2005 monies.

- ***Question:*** **Has the Cord Blood Bank been established? What are the terms and conditions for the grants or loans provided by the department?**

- **Answer:** This grant was awarded to the Coriell Institute for Medical Research to continue the Cord Blood Bank that was established prior to the issuance of this grant.

  The Terms and Conditions of this Grant are as follows:
  - Grant funds were provided for the collection and long-term storage of cord blood samples, and for research directed at the growth of stem cells in such samples. The collection and storage of cord blood samples shall occur in New Jersey and shall be completed on a not-for-profit basis.
  - The grantee shall track the number of specimens collected, processed, cryogenically stored, and to submit related information for inclusion on the National Marrow Donor Program (NMDP) Umbilical Cord Blood Registry and/or the Caitlyn Raymond Umbilical Cord Blood Registry.
  - The grantee is to establish and maintain a publicly accessible, allogeneic cord blood bank. With medical authorization, the grantee will release allogeneic umbilical cord blood for use in bone marrow transplantation.
  - The grantee is to implement an education and outreach program to enhance the collection of umbilical cord blood from consenting expectant mothers. The education and outreach program includes the production and distribution of brochures to participating Hospital Clinics and Physician offices.

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From the Institutes' 2005 annual report, they should have banked almost 2,100 cord blood units over the last five years. In 2005, eight units were made available for transplant.

8. The FY 2005 budget included a new $200,000 appropriation for an Office of Animal Welfare. Newspaper reports indicate that in FY 2007 the department will eliminate this office and have its duties assumed by the Infectious and Zoonotic Disease Program. However, the proposed budget maintains level FY 2006 funding for the office, with a $300,000 appropriation.

- ***Question:* When will the functions of the office be transferred? Can the $300,000 appropriation be reduced or eliminated once the duties are absorbed in the normal operations of the department?**

- **Answer:** The Office of Animal Welfare (OAW) was placed in the Infectious and Zoonotic Disease Program (IZDP) in the Communicable Disease Service effective February 15, 2006. The Office will continue to provide oversight, education and assistance to 114 local health departments and Animal Control Officers in carrying out their duties and responsibilities related to inspections of animal facilities including pet shops, pounds and animal shelters. During the last 18 months (June, 2004 through December, 2005) the OAW conducted 337 inspections and responded to over 200 complaints regarding unsanitary conditions and animal abuse. Prior to the creation of the OAW, IZDP staff was diverted from disease prevention and control activities in order to perform the 10 to 12 investigations per year of serious violations of facilities brought to the attention of the DHSS through constituent complaints and newspaper articles.

  Based on the additional tasks and volume of constituent correspondence generated, continued funding for the remaining three positions in the OAW must be maintained. This additional work can not be absorbed by existing IZDP staff that has a full complement of job responsibilities relevant to disease prevention and control.

9. In FY 2006, the Legislature appropriated a total of approximately $49.3 million to the Cancer Institute of New Jersey (CINJ) and its affiliates as follows:

- CINJ: $22.3 million
- CINJ, Newark: $9 million
- CINJ, South Jersey: $9 million
- Robert Wood Johnson University Hospital, New Brunswick: $9 million

A portion of these monies were intended for faculty recruitment and the development of new programs and treatment facilities.

- ***Question*: Specifically, what new programs and treatment facilities were established through these monies? How many new faculty positions have been created through this funding?**

- **Answer: See Attachment 1**

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10. In September 2005 the Department of the Treasury began a three-year contract with a vendor to detect drug abuse among inmates and parolees through the analysis of saliva, hair or sweat. Previously, the Judiciary reimbursed Laboratory Services to detect drug abuse through urine samples.

- *Question:* **Will revenue received by Laboratory Services be reduced as a result of the contract? Could the division provide these services, thereby avoiding the need for the State to contract with a vendor?**

- **Answer:** The Department of Health and Senior Services through the State Laboratory Division of Public Health and Environmental Laboratories currently screens (urine) specimens for the AOC for drugs of abuse. This work is performed on a fee-for-service basis under a 2 year MOA. The annual workload and revenue under this contract have been:

	FY04	FY05	FY06 (est.)
Specimens	171,000	186,000	144,000
Revenue	$1.24	$1.25	$1.0

Since Public Health and Environmental Laboratories has currently experienced a 10% reduction in testing under this contract, our anticipation is that the FY07 reduction would be approximately 15%. This projects to be a reduction of approximately $250,000 annually in revenue.

Public Health and Environmental Laboratories is in the process of preparing to test oral fluid. Instrumentation to perform the initial screening has been purchased, and the laboratory is in the process of validating methodologies. This will be completed in early to mid FY07, at which time Public Health and Environmental Laboratories will be capable of providing these services. At this point DHSS/PHEL can petition Treasury to give notice to the existing vendor that viral specimen testing will begin to be forwarded to the State laboratory.

11. The proposed budget estimates that the Pharmaceutical Assistance to the Aged and Disabled (PAAD) program and the Senior Gold program will save $6.3 million through bulk purchasing and $3.3 million as a result of reimbursement changes in the Medicaid program mandated by federal law. There is no mention of how much the AIDS Drug Distribution Program (ADDP) and the Pharmaceutical Services for Adults with Cystic Fibrosis program may save as a result of these proposals.

- *Question:* **How much will ADDP and the Pharmaceutical Services for Adults with Cystic Fibrosis program save through the proposed changes?**

- ***Answer:*** The proposed budget did not allocate any savings to ADDP or the Pharmaceutical Services for Adults with Cystic Fibrosis programs from the bulk purchasing initiative or the changing of pharmacy reimbursement.

  The proposed allocation for the Pharmaceutical Services for Adults with Cystic Fibrosis program in FY 2007 is $348,000. In addition to prescription medications, this program also

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supports therapeutic supplements that are not ordinarily covered on pharmaceutical formularies. As such, savings through bulk purchasing and reimbursement changes would be minimal. The ADDP budget is primarily federally funded.

In the implementation of both the bulk purchasing initiative and reimbursement changes, all applicable programs will be considered.

12. In FY 2006, $5.7 million was provided to clinics for Rapid AIDS testing, with $4.2 million proposed for FY 2007. The test indicates HIV-status in minutes as opposed to weeks with other methods, and thus eliminates the need for a second visit to a provider to receive test results. The department has stated that under other methods some test results were not received by HIV-positive persons, increasing the likelihood that infected persons continued to spread the disease. Approximately $3 million was expended by the program in FY 2005.

- ***Question*: How many clients received the Rapid AIDS test each year? How many were tested by other methods before the program began? Has the department seen a reduction in HIV transmission that may be attributed to the program?**

- **Answer:** Funding was not reduced for Rapid HIV Testing, it was reduced for the advertising campaign associated with it. Funding for the actual test was not reduced in the Governor's Budget Recommendation.

  Rapid HIV testing began in New Jersey in November 2003 with the licensing of its first site in New Brunswick. Prior to this, all testing was conducted either by non-rapid oral fluid or blood collection. During the three-year period 2001-2003, non-rapid oral fluid and blood or serum testing averaged 66,636 patients per year. For the two full years when rapid testing was available, i.e., 2004 and 2005, the number of people tested averaged 72,710.

  HIV Testing in New Jersey

	2004	2005
OraSure & Serum Testing	60,376	39,686
Rapid Testing	11,587	33,771
Total	71,963	73,457

  It is estimated that 25% - 40% of those with HIV disease are unaware of their infection. Many of these individuals continue to engage in high risk behaviors (with a minimum of two partners), putting numerous others at risk of being infected, thus expanding the epidemic. To reduce transmission of HIV, the CDC has recommended the provision of routine HIV testing in a variety of public health locations. In so doing, individuals can become aware of their status, and if infected, enrolled into care. Studies have indicated that once an individual becomes aware of their HIV status, they are more likely to reduce risk behaviors, or seek care if infected. (MMWR July 18, 2003 pages 1-24)

  Over 99% of patients being tested with the rapid technology wait to get their results, compared to 65% of patients tested with the conventional methodology (where patients must return 1-2 weeks later). Rapid test results are available in less than 30 minutes. Rapid testing

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has also facilitated the identification of HIV positive patients who were not previously known to our system. Approximately 70% of all patients testing positive are "new." By informing newly infected patients on the same day, counselors can provide risk reduction messages, as well as make referrals to HIV care and treatment resources. This facilitated access to services, helps reduce further transmission, and improves the quality of life for those infected.

HEALTH PLANNING AND EVALUATION

13. a. The FY 2006 Appropriations Act provided a total of $2.8 million for Salaries and Wages in Health Planning and Evaluation ($1.7 million for Long Term Care Systems and $1.1 million for Health Care Systems Analysis). However, the FY 2006 Adjusted Appropriation, displayed in the Governor's budget, indicates that a total of $1.8 million has been appropriated for the program.

- ***Question:*** **What accounts for the difference between the $2.8 million originally appropriated for Salaries and Wages in FY 2006 and the $1.8 million adjusted appropriation?**

- **Answer:** The fiscal year 2006 Appropriations Act required $3.5 million in "efficiencies" throughout the Department. The Department applied $1 million of that reduction in the area of Health Care Systems Analysis.

13. b. The FY 2007 proposed budget increases Salaries and Wages in Health Planning and Evaluation by $4.2 million, from $1.8 million to $6 million. However, personnel data indicate that the number of State-supported positions will be reduced by 21 positions, from 89 to 61 in FY 2007.

- ***Question:*** **Given the reduction in State-supported positions, what accounts for the increase in Salaries and Wages?**

- **Answer:** The Fiscal Year 2007 budget increase reflects the loss of funding provided for hospital inspection staff that where formerly funded by the Health Care Reduction Fund (.53% surcharge). Senate Bill S-2260, redirected the use of these funds for Federally Qualified Health Centers, therefore administrative costs associated with this staff were no longer allowed to be charged off to this non-state funding source. The reduction of staff is attributable to an $874,000 reduction in that account as part of a DHSS reorganization which had the effect of reducing overall staffing needs.

14. The FY 2006 Appropriations Act provided approximately $1.2 million to the Nursing Home Background Checks/Nursing Aide Certification Program to cover DHSS personnel costs for the processing of applications and State Police costs for background checks. The proposed FY 2007 budget decreases the appropriation by $200,000 to approximately $1 million.

- ***Question:*** **Can the program be adequately supported with the proposed FY 2007 reduction? Does the department intend to reduce administrative costs or payments to State police to offset the reduction, or is there another mechanism to provide the same services with less dollars?**

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- **Answer**: The reduction is the result of several cost saving efficiencies that the Department has experienced over the past year. The Department has consolidated all criminal background checks, including nursing home background checks, under the aegis of one unit. By avoiding duplication of services, there is economy of scale savings. Additionally, the Department has fully implemented the use of archived fingerprint images to recertify nurse aide candidates. There is direct cost savings associated with the use of an archived fingerprint image (as opposed to having a candidate report to a site to get fingerprinted). Further, we have fully implemented a flagging system with the State Police which eliminates the need to run a State fingerprint check every 2 years. Now, the Department receives conviction notices from the State Police when a conviction is reported. Combined, this saves the Department a total of $45 for each nurse aide renewal. The current recommended appropriation of $1 million will be adequate to fully fund the cost of background checks, administrative costs and the cost of funding existing staff positions. There can be no reduction in payments to the State Police, FBI or the fingerprint vendor, as the Department does not fix these costs. All savings are the result of administrative economies.

15. Between FY 2001 and FY 2006, University Hospital received upwards of $464 million in Charity Care funds from the State. All hospitals must comply with various procedural requirements and provide data to DHSS to substantiate their receipt of Charity Care.

- ***Question:*** **In view of the Medicare/Medicaid fraud acknowledged by University Hospital, has DHSS reexamined the Charity Care documentation provided by the hospital to determine its validity and accuracy? If the department determines that Charity Care payments were made improperly, what recourse is available to recover those funds?**

- ***Answer:*** Charity Care does not cover physician bills so there is no opportunity to double bill charity care for physician services in the way they have acknowledged as fraudulent. Since Charity Care uses pricing rates set by Medicaid, questions regarding the accuracy of the Medicaid rates should be directed to DMAHS.

  The documentation provided by UMNDJ and all hospitals to support their charity care claims between FY01 and FY06 have been audited on a regular basis according to regulation and contract. No issues related to fraud by UMDNJ were revealed during those audits. If fraud were occurring the current audit process was not been able to detect it.

  It should be noted that Charity Care does not reimburse or pay claims, but only uses claim totals in allocating a formula based subsidy. Charity care legislation and regulations are silent on recourse if fraud is identified retroactively after the subsidy has been allocated and distributed and there is no mechanism established to recoup charity care subsidies.

16. In February 2005, Atlantic Health System launched its own helicopter service to transport patients with medical emergencies. Previously, this service was solely provided by the Jersey Emergency Medical Shock Trauma Air Rescue (JEMSTAR) program, operated by DHSS, the New Jersey State Police UMDNJ and Virtua Health System.

- ***Question:*** **How much will it cost Atlantic Health to provide these services compared to what it costs the State? Will the provision of these services be self-supporting, or will**

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the deficit be charged to Charity Care? What impact will the availability of emergency medical transportation from Atlantic Health have on the operating costs of the JEMSTAR program?

- ***Answer:*** Helicopter emergency services provided to charity care eligible patients should be submitted by the treating hospital as part of the charity care claim for that patient. Such claims would be subject to same pricing system as any other claim and would be priced accordingly. There is no legislation that suggests or directs any specific fiscal connection between the provision of air emergency services by the Atlantic Health System and Charity Care. There is no reason or mechanism to charge any possible deficit in the operations of Atlantic Health System's helicopter service to Charity Care.

Through *N.J.S.A. 26-K-35-et seq* New Jersey legislatively created the Jersey Emergency Medical Shock and Trauma Air Rescue (JEMSTAR) system as the primary program for rapid emergency transport and care for trauma patients in New Jersey. The program became operational in 1988 and operated on a 16 hour schedule through 1992. In August 1992, the Legislature authorized a dedicated funding source for the operation of this program in the form of a $1 surcharge on all motor vehicle registrations in the State. This dedicated fund, the New Jersey Emergency Medical Service Helicopter Response Program Fund, enabled the program to expand to 24/7 operations. The fund supports NJ State Police operation of the JEMSTAR aviation component and establishes funds for DHSS to provide grants for operation of the medical component. Patients treated or transported by JEMSTAR receive a bill for $1,337 which, along with the motor vehicle registration surcharge, supports program operational expenses. JEMSTAR is the primary provider of scene responses in NJ but also may be called to perform inter-facility transportation. Regardless of what service is provided patients receive a bill for only $1,337. In FY 05 the surcharge was raised to $3 to account for increased operating costs. This was the first surcharge increase since program inception.

DHSS currently provides grants for the JEMSTAR medical component to UMDNJ and Viruta Health System. These three year grants are up for re-bid this year in response to an RFP that DHSS will soon issue.

Impact of Atlantic on JEMSTAR

Atlantic Health System and the eight other private air ambulance services licensed by DHSS are primarily used to perform inter-facility transportation and back-up on-scene response if JEMSTAR is unable to respond to a request for service. JEMSTAR is the State's primary on-scene provider and is therefore not impacted by the availability of the Atlantic Health air ambulance program.

Patients are significantly affected fiscally when transported by a service other than JEMSTAR. As noted previously, JEMSTAR will bill a patient $1337 regardless of services provided. DHSS is able to control this cost since JEMSTAR is a State program. In contrast, patients treated by a private air ambulance service receive bills for service ranging from $7,000 to an extreme a bill of $33,000. DHSS does not have the ability to control the charges of private air ambulance services.

This year DHSS will put the JEMSTAR program out for bid and Atlantic Health System is eligible to apply for the JEMSTAR grant. DHSS cannot predict Atlantic Health System's

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bid, however, three years ago Atlantic Health System bid on the JEMSTAR grant and exceeded the UMDNJ bid by approximately $200,000.

Charity Care Issue

Any deficit by Atlantic Health in operations of the service could not be charged to charity care. Charity care payment is not based on fee for service reimbursement. Any service provided by a licensed acute care hospital to a charity care patient is submitted to the states intermediary at a Medicaid priced rate. The hospital's reimbursement is then determined using the charity care formula from a fixed amount of money.

SENIOR SERVICES

17. The FY 2007 budget recommends $737,000 for Fiscal Agent – Medical Assistance for the Aged. The fiscal agent services provided by the vendor are similar to the fiscal agent services Unisys provides the Medicaid program. In fact, Medicaid claims processed by the fiscal agent are submitted to Unisys for payment.

- ***Question:* Should Fiscal Agent services be transferred to Unisys?**

- **Answer:** The premise of this question is in error, since Unisys is the Department's fiscal agent. This account pays Unisys for processing all claims for nursing homes, medical day care, assisted living and CCPED.

18. The Adult Family Care (AFC) program is a component of the department's Enhanced Community Options (ECO) Medicaid Waiver which provides various community services to elderly persons as an alternative to nursing home placement.

AFC is the smallest component of ECO in terms of enrollment and expenditures: Only 40 - 50 persons (about 1% of ECO enrollment) participate monthly at an annual cost of about $500,000 (gross). AFC enrollment has also declined from 90 (June 2000) to 45 (December 2005) as it is difficult to find family providers.

- ***Question:* Should AFC be discontinued and merged into other ECO programs?**

Answer: No, the Department has structured its rebalancing efforts based upon providing consumer choice and created a wide variety of home and community based options. Even though enrollment is small, the arrangement has been successful for those individuals and the costs to administer the program are negligible due to its similarities to other programs.

Furthermore, legislation concerning adult family care was signed by the Governor on January 2, 2002 to promote the cost-effective means of fulfilling basic shelter and everyday service

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needs of elders and physically disabled adults, thereby enabling them to preserve their independence, choice and dignity in a secure environment.

19. The Governor's recommended budget indicates that a FY 2006 supplemental appropriation will be required to address various funding shortfalls. Included in the supplemental appropriation would be $32.5 million to offset deficits in the Payments for Medical Assistance Recipients – Nursing Homes and the Medical Day Care Services accounts.

The FY 2006 Appropriations Act reduced the Payments for Medical Assistance Recipients – Nursing Homes account by $15.0 million to fund a Global Budget Long Term Care Initiative. As of this writing, no Global Budget funds have been expended.

- ***Question:* Does the $32.5 million FY 2006 supplemental appropriation factor in the transfer of the unexpended $15.0 million in Global Budget funds into the Nursing Homes and Medical Day Care accounts?**

- **Answer:** All projected surpluses in DHSS entitlement accounts, including Global Budgeting, were factored into the proposed supplemental for nursing homes that reflected in the Governor's Budget Recommendation.

20. Savings of $15.0 million are anticipated by increasing the lookback period for Nursing Home eligibility, from three to five years as mandated by federal law.

A September 2005 federal GAO report, Transfers of Assets by Elderly Individuals to Obtain Long-Term Care Coverage, concluded that it was difficult to document any savings from the current three-year lookback period due to poor record keeping on the part of the states. In New Jersey, there is no uniformity in administration of the lookback period among the 21 counties that determine eligibility for nursing homes.

- ***Question:* In view of the GAO's findings, how was the $15.0 million estimate determined?**

- ***Answer:*** The Department projected the savings of $15 million based on national estimates of the savings from the extension of the look-back period from three to five years. Both National Governor's Association (NGA) and the Congressional Budget office (CBO) estimated the savings for the national Medicaid budget . $15 million represents a prorated estimate based on the number of New Jersey Medicaid nursing home residents versus the number of Medicaid nursing home residents nationally.

21.a. The department contracts with Myers and Stauffer LC to conduct upwards of 45 Nursing Home audits (40 per diem and five patient income). In April 2005, the department indicated that only six of 42 audits had been finalized.

- ***Question:* How many FY 2005 audits were finalized? How much in potential recoveries was identified? In FY 2006, how many audits have been initiated, finalized and how much in potential recoveries was identified?**

Discussion Points (Cont'd)

- **Answer:** Ten audits were completed and all ten nursing homes rates were recalculated for an estimated recovery of $156,000. An additional 32 audits remain outstanding for SFY 2005. In SFY 2006, 40 audits were initiated and all remain outstanding as of this writing. The audit firm has committed to completing all full facility audits (72) by June 30, 2006.

21.b. In April 2005, the department indicated that 42 Nursing Home rate recalculations valued at $2.1 million during the July 2004 – March 2005 period had been completed.

- ***Question:* How many rate recalculations were completed during FY 2005? How many will be completed during FY 2006? What is the total dollar value of recoveries actually realized in FY 2005 and FY 2006 to date?**

- **Answer:** In FY 2005, 13 rate recalculations were done and 31 rate recalculations have been completed in FY 2006. In FY 2005, recoveries representing audits and attendant rate recalculations from multiple years totaled approximately $2.2 million. In FY 2006, recoveries representing audits and attendant rate recalculations from multiple years totaled, to date, approximately $2.3 million.

21.c. The Myers and Stauffer Nursing Home audit contract also permits "focused audits that will yield substantial returns on any audit adjustment."

- ***Question:* How many focused nursing home audits were conducted? How much in recoveries did these audits produce?**

- **Answer:** A total of 122 nursing facilities were selected for focused audits, with nine of them being performed by the Department's internal audit staff. No focused audits have been finalized yet. The audit firm has committed to completion of all focused audits by August 31, 2006.

21.d. Establishing Medicaid Nursing Home reimbursement rates annually is a time consuming process that involves nursing homes submitting cost reports, and the department screening the cost reports and determining the reasonable Medicaid reimbursement for various services.

As discussed in a Background Paper, Medicare nursing home reimbursement rates are updated annually through the use of various "price proxies, " such as the Producer Price Index (PPI), the Consumer Price Index (CPI) and the Employment Cost Index (ECI). If the department adopted a rate setting process in which a formal review of cost reports was conducted every second year, with a rate adjustment in the off-year based on the use of "price proxies," the backlog of rate recalculations and nursing home rate appeals could be reduced or eliminated.

- ***Question:* Has the department considered modifying the nursing home rate setting process to become a biennial process in which rates every second year are adjusted by the use of indexes such as the PPI, CPI and ECI? If not, why not?**

- **Answer:** The Department would support a two year rate-setting process for nursing homes with rates adjusted the second year by a "price proxy".

Discussion Points (Cont'd)

21.e. Approximately $135.4 million in Nursing Home Provider Assessment Fee revenue is anticipated. This amount represents a reduction from the amount that had been anticipated when the revised legislation was enacted in June 2004. In addition, several facilities affected by the assessment have challenged the legislation and are not remitting their assessment.

- ***Question:*** **What is the status of the legal challenges against the assessment? Please provide an updated list indicating the amount each facility is assessed and the amount of additional Medicaid reimbursement each facility obtains.**

- **Answer**: The Division of Taxation in the Department of Treasury is responsible for any litigation regarding the tax. One facility has filed a suit which challenges the implementation date of the Provider Tax in July 2004. Treasury has advised us that the tax court has dismissed the case and remanded it to the Division of Taxation since the plaintiffs had not exercised all administrative remedies. They have received no distributions. The assessment forms for the third quarter are due April 20, 2006.

22.a. To control Medical Day Care Services costs, a prior authorization program was adopted and implemented in February 2006.

Despite prior authorization, and $2.0 million in savings to be achieved by not adjusting Medicaid reimbursement for inflation, program costs are expected to increase by $15.6%, to $89.9 million.

- ***Question:*** **How much is expected to be saved in FY 2007 as a result of the implementation of prior authorization? What accounts for the $15.6% increase in program costs?**

- **Answer:** FY 2007 is the first entire state fiscal year to benefit from the cost savings of prior authorization on new enrollees estimated at $549,315 ($1.1 million gross).

  The 15 percent increase in program costs represents the actual cost of the program, which has exceeded the appropriation due to program growth. In addition, medical day care provider rates are based on 45% of the current nursing home rate. As nursing home rates go up by the rate of inflation, medical day care rates have experienced the same growth.

22.b. The FY 2006 Medical Day Care Services appropriations is $73.8 million. Based on expenditure data through February 2006, projected Medical Day Care Services costs will be between $84 million - $88 million in FY 2006. The $4.0 million proposed supplemental appropriation would still leave the account with insufficient funds to cover projected expenditures.

- ***Question:*** **Is the proposed $4.0 million supplemental appropriation adequate?**

- **Answer:** All projected surpluses in DHSS entitlement accounts where factored into the proposed supplemental for Medical Day Care that reflected in the Governor's budget Recommendation. We anticipate that the $4 million is adequate at this time.

23. P.L.2005, c.363 authorized the division to "provide additional compensation to pharmacies who serve a disproportionate share of PAAD and Senior Gold participants due to a significant decline in a pharmacy's total prescription fee compensation resulting from changes in federal law."

Discussion Points (Cont'd)

- *Question:* **Will additional compensation be provided to pharmacies? If yes, how much additional compensation will be provided?**

- **Answer**: Yes. On April 12, 2006, pharmacies were paid in full for the compensation provided through P. L. 2005, c. 363. The legislation provided a payment of $2 for each prescription filled under PAAD and Senior Gold between January 1, 2005 and June 30, 2005 to each PAAD and Senior Gold pharmacy provider receiving a high impact allowance with a total of 10,443 or less PAAD and Senior Gold pharmacy claims in all of calendar year 2005. PAAD and Senior Gold distributed a total payment of $748,781 among 233 pharmacies.

24. PAAD will provide wrap around coverage to its recipients enrolled in Medicare Part D. This will include the payment of any monthly premiums, deductibles and copays in excess of $5.00 per prescription, coverage for non-formularly prescription drugs and drug coverage to persons who reach the so-called "donut hole."

As of this writing, the federal government has provided no information as to the number of PAAD recipients who qualify for the low-income subsidies, the number of PAAD recipients who have monthly premiums, deductibles and copays in excess of $5.00 per prescription, the number of claims paid by PAAD for non-formulary drugs, or the number of PAAD recipients who will reach the donut hole. Without such basic statistical information, the adequacy of the FY 2007 recommended appropriation cannot be assessed.

- *Question:* **Of the approximate 188,000 PAAD eligibles, how many are not subject to monthly premiums and deductibles? For those PAAD recipients that are subject to monthly premiums, deductibles and copayments, what are their monthly average premiums, deductibles and copayments?**

- **Answer:** Of the 188,000 PAAD eligibles, approximately 4,600 are not eligible for Medicare Part D, approximately 4,824 beneficiaries have other prescription coverage through employer groups and PAAD will cost avoid prescription claims to that plan instead of Medicare Part D. This avoids the need for the State to pay premium costs for these beneficiaries, since the employer is paying the premium. Approximately 36,000 PAAD beneficiaries are enrolled in Medicare Part D and the low income subsidy program so they will not incur premiums or deductibles, or donut hole costs. 7,852 PAAD beneficiaries have partial premium subsidies and a $50 deductible. 16,000 PAAD beneficiaries have been screened for LIS and are awaiting CMS/SSA determination. The remaining 118,637 beneficiaries are enrolled in Medicare Part d and will have a monthly premium of approximately $29 per month plus a deductible of $250.

188,178	New Jerseys enrolled in PAAD
7,852	Partial Low Income Subsidy
36,176	Full Low Income Subsidy
16,000	Projected LIS- Screened and waiting for SSA/CMS Determination
4,824	Employer Subsidized (No Premium cost to the State)
4,671	Not eligible for Medicare Part D
118,637	PAAD pays full Premiums

Discussion Points (Cont'd)

25. Savings of $3.3 million in the PAAD and Senior Gold programs are anticipated by increasing the discount the State obtains when it reimburses for prescription drugs for the July – December 2006 period from 12.5% to 15%. Beginning January 2007, reimbursement would be based on the Average Manufacturers' Price.

- ***Question:* How much of the $3.3 million in savings can be attributed to the increase in the percentage discount from 12.5% to 15%?**

- **Answer:** It is anticipated that $2.4 million will be saved from July 1 2006 to December 31, 2006, as a result of increasing the percentage discount from 12.5% to 15%. Another $900,000 in savings is expected from January 1, 2007 to June 30, 2007 as a result of basing reimbursement on the Average Manufacturer's Price (AMP)

I. The Cancer Institute of New Jersey (CINJ): $22.3 million

The appropriation from the Department of Health and Senior Services to CINJ is allocated to five areas: 1) stabilize CINJ by supporting recruitment and retention of outstanding faculty; 2) support work in cancer control; 3) increase access to cancer care and clinical research to underserved populations; 4) become a visible leader in cancer research and; 5) increase access to cancer clinical trials for all New Jerseyans.

Thirteen new faculty that have been recruited with the state appropriation from FY 2006. They are as follows:

- Zhiyuan Shen, M.D., Ph.D., Associate Professor of Radiation Oncology was recruited from Los Alamos National Laboratory to serve as the Chief of the newly formed Division of Radiation Cancer Biology
- Jonathon Lee, M.D., Assistant Professor of Surgery, recruited from John Wayne Cancer Institute
- Giuseppe Longo, M.D., Medical Oncology recruited from Institute of Hematology of the University of Catania, Italy
- Mika Sovak, M.D., Ph.D., Medical Oncology recruited from Memorial Sloan-Kettering Cancer Center to augment the thoracic oncology clinical program and new drug development
- Kim Marie Hirshfield, M.D., Ph.D., Medical Oncologist trained at Johns Hopkins and Robert Wood Johnson Medical School (RWJMS)
- Ning Jeff Yue, Ph.D., Professor of Radiation Oncology recruited from University of Pittsburgh Cancer Center to serve as Chief of the newly formed Research Division of Radiation Physics
- Salma Jabbour, M.D., Radiation Oncology recruited from Johns Hopkins Medical Center with a clinical focus of gastrointestinal and lung cancer
- Vassiliki Karantza-Wadsworth, M.D., Ph.D., Medical Oncology trained at Yale University and RWJMS
- Sung Kim, M.D., Gynecologic Oncologist recruited from Harvard Medical School – Massachusetts General Hospital
- Aaron Weiss, D.O., Pediatric Hematology/Oncology recruited from St. Jude's Cancer Center, Memphis
- Alan Cohler, M.D., Radiation Oncology recruited from Thomas Jefferson University Hospital
- Bruce G. Haffty, M.D., Professor and Chair of Radiation Oncology recruited from Yale University School of Medicine
- Isaac Kim, M.D., Ph.D., Urologic Oncology recruited from University of California at Irvine

Programs and Treatment Facilities

CINJ's Research Programs reside within three Divisions:

1) Division of Basic Science, which include the following programs:

Molecular Mechanisms of Tumor Growth
Cytokines, Cytokine Signaling and Cancer
Transcriptional Regulation and Oncogenesis

2) Division of Clinical Science, which include the following programs:
Cancer Pharmacology/Developmental Therapeutics
Breast Cancer Research
Prostate

3) Division of Prevention, Control, and Population Science, which include the following programs:
Carcinogenesis and Chemoprevention
Population Science

The two most recently formed programs are the Breast Cancer Research Program and the Prostate Program. With the infrastructure support provided by state appropriations, both of these programs have been able to contribute to the additional goals of the original five-point cancer plan: cancer control, access for cancer care for the underserved, increase New Jersey visibility in cancer research, and to increase access to clinical trials for all of New Jersey.

While new treatment facilities were not included in the state appropriation, nor have any opened, these dollars did permit programmatic expansion of the LIFE Center to other sites throughout the state. These sites include the Robert Wood Johnson University Hospital at Hamilton and the Atlantic Health System (Morristown Memorial Hospital, Mountainside Hospital and Overlook Hospital). In addition, it is anticipated that the LIFE Center program will be offered at CentraState Healthcare System in Freehold later this year. Providing these services at our Network hospitals across the state allows CINJ to serve as a statewide resource for all New Jersey women.

II. New Jersey State Cancer Grant to NJMS – University Hospital Cancer Center, Newark: $9 million

Major funds were expended to operationalize the New Jersey Medical School – University Hospital Cancer Center at UMDNJ in Newark. This plan utilized funds awarded in the FY06 award, continuing the process begun in FY05. Construction has proceeded on the previously established schedule with occupancy anticipated in August 2006. This will result in a major increase in available facilities for cancer patient care and research. It will also permit the consolidation of medical, radiological and surgical activities in a site-specific team approach to cancer diagnosis and treatment.

New program implementation will be largely established upon occupancy of the new facilities. Existing space constraints have limited new faculty appointments. Searches have been initiated for an increase in clinical and research faculty, effective July 1, 2006 or shortly thereafter. Specifically, 2 clinical faculty have been recruited. An interim

Director of Medical Oncology was appointed, with a search for a permanent Director to be initiated shortly.

III. CINJ at Cooper Grant, South Jersey: $9 million

The following programs were developed at CINJ South Jersey:

- Neuro-oncology
- Head and Neck Program
- Complementary Medicine
- Pain/Palliative Care
- Behavioral Medicine
- Geriatric Oncology in conjunction with UMDNJ/SOM
- Basic Research in conjunction with UMDNJ/RWJ

The following treatment facilities have been established/enhanced:

- Enhancements in Imaging
- Development of Willingboro Office
- Camden Hospital Outpatient Infusion Area
- Voorhees Facility Renovation

New Faculty positions have been created through this funding. They include:

- 9 new faculty
- 2 existing faculty joined CINJ at Cooper
- 1 faculty support – UMDNJ/RWJ
- 5 new nurse/patient resource positions

IV. Robert Wood Johnson University Hospital, New Brunswick: $9 million

The $9 million oncology grant awarded to Robert Wood Johnson University Hospital (RWJUH) is being used to fund the following three aspects of world class oncology care.

1) **State-of-the-Art Equipment** - $3.5 million of the grant proceeds are being applied to the acquisition of radiation oncology treatment equipment.

2) **Information Systems** - $1 million of the grant proceeds are being applied to the costs of acquiring, installing and implementing a new clinical information system on the oncology inpatient units.

3) **Technical Program Support** ($4.5) – RWJUH looses on the average oncology patient. Such losses primarily result from the extremely ill nature of the oncology patients that are referred to RWJUH. Compounding the costs associated with such severity of illness are research costs and a relatively high proportion of uninsured cancer patients. Only through the grant process, can RWJUH continue to support the hospital "technical component" cancer program costs which include:

- approximately 127 nursing personnel

- approximately 185 technical/support personnel
- approximately 55 clerical personnel
- approximately 15 supervisory personnel

In all, portions of nearly 400 full-time equivalent employees' salary and benefits are supported through these grant proceeds.