Discussion Points

Health Services

Lead Testing

1. P.L.2017, c.7 (N.J.S.A.26:2-131 et al.) requires the Department of Health (DOH) to ensure that all department regulations regarding elevated blood lead levels and the appropriate responses thereto are consistent with the most recent recommendations of the federal Centers for Disease Control and Prevention (CDC). In practice, this law compels the State to take responsive action where a lead screening test shows n elevated blood lead level of five micrograms per deciliter or more. This is lower than the previous standard, which required action at 10 micrograms per deciliter or more. Additionally, the law requires the department to, on at least a biennial basis, review and revise the rules and regulations to ensure that they comport with the CDC's latest guidance on this issue.

State law and regulations (N.J.S.A.26:2-137.1 through N.J.S.A.26:2-137.7 and N.J.A.C.8:51A) require a physician, a registered professional nurse, or a health care facility, unless exempt, to perform a two-part lead screening test on each patient who is between six months and six years of age. If the child's test indicates an elevated blood lead level then the local board of health will be required to provide environmental intervention at the child's primary residence, and at any planned relocation address, and to ensure that a public health nurse provides case management services to the child and the family. Case management involves the coordination, oversight, and provision of services necessary to identify the lead source, eliminate the child's exposure to lead, and reduce the child's blood lead level below a level of concern.

Evaluation Data in the Governor's FY 2019 Budget show an increase in the number of children with a diagnosis of elevated blood lead levels from 1,029 in FY 2017 to an estimated 3,720 in FY 2018 and an estimated 4,700 in FY 2019. The department attributes the increase to the changed standards for elevated blood lead level identification.

- **Questions:**
  - **a. What is the department's FY 2018 and recommended FY 2019 appropriation for lead prevention activities? In what line items are these appropriations located?**

SFY2018:	$14,023,000	
State:	$12,180,000	Maternal Child and Chronic Health Block (MCCHBG)
Federal:	$846,000	Maternal and Child Health Services Block Grant (MCHBG)
Federal:	$316,000	CDC Cooperative Agreement/Childhood Lead Poisoning Prevention Surveillance
Federal:	$410,000	Lead Abatement
Federal:	$25,000	Adult Blood Lead Survey (award not received)
Federal:	$86,000	Lead Training and Cert Enforcement
Other:	$160,000	Lead Abatement Certification Revenue

SFY2019:	$14,023,000	
State:	$12,180,000	Maternal Child and Chronic Health Block (MCCHBG)
Federal:	$846,000	Maternal and Child Health Services Block Grant (MCHBG)
Federal:	$316,000	CDC Cooperative Agreement/Childhood Lead Poisoning Prevention Surveillance
Federal:	$410,000	Lead Abatement
Federal:	$25,000	Adult Blood Lead Survey (award not received)
Federal:	$86,000	Lead Training and Cert Enforcement
Other:	$160,000	Lead Abatement Certification Revenue

Discussion Points (Cont'd)

b. What is each local board of health's FY 2018 and recommended FY 2019 appropriation for lead prevention activities?

FY 2018 for case management and environmental investigations

• East Orange Health Dept.	$512,750
• Newark Health Dept.	$1,478,731
• Cumberland County Health Dept.	$516,209
• Passaic (city) Health Dept.	$575,665
• Trenton Health Dept.	$646,250
• Camden County Health Dept.	$369,747
• Hudson Regional Health Commission	$226,875
• Irvington Health Dept.	$715,766
• Jersey City Health Dept.	$898,608
• Middlesex County Health Dept.	$681,350
• Monmouth County Health Dept.	$377,281
• JFK-Muhlenberg*	$194,025
• Ocean County Health Dept.	$225,247
• Paterson Health Dept.	$725,133
• Atlantic County Health Dept.	$214,489
• Bergen County Health Dept.	$374,006
• Burlington County Health Dept.	$133,725
• Bloomfield Health Dept.	$150,784
• Montclair Health Dept.	$ 54,853
• Gloucester County Health Dept.	$214,480
• Salem County Health Dept.	$174,101
• Somerset County Health Dept.	$175,744
• Elizabeth Health Dept.	$190,169
• Plainfield Health Dept.	$499,689
• Warren County Health Dept.	$140,598

* Plainfield prior to RFA funding being awarded to Plainfield Health Dept.

FY 2019 for case management and environmental investigations

Subsequent funding for FY 19 is contingent upon the availability of funds, timely and accurate submission of reports, satisfactory progress toward completion of SFY 2018 grant objectives, an approved annual work plan and a well-defined sustainability plan per the RFA issued October 16, 2017.

- East Orange Health Dept.
- Newark Health Dept.
- Cumberland County Health Dept.
- Passaic (city) Health Dept.
- Trenton Health Dept.
- Camden County Health Dept.
- Hudson Regional Health Commission
- Irvington Health Dept.

Discussion Points (Cont'd)

- Jersey City Health Dept.
- Middlesex County Health Dept.
- Monmouth County Health Dept.
- Ocean County Health Dept.
- Paterson Health Dept.
- Atlantic County Health Dept.
- Bergen County Health Dept.
- Burlington County Health Dept.
- Bloomfield Health Dept.
- Montclair Health Dept.
- Gloucester County Health Dept.
- Salem County Health Dept.
- Somerset County Health Dept.
- Elizabeth Health Dept.
- Plainfield Health Dept.
- Warren County Health Dept.

Medical Marijuana Program

2. Subsequent to a review conducted under Executive Order No. 6 of 2018, the department has reported that it will be expanding the medical marijuana program in a number of ways, including: allowing alternative treatment centers to obtain different endorsements for the cultivation, production, and dispensing of medical marijuana; allowing alternative treatment centers to open satellite dispensary locations and, with department approval, cultivate medical marijuana at more than one location; eliminating the physician registration requirement; streamlining the process for approving additional medical conditions that qualify patients for the use of medical marijuana; reducing the general registration fee for patients and primary caregivers from $200 to $100 and allowing senior citizens and military veterans to pay the $20 registration fee currently authorized for recipients of certain benefits programs; allowing patients to have up to two primary caregivers; and creating a new "access portal" for patients, primary caregivers, and physicians.

The department further recommended legislative action to: allow patients to obtain medical marijuana from any alternative treatment center; raise the maximum quantity limit for a 30-day supply of medical marijuana from two ounces to four ounces; eliminate the maximum quantity limits for patients in hospice care; eliminate a requirement that certain debilitating medical conditions be "resistant to conventional medical therapy" before the patient may be authorized for the medical use of marijuana; and remove the requirement that the first six alternative treatment centers issued a permit be non-profit.

The department additionally indicated it will review ways to potentially establish a system of home delivery of medical marijuana, determine whether external laboratories can be used to supplement the department's laboratory testing system, develop an educational program for physicians concerning best practices for medical marijuana, promulgate standardized dosage guidelines and administration protocols, review the alternative treatment center permitting and criminal history record background check requirements to improve efficiency, and work with the Department of the Treasury to exempt medical marijuana from the State sales and use tax.

In addition, on March 22, 2018, the department expanded the list of debilitating medical conditions that qualify a patient for participation in the medical marijuana program to include chronic pain related to musculoskeletal disorders, chronic pain of visceral origin, migraine, anxiety, and Tourette's syndrome.

In FY 2018, the administrative expenditures of the medical marijuana program are supported by an $857,000 State appropriation and an estimated $1.5 million in program fee collections. The Governor's FY 2019 Budget does not change the two amounts but anticipates $20 million in revenues from the expanded medical marijuana program that would be available for general State purposes.

Discussion Points (Cont'd)

- **Questions:**

a. What is the number of patients in the medical marijuana program before the adoption of the 2018 changes? What is the anticipated growth in the number of patients in FY 2019? How many additional patients does the department anticipate will qualify for medical marijuana based on chronic pain related to musculoskeletal disorders, chronic pain of visceral origin, migraine, anxiety, and Tourette's syndrome?

There were 18,556 active patients in the program at the time of the EO6 report. We are projecting program enrollment to reach 40,000 to 50,000 active patients by the end of FY2019. In the past year (May 2017-April 2018), the program added 9,100 new patients, and historically, the number of new patients per calendar year has almost doubled year over year. With the new conditions, we are anticipating enrollment growing from 800-1000 new patients per month to close to 2,000 new patients every month during FY19. This projection also accounts for patients who become inactive in the program, which is 16-20% of the total patient population year over year.

To give a sense for the scope of potential patients eligible under the new conditions, the National Institutes of Health (NIH) estimates from the past several years indicate that 19.1% of US Adults suffered from some form of anxiety in the past year[1], roughly 11.2% experienced chronic pain[2], and 14.2% reported migraines or severe headaches[3]. However, experience from other states suggests that once you add chronic pain and anxiety to conditions treatable with medicinal marijuana, between 1% and 2% of the total population could become enrolled should they decide, along with medical advice, to enroll in the program [4].

[1] https://www.nimh.nih.gov/health/statistics/any-anxiety-disorder.shtml
[2] https://nccih.nih.gov/news/press/08112015
[3] https://www.ncbi.nlm.nih.gov/pubmed/25600719
[4] Based on analysis of enrollment statistics from every operational state medicinal marijuana program.

b. Does the department anticipate any reductions in the number of registered patients in the event the State legalizes or decriminalizes recreational marijuana?

Yes, the Department anticipates reductions in the number of registered patients if the State legalizes adult-use marijuana; however, given the program expansion, we don't expect enrollment to dip too far below our current patient base projections. But both legalization and decriminalization is expected to alter enrollment in the medicinal marijuana program over time.

c. Does the department anticipate issuing any new alternative treatment center permits in FY 2018 or FY 2019?

We are undertaking a thorough review of current supply and additional patient need which will determine a comprehensive answer to this question. It is our current assumption that we will need additional Alternative Treatment Centers (ATC) to meet patient needs and expect to release a RFA for new ATC locations once we go through the rule-making process. We do anticipate that we will also be approving satellite locations of the current ATCs.

Discussion Points (Cont'd)

d. Does the department anticipate any need to hire additional staff in FY 2018 or FY 2019 to perform administrative, oversight, and regulatory tasks under the expanded medical marijuana program? What additional staff does the department anticipate needing, and what is the expected annualized cost of the additional staff? Does the program expansion necessitate an increase in the Governor's proposed $857,000 State appropriation for the program in FY 2019?

We recently added four temporary customer service representatives which have expanded our capacity to respond to patient inquiries and requests, which are included in our current budget. As the program expands, we will likely need to bring on additional customer service representatives to help patients and investigators to vet ATC permit applications.

e. How will the program expansion affect anticipated FY 2019 medical marijuana program fee collections of $1.5 million? Please provide by fee category anticipated FY 2019 fee collections as they are forecast in the Governor's FY 2019 Budget Recommendation and as the department expects them to accrue under the expanded program. Please project the impact of legalizing or decriminalizing recreational marijuana on medical marijuana program fee collections.

Five factors will affect our fee collections: 1) the number of new patients in the program; 2) the number of total patients who qualify for reduced fees given our expansion of those fee reductions; 3) the number of ATCs; 4) the number of caregivers; and 5) the overall reduction of the registration fee. Because the overall program fees will be reduced, additional patient enrollment will be needed to meet that $1.5 million projection. However, if enrollment tracks with our projections, revenue from the program could exceed $1.5 million – but such growth would be used to offset additional program costs.

Total Anticipated Revenue: $1.518 million; Revenue from Patient Registrations: $1.352 million; Revenue from ATC Permits: $120,000; Revenue from Caregiver Registration: $46,800.

We do not yet have a legalization program to determine what the impact would be on fee collection.

f. What are the anticipated costs or savings to the State of utilizing external laboratories to test medical marijuana?

Currently, the ATCs pay the cost of lab testing, which can cost upwards of $2,000 per test. We are exploring additional approaches, including allowing ATCs to do their own testing with validation from DOH, and/or the use of external laboratories for testing. We believe this could be one measure that ultimately reduces the cost of operation for ATCs and therefore could also reduce the cost for patients, but we would need to have the appropriate regulatory oversight to ensure accuracy and safety.

g. What are the anticipated costs of establishing a new access portal? Does the department anticipate issuing a request for proposals for a private entity to create the portal? What are the anticipated ongoing costs of operating and maintaining the portal?

We are currently in the design stages of the new patient portal so we do not yet have an in-depth cost-estimate. However, an initial internal estimate projects the cost at being $850,000 for the design and implementation phase alone.

Discussion Points (Cont'd)

Maternal, Child and Chronic Health Services

3. A variety of grant programs in the Division of Family Health Services are funded under the Maternal, Child and Chronic Health Services (MCCH) budget line (page D-154). The Governor's FY 2019 Budget Recommendation maintains the MCCH Grants-in-Aid appropriation at $36.95 million. Additionally, annual appropriations language funds DOH administrative expenditures for the MCCH program out of the program's Grants-in-Aid appropriation (about $1.7 million per year).

- **Questions:**
  - **a. Please break down the MCCH funding by program and the amount each grantee received or is intended to receive in FY 2018 and FY 2019.**

Description	Allocation	Grantee	FY2018	FY2019
Hemophilia	1,245,000			
		HEMOPHILIA ASSOC OF NJ	457,408	457,408
		NEWARK BETH ISRAEL MEDICAL CEN	175,840	175,840
		PRIME HEALTHCARE SERVICES - SA	192,409	192,409
		RUTGERS THE STATE UNIV RBHS	275,673	275,673
		THE CHILDREN'S HOSPITAL OF PHI	143,670	143,670
			1,245,000	**1,245,000**
Case Management	669,741			
		ATLANTIC CO TREASURER	39,336	39,336
		ATLANTIC HEALTH SYSTEM	38,862	38,862
		BERGEN CO	16,928	16,928
		BURLINGTON CO TREASURERS OFF	35,352	35,352
		CAMDEN CO COURT HOUSE	68,004	68,004
		CAPE MAY CO MENT HLTH	5,032	5,032
		CATHOLIC FAMILY AND COMMUNITY	13,759	13,759
		CHILDRENS SPECIALIZED HOSPITAL	25,700	25,700
		CUMBERLAND CO	13,006	13,006
		ESSEX CO TREASURER	88,490	88,490
		GLOUCESTER CO	31,127	31,127
		HUNTERDON MEDICAL CENTER	5,808	5,808
		JERSEY CITY MEDICAL CENTER	5,549	5,549
		MERCER CO SPECIAL SERVICES	16,491	16,491
		MIDDLESEX CO TREASURER	12,146	12,146
		OCEAN COUNTY BOARD OF	15,670	15,670
		SALEM CO CLERKS OFFICE	7,158	7,158
		SOMERSET CRIPPLED	14,635	14,635
		STATEWIDE PARENT ADVOCACY NETW	92,684	92,684
		SUSSEX CO	11,000	11,000
		VISITING NURSE ASSOCIATION OF	43,975	43,975
		WARREN CO	14,029	14,029
		FEE for SERVICE	55,000	55,000
			669,741	**669,741**
SCHS- Ped Tertiary	1,069,194			
		MONMOUTH MEDICAL CTR	22,100	22,100
		NEWARK BETH ISRAEL MEDICAL CEN	310,500	310,500
		RUTGERS THE STATE UNIV RBHS	273,100	273,100
		SAINT BARNABAS MEDICAL CENTER	83,300	83,300
		ST. JOSEPHS REGIONAL MEDICAL C	39,900	39,900
		ST. PETERS UNIVERSITY HOSPITAL	19,200	19,200

Discussion Points (Cont'd)

		COOPER	315,100	315,100
			1,063,200	**1,063,200**
SCHS- Child Evaluation	733,435			
		ATLANTIC HEALTH SYSTEM	31,000	31,000
		CHILDRENS SPECIALIZED HOSPITAL	133,760	133,760
		COMMUNITY HOSPITAL GROUP JFK M	78,000	78,000
		JERSEY CITY MEDICAL CENTER	93,300	93,300
		MERIDIAN HEALTH	37,000	37,000
		RUTGERS THE STATE UNIV RBHS	103,000	103,000
		ST. JOSEPHS REGIONAL MEDICAL C	84,000	84,000
		THE CHILDREN'S HOSPITAL OF PHI	91,000	91,000
		COOPER	78,000	78,000
			729,060	**729,060**
Renal	507,630			
		TRANS ATLANTIC RENAL COUNCIL	505,346	480,570
			505,346	**480,570**
Cystic Fibrosis	370,000			
		NEW JERSEY STATE ORGANIZATION	368,148	368,148
			368,148	**368,148**
Birth Defects	35,000			
		RUTGERS THE STATE UNIV RBHS	1,895	1,895
		ST. PETERS UNIVERSITY HOSPITAL	32,930	32,930
			34,825	**34,825**
Newborn Screening	293,550			
		HACKENSACK UNIVERSITY MEDICAL	37,939	37,939
		NEWARK BETH ISRAEL MEDICAL CEN	12,000	12,000
		RUTGERS THE STATE UNIV RBHS	92,301	92,301
		ST. JOSEPHS REGIONAL MEDICAL C	35,117	35,117
		ST. PETERS UNIVERSITY HOSPITAL	30,175	30,175
		THE CHILDREN'S HOSPITAL OF PHI	20,550	20,550
		THE COOPER HEALTH SYSTEM	64,000	64,000
			292,082	**292,082**
MCH-Ped Tertiary	41,790			
		MONMOUTH MEDICAL CTR	8,000	8,000
		SAINT BARNABAS MEDICAL CENTER	10,000	10,000
		ST. JOSEPHS REGIONAL MEDICAL C	790	790
		ST. PETERS UNIVERSITY HOSPITAL	11,000	11,000
		COOPER	12,000	12,000
			41,790	**41,790**
MCH-Case Management	1,231,360			
		ATLANTIC CO TREASURER	40,000	40,000
		ATLANTIC HEALTH SYSTEM	34,300	34,300
		BERGEN CO	53,950	53,950
		BURLINGTON CO TREASURERS OFF	57,685	57,685
		CAMDEN CO COURT HOUSE	158,207	158,207
		CAPE MAY CO MENT HLTH	4,485	4,485
		CATHOLIC FAMILY AND COMMUNITY	109,533	109,533
		CHILDRENS SPECIALIZED HOSPITAL	14,532	14,532
		CUMBERLAND CO	40,600	40,600
		ESSEX CO TREASURER	85,000	85,000
		GLOUCESTER CO	109,600	109,600
		HUNTERDON MEDICAL CENTER	5,323	5,323

Discussion Points (Cont'd)

		JERSEY CITY MEDICAL CENTER	37,300	37,300
		MERCER CO SPECIAL SERVICES	67,600	67,600
		MIDDLESEX CO TREASURER	103,459	103,459
		NJ CHAPTER AMERICAN ACADEMY OF	50,000	50,000
		OCEAN COUNTY BOARD OF	43,000	43,000
		SALEM CO CLERKS OFFICE	4,195	4,195
		SOMERSET CRIPPLED	26,676	26,676
		STATEWIDE PARENT ADVOCACY NETW	35,415	35,415
		SUSSEX CO	21,100	21,100
		VISITING NURSE ASSOCIATION OF	106,100	106,100
		WARREN CO	23,300	23,300
			1,231,360	**1,231,360**
MCH-Child Evaluation	846,680			
		ATLANTIC HEALTH SYSTEM	44,000	44,000
		CHILDRENS SPECIALIZED HOSPITAL	151,700	151,700
		COMMUNITY HOSPITAL GROUP JFK M	2,000	2,000
		JERSEY CITY MEDICAL CENTER	131,000	131,000
		MERIDIAN HEALTH	156,180	156,180
		RUTGERS THE STATE UNIV RBHS	151,000	151,000
		ST. JOSEPHS REGIONAL MEDICAL C	44,300	44,300
		THE CHILDREN'S HOSPITAL OF PHI	87,000	87,000
		COOPER	79,500	79,500
			846,680	**846,680**
MCH-Lead Poisoning	11,194,620			
		ATLANTIC CO TREASURER	214,489	
		BERGEN CO	374,006	
		BLOOMFIELD TWP	150,784	
		BURLINGTON CO TREASURERS OFF	133,725	
		CAMDEN CO COURT HOUSE	295,122	
		CITY OF JERSEY CITY	740,796	
		CUMBERLAND CO	393,776	
		EAST ORANGE CITY	315,212	
		ELIZABETH CITY	190,169	
		GLOUCESTER CO	214,480	
		HUDSON REGIONAL HEALTH COMM	202,000	
		IRVINGTON TREASURER	606,316	
		JFK HEALTH SYSTEMS INC	93,530	
		MIDDLESEX CO TREASURER	681,350	
		MONMOUTH CO	443,946	
		MONTCLAIR TWP	54,853	
		NEWARK CITY	1,195,435	
		OCEAN COUNTY BOARD OF	150,622	
		PASSAIC CITY	526,042	
		PATERSON CITY	628,825	
		PLAINFIELD CITY	499,689	
		SALEM CO CLERKS OFFICE	174,101	
		SOMERSET CO	175,744	
		SOUTHERN NEW JERSEY PERINATAL	58,532	
		THE PARTNERSHIP FOR MATERNAL &	230,337	
		TRENTON CITY	641,823	
		WARREN CO	140,598	
		OMB Budget Reserve	1,386,228	

Discussion Points (Cont'd)

		TBD	282,090	
			11,194,620	**11,194,620**
MCH-Outreach/Education	964,000			
		CENTER FOR FAMILY SERVICES	3,800	3,800
		CHILDRENS FUTURES INC.	1,000	1,000
		THE CHILDRENS HOME SOCIETY OF	150,000	150,000
		THE PARTNERSHIP FOR MATERNAL &	400,000	400,000
		ZUFALL HEALTH CENTER INC	150,000	150,000
		THE PARTNERSHIP FOR MATERNAL &	203,993	203,993
		CENTER FOR FAMILY SERVICES	55,000	55,000
			963,793	**963,793**
MCH-Health Corp School	225,000			
		HEALTHCORPS, INC.	225,000	225,000
			225,000	**225,000**
MCH-Fetal Alcohol	419,000			
		CENTRAL JERSEY FAMILY HEALTH C	99,500	99,500
		FAMILY HEALTH INITIATIVES	74,624	74,624
		SOUTHERN NEW JERSEY PERINATAL	93,530	93,530
		THE PARTNERSHIP FOR MATERNAL &	149,249	149,249
			416,903	**416,903**
MCH-Oral Health	214,000			
		SOUTHERN JERSEY FAMILY MEDICAL	100,000	100,000
		ZUFALL HEALTH CENTER INC	114,000	114,000
			214,000	**214,000**
MCH-IPO	592,000			
		BURLINGTON CO CAP	100,000	100,000
		CHILDRENS FUTURES INC.	210,000	210,000
		RUTGERS THE STATE UNIV RBHS	1,105	1,105
		SOUTHERN NEW JERSEY PERINATAL	182,500	182,500
		THE PARTNERSHIP FOR MATERNAL &	92,000	92,000
			585,605	**585,605**
Lead Poisoning	985,000			
		CAMDEN CO COURT HOUSE	64,675	64,675
		CITY OF JERSEY CITY	64,675	64,675
		CUMBERLAND CO	92,976	92,976
		EAST ORANGE CITY	126,540	126,540
		IRVINGTON TREASURER	99,454	99,454
		JFK HEALTH SYSTEMS INC	60,695	60,695
		MONMOUTH CO	57,710	57,710
		NEWARK CITY	61,411	61,411
		NJ CHAPTER AMERICAN ACADEMY OF	40,297	40,297
		PASSAIC CITY	20,519	20,519
		PATERSON CITY	56,313	56,313
		SOUTHERN NEW JERSEY PERINATAL	85,743	85,743
		THE PARTNERSHIP FOR MATERNAL &	131,738	131,738
		TBD	19,839	19,839
			982,585	**982,585**
Cleft Palate	690,000			
		MONMOUTH MEDICAL CTR	78,200	78,200
		SAINT BARNABAS MEDICAL CENTER	93,400	93,400
		ST. JOSEPHS REGIONAL MEDICAL C	197,830	197,830
		ST. PETERS UNIVERSITY HOSPITAL	142,300	142,300

Discussion Points (Cont'd)

		COOPER	177,800	177,800
			689,530	**689,530**
Tourette's Syndrome	400,000			
		NEW JERSEY CENTER FOR TOURETTE	400,000	400,000
			400,000	**400,000**
Cancer Screening Detection & Educ	5,370,000			
		ATLANTIC HEALTH SYSTEM	220,230	220,230
		BERGEN CO	400,128	400,128
		CAPE MAY CO MENT HLTH	101,900	101,900
		COMMUNITY MEDICAL CENTER	209,187	209,187
		HOBOKEN FAMILY PLAN INC	870,903	870,903
		HUNTERDON MEDICAL CENTER	99,250	99,250
		INSPIRA MEDICAL CENTER	92,940	92,940
		INSPIRA MEDICAL CENTERS	106,539	106,539
		MIDDLESEX CO TREASURER	411,712	411,712
		NORTHWEST NJ COMMUNITY ACTION	99,829	99,829
		PRIME HEALTHCARE SERVICES - SA	337,912	337,912
		RUTGERS THE STATE UNIV RBHS	322,320	322,320
		SHILOH COMMUNITY DEVELOPMENT	206,526	206,526
		SHORE MEMORIAL HOSPITAL	224,269	224,269
		ST. JOSEPHS REGIONAL MEDICAL C	481,919	481,919
		SUSSEX CO	101,002	101,002
		VIRTUA HEALTH	187,231	187,231
		VISITING NURSE ASSOCIATION OF	328,100	328,100
		ZUFALL HEALTH CENTER INC	208,304	208,304
		COOPER	333,083	333,083
		TBD	26,716	26,716
			5,370,000	**5,370,000**
SIDS Assistance	221,000			
		RUTGERS THE STATE UNIV RBHS	219,895	219,895
			219,895	**219,895**
Huntington's	310,000			
		ROWAN UNIVERSITY	308,450	308,450
			308,450	**308,450**
Postpartum Screening	1,900,000			
		CENTER FOR FAMILY SERVICES	241,700	241,700
		CENTRAL JERSEY FAMILY HEALTH C	471,300	471,300
		MERCER CO	40,000	40,000
		RUTGERS THE STATE UNIV RBHS	260,000	260,000
		SOUTHERN NEW JERSEY PERINATAL	353,500	353,500
		THE PARTNERSHIP FOR MATERNAL &	524,000	524,000
			1,890,500	**1,890,500**
NJ Council on Physical Fitness	50,000			
		FAMILY HEALTH INITIATIVES	50,000	50,000
			50,000	**50,000**
Infant Mortality	2,000,000			
		CENTRAL JERSEY FAMILY HEALTH C	490,000	490,000
		CHILDRENS FUTURES INC.	159,000	159,000
		CUMBERLAND CO	300,000	300,000
		RUTGERS THE STATE UNIV RBHS	29,000	29,000
		SOUTHERN NEW JERSEY PERINATAL	353,500	353,500

Discussion Points (Cont'd)

		STATEWIDE PARENT ADVOCACY NETW	2,975	2,975
		THE PARTNERSHIP FOR MATERNAL &	300,000	300,000
		VISITING NURSE ASSOCIATION OF	300,000	300,000
		TBD	65,525	65,525
			2,000,000	**2,000,000**
Tuberculosis Services (EPI)	2,150,000			
		BERGEN CO	272,472	272,472
		CAMDEN CO COURT HOUSE	107,603	107,603
		HUDSON CO	302,780	302,780
		MIDDLESEX CO TREASURER	219,121	219,121
		PATERSON CITY	208,700	208,700
		RUTGERS THE STATE UNIV RBHS	682,720	682,720
		SOMERSET CO	72,086	72,086
		COOPER	284,518	284,518
			2,150,000	**2,150,000**
Immunization Services	525,000			
		CAMDEN CO COURT HOUSE	25,675	25,675
		CENTER FOR HEALTH EDUCATION ME	75,000	75,000
		CENTRAL JERSEY FAMILY HEALTH C	90,000	90,000
		CITY OF JERSEY CITY	19,200	19,200
		ELIZABETH CITY	9,100	9,100
		HENRY J. AUSTIN HEALTH CENTER	3,565	3,565
		MONMOUTH CO	9,800	9,800
		NORTH JERSEY AIDS ALLIANCE INC	34,790	34,790
		PATERSON CITY	22,495	22,495
		THE PARTNERSHIP FOR MATERNAL &	233,000	233,000
			522,625	**522,625**
Administrative Funding	1,695,000		1,695,000	1,695,000
				1,695,000
Audit Fees Not Included Above			**42,262**	**67,038**
Totals	**36,948,000**		**36,948,000**	**36,948,000**

b. Please provide the anticipated amount of administrative funding contained within the MCCH line in FY 2018 and FY 2019.

The anticipated amount of administrative funding contained within the MCCH line in FY 2018 and FY 2019 is between 4%-6% of the appropriation.

c. Please detail the positions, salaries, and other administrative expenditures that are anticipated to be charged to the MCCH line in FY 2018 and FY 2019.

Administrative funding authorized from the MCCH line is based on availability of funds and can be used to cover divisional support costs such as salaries, office automation, telephone, and postage. The potential charges vary annually and are subject to the approval of OMB. In FY2018, OMB approved the use of $200,000 for Childhood Lead-related costs for a Nurse, Health Educator, Environmental Intervention Consultant, and Data Entry Technician. These funds were allocated to support the pro-rated annual salary and administrative costs of these positions. For FY 2019, it is anticipated that administrative funding would be needed to support the full annualized salary and non-salary costs of these new lead positions including any cost of living adjustments or salary step increases.

Discussion Points (Cont'd)

Tobacco Prevention and Cessation Programs

4. According to current department statistics, in New Jersey, 13.8 percent (1,260,840) of adults (aged 18+ years) are cigarette smokers. New Jersey ranks sixth lowest among all states for the prevalence of cigarette smoking among adults. Among youth aged 12 to 18 years, 8.2 percent smoke in New Jersey. According to the department's website, "a major goal of the DOH is to decrease deaths, sickness and disability among New Jersey residents who use tobacco or are exposed to environmental tobacco smoke. The department's Comprehensive Tobacco Control Program and its partners implement comprehensive programs to prevent the initiation of tobacco use among young people, to help tobacco users quit, to eliminate nonsmokers' exposure to secondhand smoke, and to reduce tobacco-related disparities. These programs include free quitting services, school- and community-based prevention programs and education regarding the New Jersey Smoke-Free Air Act."[1]

As of November 1, 2017, the legal age for purchasing tobacco products in New Jersey increased from 19 to 21. In addition, P.L.2017, c.242 requires that, commencing in FY 2019, one percent of annual cigarette tax collections be directed to the department to fund and implement evidence-based tobacco control programs that align with the federal Centers for Disease Control and Prevention Best Practices for Comprehensive Tobacco Control Programs and that include the goals of preventing youth initiation of tobacco usage, reducing exposure to secondhand smoke, and promoting tobacco cessation.

The Governor's FY 2019 Budget anticipates $7.1 million in FY 2019 Anti-Smoking Cigarette Tax Dedication revenue in accordance with P.L.2017, c.242 but does not detail which specific programs are intended to receive funding out of the anticipated $7.1 million. The Governor's FY 2019 Budget also recommends not renewing a $500,000 FY 2018 appropriation for Smoking Cessation and Prevention, which was added to the FY 2018 Appropriations Act by the Legislature. Although the $500,000 appropriation was the only line in the department's budget that was explicitly dedicated to anti-smoking programs, the department indicated in its response to an FY 2018 OLS Discussion Point that it intended to spend $10.8 million on several tobacco prevention and cessation programs in FY 2018, a total that did not include the subsequent $500,000 legislative addition to the FY 2018 Appropriations Act.

- **Questions:**

  a. How much did the State spend on tobacco prevention and cessation programs in FY 2017, and how much does the State anticipate spending thereon in FY 2018 and FY 2019?

  The State spending on tobacco prevention and cessation programs in FY 2017 and projections for FY 2018 and FY 2019 are as follows:

Actual and Projected Tobacco Prevention and Cessation Programs
($ in thousands)

Department	FY17	Proj.FY18	Proj. FY19
Health	4,056	4,619	11,177
Education, Interdepartmental, and Treasury*	1,912	2,103	2,313
Human Services**	3,883	3,519	3,777
Total	**9,851**	**10,241**	**17,267**

*Information is for calendar year.

**Medicaid data is by service date.

[1] http://www.nj.gov/health/chs/hnj2020/health/tobacco/index.shtml

Discussion Points (Cont'd)

b. Please detail the programs these funds have supported or are recommended to support and where the funding can be located in the Governor's FY 2019 Budget Recommendation. Please provide a separate listing of the programs that will be funded through the Anti-Smoking Cigarette Tax Dedication in FY 2019.

Department of Health

- The Maternal Child and Chronic Health Services account funds an annual grant to combat tobacco-related addiction services. (D-154, State funds)
- New Jersey Quitline provides phone counseling services and Nicotine Replacement Therapy. (C-19, federal funds)
- The Tobacco Age of Sale (TASE) conducts inspections assessing retailer's compliance with the age of sale requirements for tobacco and nicotine. It also conducts advertising/labelling inspections. (C-19, federal funds)
- The Chronic Disease Prevention and Health Promotion Program reduces secondhand smoke exposure (outdoor ordinances), promotes the use of the New Jersey Quitline, and provides public education and research on emerging tobacco products. (C-18, federal funds)
- The Preventive Health Services Block Grant funds the tobacco cessation program for pregnant women and new parents. (C-19, federal funds)
- The Youth Anti-Smoking Program is designed to reduce youth smoking and enforce compliance with state tobacco age of sale laws. (C-12, State fund)

Department of Education, Interdepartmental, and Treasury

- The actual and projected State prescription drug costs for smoking cessation drugs for active and retired members are budgeted in Education, Interdepartmental, and Treasury.

Department of Human Services

- The actual and projected State and federal costs for all medication and individual counseling therapies to treat tobacco use disorder for those enrolled in NJ FamilyCare are budgeted within various line items in the Division of Medical Assistance and Health Services. The amounts in the chart above represent gross payments.

Anti-Smoking Cigarette Tax Dedication

Governor Murphy's proposed SFY 2019 budget, includes $7.058 million for "Anti-Smoking Cigarette Tax Dedication, as presented on page C-11. A description of State-funded prevention and cessation initiatives for SFY 2018 and proposals for FY 2019 follows:

<u>Tobacco Cessation and Prevention Direct Services Appropriations – SFY 2018</u>

Tobacco Free College Campus Initiative (TFCCI)

The State legislature has increased the legal age of sale of tobacco to 21 years of age. As a result, concerns about tobacco use among young adults, particularly 19 and 20-year-olds has been expressed. Because of New Jersey's new Tobacco 21 law, which took effect November 1, 2017, the Department of Health's Office of Tobacco Control, Nutrition and Fitness's (OTCNF's) goal was to develop a college campus initiative that will create an environment that supports tobacco free living as well as quitting. The plan is to present to key decision makers for their support and to develop an implementation plan for institutionalizing it within the higher education system.

Discussion Points (Cont'd)

New Jersey Quitline
This funding supplemented the well needed telephone-based tobacco cessation counseling services and a 2-week starter kit of Nicotine Replacement Therapy (patches) (while supplies last) that is offered to all qualified clients.

Future Prevention and Intervention Programs Planned – SFY 2019

In moving forward with the anticipation of State tobacco funding due to the new legislation (Anti-Smoking Cigarette Tax Dedication), OTCNF has recommended plans to develop, revitalize and/or enhance statewide tobacco control programming that is based on CDC's Best Practices for Comprehensive Tobacco Control Programs. Specifically, OTCNF will examine the following five overarching components:

State and Community Interventions
State and Community Interventions will develop and maintain population-wide tobacco prevention and control policy interventions. Interventions will focus on building community capacity, awareness, engagement, and mobilization; coordination of state efforts, policies, laws, and regulations; and influencing people in their daily environments.

Effective state and community interventions and strategies will employ a wide range of efforts, including:

- Preventing initiation among youth and young adults
- Promoting quitting among adults and youth
- Eliminating exposure to secondhand smoke
- Identifying and eliminating tobacco-related disparities among population subgroups

Mass-Reach Health Communications Interventions
Mass-reach health communication interventions will create meaningful changes in population-level awareness. Specifically, these interventions will focus on preventing the initiation of tobacco use, promoting and facilitating cessation, and shaping social norms related to tobacco use. Communication interventions will target and engage multiple communication channels (such as online video, mobile, web, smartphone and tablet applications, and social media campaigns).

Effective health communication interventions and counter-marketing strategies will employ a wide range of efforts, including:

- Paid television, radio, out-of-home (e.g., billboards, transit), print, and digital advertising at state and local levels.
- Media advocacy through public relations/earned media efforts (press releases, conferences, social media, and local events).
- Efforts to reduce or replace tobacco industry sponsorship and promotions. (counter-marketing)

Cessation Interventions
Cessation interventions will provide treatment services, such as the NJ Quitline. Cessation interventions include population-level, strategic efforts to reconfigure policies and systems in ways that normalize quitting and institutionalize tobacco use screening and intervention with medical care.

Effective cessation intervention activities employ a wide range of efforts, including:

- Supporting the NJ Quitline capacity.

Discussion Points (Cont'd)

- Promoting health systems change, including tobacco use screening, patients receiving interventions to assist with quitting, integrating tobacco treatment into clinical care, and offering counseling services.
- Expanding insurance coverage and utilization of proven cessation treatments.

Surveillance and Evaluation
Surveillance and evaluation will monitor and document key short-term, intermediate, and long-term outcomes within populations, incorporating the collection of data on knowledge, attitudes, behaviors, environmental indicators, infrastructure, program planning, and implementation to document and measure the effectiveness of a program, including policy and media efforts.

Surveillance and Evaluation efforts will include:
- Development of an ongoing written evaluation plan that is integrated with the program's overall strategic plan
- Linking statewide and local program efforts to monitor progress toward program objectives
- Technical assistance efforts to funded sites, partners, stakeholders, and local programs.

Possible surveillance surveys include but are not limited to:
- Adult Tobacco Survey (ATS)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Youth Risk Behavior Surveillance System (YRBSS)
- Youth Tobacco Survey (YTS)
- NJ Quitline Questionnaires/survey

Infrastructure, Administration, and Management
Infrastructure, administration, and management efforts include necessary staffing to provide or facilitate program oversight, technical assistance, and training, to support program capacity, implementation, and sustainability.

Effective infrastructure, administration, and management will employ a wide range of efforts, including:
- Strategic planning
- Recruiting and developing qualified and diverse technical, program, and administrative staff
- Awarding and monitoring program contracts and grants, coordinating implementation across program areas, and assessing grantee program performance
- Developing and maintaining real-time fiscal management
- Increasing capacity at the local level by providing ongoing training and technical assistance

c. Please clarify the source of this funding: State, federal or dedicated other funds.

Please refer to answers provided on Section B of this question for this information

d. Do any of the currently funded programs focus on e-cigarettes, vaping, or smokeless tobacco?

Yes. The major objective of the *Tobacco Free College Campus Initiative* includes efforts to prohibit the sale and use of tobacco products campus wide, inclusive of e-cigarettes, vaping and smokeless tobacco.

Discussion Points (Cont'd)

e. What effect has the increased tobacco purchase age had on smoking prevalence rates in FY 2018?

It is too soon to tell what impact the change has had on the smoking prevalence of individuals under the age of 21. However, the literature indicates some projections that range from 6 to 8 percentage point drops in the age groups for those under 21, as a result in a change of age of sale law. OTCNF will work to monitor the changing trends through the New Jersey Youth Tobacco Survey as well as other available data.

Adoption Records

5. In November 1940, legislation was enacted that required adopted children's original birth certificates to be sealed and such record could only be accessed pursuant to a court order. P.L.2014, c.9 amended this vital records law to allow an adult adoptee, whose original birth certificate was placed in a sealed file, to obtain a non-certified copy of that original birth certificate, upon request beginning in January 2017. Prior to December 31, 2016, the law established a system to allow birth parents to modify the records to redact their names and information from the birth certificate, and if they chose, to provide contact information either directly or through an intermediary. The department is additionally to maintain a file of birth parent contact preference and family history information, and request that birth parents update this information every 10 years until the birth parent reaches age 40, and thereafter every five years.

According to a reply by the department to an FY 2018 OLS Discussion Point, through March 31, 2017, the department received 2,939 requests from adult adoptees for copies of their original birth certificates. Moreover, prior to the December 31, 2016 deadline, the department received 558 requests for redaction of names or information from birth certificates and 374 requests to provide contact information to adopted children. The department indicated further that it expended approximately $650,000 to fulfill the requests.

- **Questions:**

a. How many requests has the State received from adult adoptees for copies of original birth certificates pursuant to P.L.2014, c.9?

As of April 5, 2018, the Department has received 4,515 requests from adult adoptees for copies of their original birth certificates pursuant to P.L. 2014, c.9.

b. Of the birth parents who made the 558 requests for redaction of names or information from birth certificates and 374 requests to provide contact information to adopted children that the department had received by the December 31, 2016 deadline, how many have since contacted the department to change their preferences?

To date, the Department has had only one request to change their preference.

c. What is the annual cost to the State to fulfill requests under P.L.2014, c.9 following the processing of the initial caseload? How many full-time equivalent positions handle requests following the processing of the initial caseload? Has the State been able to reduce the number of full-time equivalent positions allocated to the processing of requests following the handling of the initial caseload?

The Department initially had eight temporary staff, however, this is down to two state Employees currently.

Discussion Points (Cont'd)

d. What has been the cost to the State to establish a system for maintaining and requesting updates of birth parent contact preference and family history information? How many full-time equivalent positions are assigned to this task? Has the State had to hire additional personnel for that purpose?

To date, the Department has expended approximately $500,000 to establish and maintain the system for maintaining and requesting updates of birth parent contact preference and family history information. To implement, seven full time employees were deployed for 6 months to establish the system. Two FTEs are required within the Health Information Technology Office to sustain the system, currently these positions are vacant..

Needle Exchange Programs

6. A year ago, there were five needle exchange programs in the State which operated as part of larger harm reduction programs: Syringe Access Program Atlantic City; HARM Reduction Syringe Access Program in Camden; Project X-Change Works in Jersey City; North Jersey Community Research Initiative in Newark; and the Point of Home Syringe Access Program in Paterson. These needle exchange programs were initially authorized through a demonstration program as part of the "Bloodborne Disease Harm Reduction Act," P.L.2006, c.99 (N.J.S.A.26:5C-25 et seq.). P.L.2016, c.36 made these programs permanent and authorized any municipality in the State to operate a needle exchange program. In response to an FY 2018 OLS Discussion Point, the department stated that it was reviewing two additional applications for needle exchange programs.

In November 2017, the previous Administration effected a supplemental appropriation of $2.1 million to the department for the Syringe Access Program without explicit legislative approval. The moneys were to be used to double the number of Access to Reproductive Care and HIV Services nurses at the site of each needle exchange program. The program expansion would increase prevention, recognition, and referral services for injection drug users. The Governor's FY 2019 Budget recommends discontinuing the program appropriation.

Harm reduction programs are eligible to receive federal Centers for Disease Control and Prevention funding. Beginning with the Health Omnibus Programs Extension of 1988, all federal funding included a stipulation that the funding could not be used for needle exchange programs.[2] However, the Consolidated Appropriations Acts of 2016, 2017, and 2018 have included new language in Division H, Sec. 520 which still prohibits the purchase of syringes, but gives states and local communities, under limited circumstances, the opportunity to use federal funds to support the distribution and exchange of syringes, and to administer the needle exchange program.

- **Questions:**

a. Please list the needle exchange programs currently operating in this State. What have been the decisions regarding the two applications for new needle exchange programs the department was reviewing at the time of responding to last year's OLS Discussion Points? For what reasons has the department decided to approve or reject the applications?

[2] This ban was briefly lifted by a provision in the federal Consolidated Appropriations Act of 2010 which permitted federal funding to be used for needle exchange programs. The five New Jersey programs received a total, one-time appropriation of $600,000 from federal CDC funding in the 2010 federal fiscal year. The one-time appropriation permitted the programs to purchase needles. However, language included in the Consolidated Appropriations Act of 2011 reinstated the prohibition on federal money being spent on syringes and needle exchange programs and was included in each such act until the Consolidated Appropriations Act of 2016.

Discussion Points (Cont'd)

There are seven Syringe Access Programs (SAPs) in New Jersey, of which six are currently operating. The SAP sites are in Atlantic City, Newark, Jersey City, Trenton, Asbury Park, Paterson and Camden. The site in Camden is currently inactive but is expected to be up and running by end of April according to the SAP Site Coordinator. The Mayor's Office is currently reviewing Camden Area Health Education Center's (AHEC) request for a site to park its mobile SAP van. The agencies in each city operating a syringe access program are as follows:

- South Jersey AIDS Alliance, Atlantic City
- North Jersey Community Research Initiative, Newark
- Hyacinth AIDS Foundation, Jersey City
- Hyacinth AIDS Foundation, Trenton
- Visiting Nurse Association of New Jersey, Asbury Park
- Hyacinth AIDS Foundation, Paterson
- Camden Area Health Education Center, Camden

In March 2017, the Division of HIV/AID TB and STD (DHSTS) received applications from the Visiting Nurse Association of Central New Jersey and Hyacinth AIDS Foundation for Syringe Access Programs (SAPs) in Asbury Park and Trenton, respectively. The applications were reviewed and scored by internal and external reviewers. The applications were satisfactory. Feedback was provided to both agencies based on the reviews, and the agencies supplied the necessary documentation in response to the feedback. Site visits to the potential new SAP locations were carried out by division staff in Asbury Park in May 2017 and in Trenton in June 2017. Both locations were acceptable; therefore, the applications were officially approved by the end of June 2017. Both applications were complete and detailed, demonstrating an understanding of the need in the communities and an understanding of harm reduction and persons who inject drugs (PWID). They also contained well-researched and crafted policies and operating procedures. The Asbury Park SAP opened its doors in August 16, 2017. Hyacinth AIDS Foundation decided to consolidate all its Trenton HIV programming at one new site, which division staff then visited in August 2017. The site was under construction for some time; its official start date was January 16, 2018.

b. Has the department received any additional applications for needle exchange programs since responding to last year's OLS Discussion Points? If so, what is the status of the applications?

Yes. The Department received an application from Paterson Reconnect Community Development Center (PRDC) to provide SAP services on January 22, 2018. The PRDC application was denied as incomplete and non-responsive. Hyacinth AIDS Foundation submitted an application on April 10, 2018. This application is currently under review.

c. Please explain the reasons for recommending the discontinuation of the $2.1 million FY 2018 appropriation for the Syringe Access Program. Was the addition of the Access to Reproductive Care and HIV Services nurses at needle exchange program sites not effective? Will the number of nurses at the program sites be reduced or does the department expect to provide funding for that purpose from other sources? If so, please identify the alternative funding sources.

The Syringe Access Program funding is continuing as part of the Expanded Addiction Initiatives in the FY 2019 Recommended Budget. Funds are used to support 15 ARCH Nurses, eight FTEs at the existing SAP sites, and an additional eight at County Departments of Health in catchment areas with high opioid and STD rates. The ARCH Nurse program is highly effective in preventing

Discussion Points (Cont'd)

overdose deaths by the distribution of Naloxone, identifying HIV, Hepatitis C, STDs and pregnancy with subsequent linkage to infectious disease or prenatal care.

d. Has the department applied for additional federal funding to support expanded activities of the harm reduction programs, as provided for in the Consolidated Appropriations Acts of 2016, 2017, and 2018? Has the department been approved for additional federal funding and, if so, how much?

The Consolidated Appropriations Acts of 2016, 2017, and 2018 did not make additional federal funding available to jurisdictions; rather it only allowed jurisdictions to redirect their level funding to pay for syringe support program activities. Furthermore, for 2018, the Department suffered a 15% reduction in HIV prevention funding from the CDC, reducing the previous year's budget by $2,043,861. The Department has utilized federal funding to support New Jersey's SAP programs in 2016, 2017 and 2018. Prior to 2015, the Department provided no funding to support SAP activity, and thus, any funding whatsoever from 2016 and beyond enabled the SAPs to continue, as private funding for the programs was no longer available to them. The Department has been approved by the CDC to utilize its HIV Prevention funds to support the SAP programs. Again, these are not additional funds, but rather funds within the year's level budget, which, in 2018 was reduced by $2,043,861.

e. Please list the funding, by source and by recipient program, that the department provided to harm reduction programs in each of FY 2015, FY 2016, FY 2017, and FY 2018 to support the purchase of syringes.

Funds to purchase syringes were not available in FY 2015 and FY 2016. Federal funds have never been available to purchase syringes.

The following is the list of agencies that received state funding totaling $200,000 in FY 2017 to purchase syringes:

- $58,000 South Jersey AIDS Alliance
- $42,000 North Jersey Community Research Initiative
- $20,000 Hyacinth AIDS Foundation
- $25,000 Well of Hope Community Development Corp.
- $55,000 Camden Area Health Education Center

f. Please list the funding, by source and by recipient program, that the department intends to provide to the harm reduction programs in FY 2019 to support the purchase of syringes.

Based on a survey of SAP syringe inventory needs to be conducted in May 2018, additional FY 2019 funds will be distributed to purchase syringes. It is anticipated that the total will be $200,000; however, the amount to go to each agency will vary by need according to the results of the assessment.

The following agencies are anticipated to receive funds to purchase syringes:

- South Jersey AIDS Alliance
- North Jersey Community Research Initiative
- Hyacinth AIDS Foundation

Discussion Points (Cont'd)

- The Visiting Nurses Association of New Jersey
- Camden Area Health Education Center

Early Intervention Program

7. The DOH administers the Early Childhood Intervention Program (ECIP), also known as Early Intervention Program, for infants and toddlers under age three who have developmental disabilities. In FY 2019, total recommended funding for ECIP equals $196.4 million, allocated as follows: $111.4 million in State funds, $69.2 million in federal funds through the Infants and Toddlers with Disabilities Program, Part C of the Individuals with Disabilities Education Act; $11.8 million in family contributions for children who are medically eligible, but whose families' incomes are above 350 percent of federal poverty levels; and $4.0 million in dedicated funding from the Autism Medical Research and Treatment Fund. This represents a $4.0 million increase from FY 2018. The Administration also proposes the continuation of contingency language that would allow for supplemental appropriations of unspecified amounts to the program in the course of the fiscal year and without additional legislative approval. According to budget data (page D-150), the number of children receiving services through ECIP is anticipated to increase by 1,385, from 28,793 children in FY 2018 to 30,177 children in FY 2019.

According to the department's response to an FY 2016 OLS Discussion Point, the DOH contracts with 13 provider agencies to meet the federal service coordination requirements and 64 ECIP provider agencies to conduct developmental evaluations/assessments and deliver direct services to children. According to the department's website,[3] the ECIP is not currently enrolling new providers but will open enrollment opportunities for new providers when it identifies capacity needs, including service availability in a given area, availability of specialized services, and discipline-specific services.

Furthermore, in January 2017, the State Interagency Coordinating Council (SICC), Service Delivery Committee made recommendations for competency standards for ECIP providers.[4] The committee recommended that the State should use these competency standards as a basis for a competitive Request for Application (RFA) process for identifying future ECIP provider agencies. According to the department's response to an FY 2018 OLS Discussion Point, the SICC Service Delivery Commission expected to have recommendations completed for an RFA in 2017 and the department anticipated issuing a competitive RFA in 2018.

Additionally, according to the department's response to an FY 2018 OLS Discussion Point, the DOH rebid a contract originally awarded to the Computer Services Corporation for a new information technology, billing, and collection services system for the ECIP program, and awarded a contract to a new vendor effective January 1, 2017. The department anticipated the new system would be implemented in 2017. Some other program administration functions are performed directly by the department.

- **Questions:**
  - **a. What is the status of the implementation of the new information technology, billing, and collection services system? Who is the new contractor?**

    Public Consulting Group (PCG) is the new contractor awarded by Treasury. PCG's implementation of the Early Intervention Management System (EIMS) began in December 2017. Efforts are ongoing to optimize functions related to user training, enrollment, backfilling data, and billing/payment for services. To date, $22 million in claims have been processed through EIMS and four advance payments totaling $10 million have been provided to Early Intervention providers to assist with agency cash flow pending full functioning of the EIMS.

[3] http://www.nj.gov/health/fhs/eis/for-providers/become-provider/index.shtml
[4] http://nj.gov/health/fhs/eis/documents/provider_competency_standards.pdf

Discussion Points (Cont'd)

b. What is the DOH's timeline to solicit RFAs for future ECIP provider agencies? Has the department issued any RFAs and approved any additional providers?

Although an official timetable has not been established, the RFA release is still expected in calendar year 2018.

It has not been necessary for the Department to issue any other RFAs to approve additional providers.

c. For the last three fiscal years for which the data are available, what were the actual copayments from families whose children participated in the ECIP program but whose family incomes were above 350 percent of federal poverty levels? For how many children did families make copayments? Does the State actually receive the copayments?

The family incomes subject to a family cost participation (FCP) were moved down to 300% of the Federal Poverty Level (FPL) effective November 2010. The collections from co-payments for SFY 2015-2017 are $6,163,537, $6,388,229, and $7,267,700 respectively. In SFY 2017, a cumulative total of 27,431 children received early intervention services under an Individualized Family Service Plan (IFSP) and 6,550 families made a co-payment to NJEIS. FCP co-payments are received by the vendor and used to support the payments to EIPs for service delivery, with state guidance and oversight of copayment funds.

d. Has the department changed any rates charged for family contributions in FY 2018? Does the department plan any changes thereto in FY 2019? If yes, please provide specifics as to any increases or decreases.

The Department has not changed the rates for family co-payments since FY 2011 and has no plans to change family contributions in FY 2019. However, the Department adjusts the federal poverty levels annually effective July 1 each year as published by the federal government.

Statewide Trauma Registry

8. Legislative budget resolutions included a $750,000 appropriation in each of the FY 2015, FY 2016, and FY 2017 Appropriations Acts to establish a Statewide registry of hospitalizations for traumatic injury as required by P.L.2013, c.223. While the FY 2018 Appropriations Act did not make any additional appropriation to the Statewide Trauma Registry, it renewed a related language provision authorizing the use of unexpended balances in the Statewide Trauma Registry account for the establishment of the registry. The Governor's FY 2019 Budget also does not recommend any additional appropriation to the program but continues the carryforward language. Of the approximately $728,000 that was carried forward into FY 2018 in the program account, some $663,000 was uncommitted and unexpended as of March 30, 2018.

P.L.2013, c.223 was intended to establish a Statewide "trauma system that defines the roles of all health care facilities in the State, taking into account their resources and capabilities, allowing for the provision of care to injured patients in the State along the continuum of care." The DOH is the lead agency for this initiative and was directed to "appoint a State Trauma Medical Director to oversee the planning, development, ongoing maintenance, and enhancement of the formal State trauma system."

In response to the FY 2018 OLS Discussion Points, the department stated that the State currently employed a State Trauma Medical Director and that the Statewide Trauma Registry was being implemented. Rowan University would train data contributors; compile, validate, and analyze the data; and maintain the registry. The department further indicated that the one-time cost of establishing the registry

Discussion Points (Cont'd)

was $1.5 million and that the annual costs of ongoing operation and maintenance of the registry had not yet been determined.

- **Questions:**
  a. **Does the State currently employ a State Trauma Medical Director?**

     Yes, the Department currently employs a State Trauma Medical Director, Dr. Vicente Gracias.

  b. **Is the Statewide trauma registry operational, and if not, what factors account for the delay, and when is the registry expected to become operational? Is Rowan University fulfilling its obligations as a contractor for the registry?**

     The Department is collecting data from all Trauma Hospitals in phase I of the Registry implementation. Rowan University is currently conducting analyses of non-trauma hospital discharge data.

  c. **What are the anticipated annual operation and maintenance costs for the registry?**

     Approximately $300,000 annually is required to maintain a full-time data analyst, and a consultant with JAVA expertise to manage the registry and software.

Health Administration

Strategic Plan Facilitation Services

9. On January 26, 2018, the Division of Management and Administration in the DOH issued a request for quotation (RFQ) for qualified firms to assist in the development and initial implementation of a strategic plan for the DOH for the years 2018 to 2021. The submission due date for quotes was on March 7, 2018.

- **Questions:**
  a. **Why did the department request quotations from outside entities to assist in the development of a strategic plan instead of fully conducting the process internally? What capabilities is the DOH lacking to craft an effective strategic plan?**

     For the past two iterations of the DOH strategic plan, the DOH has used an external consultant to facilitate the development of the Plan. An objective facilitator can be beneficial for maintaining the integrity of the process. DOH staff are integral to developing and implementing the strategic plan. A consultant has been used to conduct focus group sessions with external and internal stakeholders and facilitate the senior management strategy sessions.

  b. **How many quotes were submitted in response to the RFQ? How many responses have been disqualified as not meeting the RFQ's criteria? Have the qualified bidders demonstrated deep knowledge of the operations of the DOH and New Jersey's public health challenges and policies?**

     The bid proposals are currently being reviewed and, as a result, information cannot be released.

  c. **What is the department's anticipated timeline for awarding the contract to a vendor and drafting a strategic plan?**

Discussion Points (Cont'd)

Decisions on the timeline will be made following technical and price evaluations of the proposal.

d. What is the overall anticipated cost of developing the strategic plan, and what are the anticipated costs in FY 2019?

Costs will be determined upon completion of the proposal review period.

e. What are the specific goals of developing a strategic plan? What changes are anticipated with regard to the department's functions, goals, and overall mission?

The goal of the Department's strategic planning process is to define and determine the organization's roles, priorities, and direction within a 2 to 3-year timeline. Through the process, DOH will review and potentially refresh its vision, mission, guiding principles and values, as well as refine strategic priorities, using measurable and time-framed goals and objectives.

Affordable Care Act Marketplace Outreach

10. Executive Order No. 4 of 2018 directs all State entities that regularly interact with the public to undertake reasonable measures, to the extent permitted by law and budgetary constraints, to provide information to the public regarding the Affordable Care Act marketplace and ways to enroll.

- **Questions:**
  What has been the department's response to Executive Order No. 4 of 2018? What related initiatives has the department already implemented and what related initiatives does it intend to implement in FY 2018 and FY 2019? What, if any, related expenditures has the department incurred to date? Will there be any additional expenses the department expects to incur to comply with the executive order in FY 2018 or FY 2019?

  The Department has convened an internal workgroup to respond to Executive Order 4 and develop strategies and organize efforts to increase enrollment and improve outreach. Our efforts are in coordination and collaboration with our external partners. We are also communicating with other state and federal agencies to achieve these goals.

  The Department is eagerly pursuing outreach, advertising and media options designed to increase enrollment. In addition, the Department's website now includes a "Get Covered" page that features information on "Getting Health Insurance Coverage in New Jersey."

  One example of an already-implemented initiative is the addition of language to the Terms and Conditions of all third-party grant awards issued by:

  Pursuant to the Governor's Executive Order 4, the Department encourages grantees to disseminate information relative to the Affordable Care Act Marketplace and to notify its service participants and employees, through information and materials or through an awareness program, of ACA marketplace insurance options and enrollment assistance where available.

  The initiatives indicated have been implemented with resources already in place and with no additional expenditures to the budget.

Discussion Points (Cont'd)

Reach NJ

11. In January 2017, the State initiated a television and radio advertising campaign promoting a newly established drug addiction hotline and website, known as the Reach NJ campaign. Kivvit, a public affairs firm, received $39.2 million to conduct the campaign, as of March 30, 2018. The campaign was suspended in January 2018 and it is not clear whether it will continue in its current or in a revised form.

The department responded to an FY 2018 OLS Discussion Point that it anticipated the expenditures to operate the Reach NJ phone hotline and website in FY 2017 and FY 2018 to range between $200,000 and $300,000. The expenditures were included within the Community Based Substance Use Disorder Treatment and Prevention Program, now in the Department of Health.

- **Questions:**

a. Since inception, how many calls has the Reach NJ hotline received and answered and how many clicks has the REACHNJ.GOV webpage registered?

The REACHNJ calls per week have varied significantly and it seemed to depend on the advertising. There have been up to almost 800 calls per week but most weeks are in the 200 - 400 range. Total number of calls since inception is 23,187. The total number of unique visitors to the website since inception is 681,799. Those unique visitors have generated a total of 1,187,207 site visits and roughly 19 million visits to individual pages within the REACH NJ site.

b. What are the anticipated FY 2018 and FY 2019 expenditures for operating the Reach NJ phone hotline and webpage? Are the expenditures still budgeted within the Community Based Substance Use Disorder Treatment and Prevention Program?

The FY18 Budget for REACH NJ is $340,000. The expenditures are budgeted in the Community Based Substance Use Disorder Treatment and Prevention Program. The FY19 budget for REACH NJ will be determined after a review of the projected program needs.

c. Are there any plans to continue a media advertising campaign in connection with Reach NJ? If so, will the campaign be redesigned, will Kivvit continue to conduct the campaign, and what are the anticipated expenditures for the campaign in FY 2018 and FY 2019?

There are no plans for continuing the marketing campaign.

d. Will any aspects or functions of Reach NJ be discontinued either in FY 2018 or in FY 2019? If so, will these aspects or functions be transferred to or undertaken by another program?

No changes were made to the REACH NJ contract in fiscal year 2018. Before contracting for fiscal year 2019, the Division and Department will review the deliverables and budget for possible revision.

Division of Mental Health and Addiction Services (DMHAS)

12. On October 1, 2017, the Division of Mental Health and Addiction Services (DMHAS) was officially transferred from the Department of Human Services (DHS) to the DOH in accordance with Reorganization Plan No. 001-2017. The jurisdictional transfer was intended to provide for the increased efficiency, coordination, and integration of the State's mental health and addiction prevention and treatment functions.

Discussion Points (Cont'd)

- **Questions:**

a. Please explain to what extent the jurisdictional transfer of the DMHAS has increased the efficiency, coordination, and integration of the State's mental health and addiction prevention and treatment functions. Please provide specific examples and detail any cost savings that are anticipated to be realized in FY 2019 as a result of the reorganization.

The jurisdictional transfer of the DMHAS from DHS to DOH was done to improve client outcomes through the provision of primary health and behavioral (mental health and addiction treatment) health care in an integrated fashion. The transfer was not intended to create cost savings. Accordingly, while the full budget of DMHAS was transitioned to DOH, there was not a reduction in force and the DHS central office employees who supported the DMHAS were transitioned to DOH as well.

The Substance Abuse and Mental Health Services Administration (SAMHSA) and Health Resources and Services Administration (HRSA), both within the US Department of Health and Human Services, have identified that individuals with mental illness and substance use disorders die earlier than the general population primarily due to untreated but preventable primary health conditions. Similarly, SAMHSA and HRSA have identified that many individuals are accessing behavioral health treatment in primary health settings. They have identified that "integrating mental health, substance abuse and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple health needs." ("What is Integrated Care," SAMHSA-HRSA Center for Integrated Health Solutions, accessed April 17, 2018, http://www.integration.samhsa.gov/about-us/what-is-integrated-care.)

b. What were the one-time costs to the DOH of effecting the jurisdictional transfer? How many employees, if any, were physically relocated as a result of the reorganization?

The operational cost to transfer DMHAS from DHS to DOH was $1.7 million. 244 Division of Mental Health and Addiction Services employees and 265 Division of Developmental Disability employees were relocated as a result of the reorganization.

c. Have there been any changes in full-time equivalent positions in the DOH as a result of the jurisdictional transfer beyond the one-to-one transfer of DMHAS employees to the department, for example, changes in full-time equivalent positions in units that provide support services to all divisions within the department? If so, what are the annualized costs of the personnel changes?

There have been some minor changes to the full-time equivalent positions that provide support services to all the divisions as a result of the jurisdictional transfer.

d. What plans exist to coordinate programs and activities in areas over which DMHAS and DHS retain shared or overlapping oversight?

The DMHAS continues to coordinate with all programs under DHS as it did prior to the reorganization.

13. The Governor's FY 2019 Budget includes $100.0 million for "Expanded Addiction Initiatives" (page D-169). Related language would direct that this amount "be used to develop, support, and expand programs and services, including providing grants to entities providing such programs and services, that the Commissioner of Health, the Commissioner of Human Services, and the Commissioner of Children and

Discussion Points (Cont'd)

Families determine to be most effective in directly addressing the statewide public health crisis associated with substance use disorders, including opioid use disorder, subject to the approval of the Director of the Division of Budget and Accounting. Such programs and services may include, but shall not be limited to, efforts to improve access to community-based behavioral health care, develop the State's anti-addiction infrastructure, support enhanced integration of care, and address relevant social and economic indicators" (page D-171).

The Governor's FY 2019 Budget also recommends not renewing $66.2 million in effected and projected FY 2018 supplemental appropriations in the Departments of Children and Families, Corrections, Education, Health, and Treasury that were intended to address the statewide public health crisis associated with substance use disorders, including opioid use disorder. The following affected DOH supplemental FY 2018 appropriations total $35.7 million:

-- Expansion of Opioid Overdose Recovery Program, $16.6 million;
-- On-Campus Recovery Programs, Substance-Free Housing and Supportive Services, $8.0 million;
-- Residential Treatment for Pregnant Women and New Mothers, $5.0 million;
-- Syringe Access Program, $2.1 million;
-- Decreasing Incidence of Substance-Exposed Infants, $1.0 million;
-- Expansion of Consumer Helpline, $1.0 million;
-- Opioid Education Campaign for Obstetricians, $1.0 million; and
-- Certified Alcohol and Drug Counselors in Prenatal Health Care Settings, $1.0 million.

- **Questions:**
  - **a. Please specify the planned allocation by program of the proposed $100.0 million appropriation for Expanded Addiction Initiatives, and indicate whether each program currently exists or would be newly created.**

	Program	Proposed dollar amount
Infrastructure and Data		
	+Building data and technology infrastructure to include resources for EHR development, +Landscape analysis and gaps in care analysis, and +Integrated Population Health Data (iPHD) system project.	$12.5M
Prevention Treatment and Recovery		
	Increased access to treatment services (intensive outpatient, outpatient, residential and detox), Increased access to medication assisted treatment, *Syringe Access Program, Screening in primary care for opioid use disorder, *Consumer helpline, and Building administrative support for single license, *Prevention outreach/support, *Peer-delivered services (Opioid Overdose Recovery Program / Prison Re-entry Recovery Coach Program, *Decreasing incidence of substance exposed infants	$52.471 M
Social Risk Factors		
	+Supported employment and supportive housing (due to needed timeframe to procure vendors through a Request for Proposal process, vendors to hire staff, admit clients and identify housing units and lease them up in SFY 2019 will reflect the phase-in time period and SFY 2020 will incur the full, annualized effect of this program's implementation.)	$7.5M to annualize to $15 M

Discussion Points (Cont'd)

Notes: Items that were funded or proposed to be funded but not started in SFY 2018 with supplemental appropriations that are proposed for continuation in SFY 2019 are marked with an asterisk (*).

Items that are proposed to be newly created are marked with a plus sign (+).

b. Please explain the reasons for recommending the discontinuation of each of the effected and projected FY 2018 supplemental appropriations in the DOH for substance use disorders that total $35.7 million. Have the programs not been effective? Would any of the concerned programs' FY 2018 supplemental funding be renewed in FY 2019 out of the recommended $100.0 million appropriation for Expanded Addiction Initiatives? If so, please identify the programs and associated amounts.

All of the programs proposed in the first two quarters of SFY 2018 did not commence such as Screening, Brief Intervention and Referral to Treatment, Enhanced Care Management and Supportive Housing. Please see chart above for those programs that commenced in SFY 2018 and will continue to be funded in SFY 2019.

c. Does the DOH intend to solicit bids from outside entities to provide goods and services for DOH programs that would receive an allocation out of the recommended $100.0 million appropriation for Expanded Addiction Initiatives? If so, what is the anticipated timeframe for issuing solicitations, and for what programs and what specific goods and services would the solicitations be issued?

DOH will follow procurement rules. Specifically, the DOH will enter into a Memorandum of Agreement or Understanding with other state entities for some of the initiatives and solicit bids for other initiatives. Solicitations for new programs will need to be developed and will be issued as soon as possible following the promulgation of the budget act.

d. Would the DOH allocation out of the recommended $100.0 million appropriation be used to hire additional department staff in connection with the expanded addiction initiatives? If so, how many additional staff, by title, would be needed and at what annualized cost? Would the positions be filled by permanent or temporary staff?

Once the final awards are made and budgets determined, DOH and DMHAS will review the specific staffing needs for each program and hire staff accordingly; the decision to hire additional permanent or temporary staff has not yet been made.

State Psychiatric Hospitals

14. In FY 2018, the State made combined adjusted appropriations of $305.2 million for the operation of the four State psychiatric hospitals. The Governor's FY 2019 Budget recommendation for the psychiatric hospitals is $297.6 million (page D-164), a reduction of approximately $7.5 million.

Following reports of overcrowding, violent attacks, and staffing shortages at the four State psychiatric hospitals, the New Jersey Health Care Facilities Financing Authority commissioned a report in December 2017, to be produced by New Solutions Inc. at a cost not to exceed $740,500, that would review the entire State psychiatric hospital system. The report was to be submitted to the DOH and the authority by March 1, 2018. The DOH has also indicated that it is developing a strategic plan to reform the system.

Discussion Points (Cont'd)

- **Questions:**
  - **a. For each of the four State psychiatric hospitals, please provide details concerning staff turnover rates, overtime payments, the number of officially-reported incidents involving violence, the number of patients on Conditional Extension Pending Placement (CEPP) status, the length of time each patient has been continuously on CEPP status, and the length of time each patient was on CEPP status prior to transitioning to a community placement.**

1. Turnover rate for FY17 (as % of FY17 initial filled positions):

a. Greystone – 12.6%
b. Trenton – 10.4%
c. Ann Klein Forensic – 11.7%
d. Ancora – 11.3%

2. Overtime Payments for FY17:

a. Greystone: $15,346,728
b. Trenton: $11,389,002
c. Ann Klein Forensic: $7,515,416
d. Ancora: $12,417,402

3. Violent incidents - Please see: http://nj.gov/health/integratedhealth/dmhas/publications-reports/hospital/CY_2017_incidents.pdf. Data are also presented below for reference.

	Department of Health				
	Division of Mental Health and Addiction Services				
	DMHAS Psychiatric Hospital Incident Data Report				
	1/1/2017 - 9/30/2017				
	Ancora	**Ann Klein**	**Greystone**	**Trenton**	**Total**
Other to Service Recipient (SR) / Major injury	0	0	0	0	**0**
Other to SR / Moderate injury	0	0	0	0	**0**
Other to Staff / Moderate injury	0	0	0	0	**0**
SR to Other / Major injury	0	0	0	0	**0**
SR to Other / Moderate injury	0	0	0	0	**0**
SR to SR / Major injury	0	2	2	5	**9**
SR to SR / Moderate injury	8	2	37	25	**72**
SR to Staff / Major injury	0	0	0	0	**0**
SR to Staff / Moderate injury	2	6	17	7	**32**
Staff to Other / Major injury	0	0	0	0	**0**

Discussion Points (Cont'd)

Staff to Other / Moderate injury	0	0	0	0	**0**
Staff to SR / Moderate injury	0	1	0	0	**1**
Staff to SR / Major injury	0	0	0	0	**0**
Staff to Staff / Major injury	0	0	0	0	**0**
Staff to Staff / Moderate injury	0	0	0	0	**0**
Total Assaults	**10**	**11**	**56**	**37**	**114**
Unexpected Deaths– Accidental	0	0	0	0	0
Unexpected Deaths-Sudden/medical	2	0	2	0	4
Unexpected Deaths-Suicide	0	0	0	0	
Unexpected Deaths-Undetermined Manner	0	0	0	0	**0**
Total Deaths	**2**	**0**	**2**	**0**	**4**

P.L. 2009, chapter 161 requires that state psychiatric hospitals report major and moderate injuries among patients; and staff members and the number of unexpected deaths at the four designated facilities. As of 6/14/2012, Hagedorn Psychiatric Hospital closed. The website posts deaths of state hospital patients who may be in general medical facilities or on brief visits not yet discharged from the hospital. This report includes substantiated incidents only. Data is subject to update on a quarterly basis as information becomes available.

Assault Physical: Act of touching or striking a victim's body to cause physical harm, which may or may not result in actual injury. The acts perpetrated under the physical assault category could occur between two service recipients, staff to staff, "other" to service recipient or staff, or service recipient to staff or "others." When staff persons charged with the responsibility of supervising or providing direct care physically strikes a service recipient, the incident is always categorized as abuse and must be reported as such.

Moderate injury: Refers to an injury that requires treatment beyond basic first aid and can only be performed by a medical professional at a physician's office, at a hospital emergency room, or by facility physicians. Examples of moderate injuries include, but are not limited to, a laceration requiring sutures or a human bite breaking the skin, injury around the eye such as bruising, swelling or lacerations.

Major injury: Refers to an injury that requires treatment that can only be performed at a hospital facility and may or may not include admission to the hospital for additional treatment or observation. Examples of major injuries include, but are not limited to, skull fractures, injuries to the eye (excluding the area around the eye), and broken bones requiring setting and casting.

Service Recipient: Refers to a child (birth to 17 years) or an adult (18 years or older) who resides in a state operated facility/institution or attends a state operated special needs educational program(OOE).

4. **CEPP at end of FY17:**
   a. Greystone: 114
   b. Trenton: 83
   c. Ann Klein Forensic: N/A
   d. Ancora: 135

Discussion Points (Cont'd)

5. Average length of time on CEPP during FY17:

a. Greystone: 146 days
b. Trenton: 124 days
c. Ann Klein Forensic: N/A
d. Ancora: 87 days

6. Average time on CEPP for FY17 Discharges:

a. Greystone: 84 days
b. Trenton: 70 days
c. Ann Klein Forensic: N/A
d. Ancora: 63 days

b. Has the DOH received the report by New Solutions Inc. on the State psychiatric hospital system? If not, what factors account for the delay and by what date does the department expect to receive the report? When will the report become publicly available? Is the State taking any anticipatory action to implement the recommendations or likely recommendations to be included in the report?

Yes, the Department of Health has received a draft of the report from New Solutions, Inc. The report identifies numerous opportunities to improve performance of the four psychiatric hospitals operated by the State of New Jersey. A thoughtful and careful analysis on our part is required to determine how best to implement the findings and recommendations that are outlined in the document.

The state has taken action in anticipation of the report. These actions have included the hiring of a Deputy Commissioner with extensive experience and expertise in hospital operations and behavioral health services, planning for the development of an electronic health record for the hospitals and the hiring of a consultant to work with the hospitals on compliance with the Centers for Medicaid and Medicare Services and The Joint Commission.

15. In February 2017, the Department of Health issued a Certificate of Need Call for 864 newly licensed hospital beds for the treatment of psychiatric disorders, including for persons with co-occurring mental health and substance use disorders. Pursuant to this call, the department issued Certificates of Need to 26 of the 30 applicants in November 2017, authorizing an additional 811 adult acute care psychiatric hospital beds. In February 2018, the department issued a subsequent call for 53 hospital beds to satisfy the remaining unmet need for beds. Any increase in private psychiatric hospital beds could potentially reduce the need for public psychiatric hospital beds in State or county facilities, but, in response to an FY 2018 OLS Discussion Point, the Department of Human Services indicated that "[w]ith rare exception, the voluntary bed complement does not serve the cohort of individuals who would otherwise be admitted to a public facility."

- **Questions:**

a. Has the recent increase in private psychiatric treatment capacity led to a decline in the number of placements at public facilities?

When capacity expansion is realized, we will be able to better analyze the impact, if any, on the number of admissions at public facilities.

Discussion Points (Cont'd)

The reductions in census in the State hospitals (e.g., a reduction in the Average Daily Population between FY16 and FY17 from 1,606 to 1,557) have been largely driven by the Division's investments in Supportive Housing placements. Further enhancements to private sector psychiatric treatment capacity may result in reductions to placements in public facilities but this is too early to determine.

b. Does the department anticipate issuing a Certificate of Need Call for additional adult acute care psychiatric beds in FY 2019?

In November 2017, the Department approved 811 of the 864 beds determined to be needed. To address the remaining need, the Department issued a CN call for 53 additional beds; applications are due on May 1, 2018. If any needs remain or are determined to exist in FY 2019 the Department may issue an additional call.

c. Have efforts to expand the private psychiatric treatment capacity been hindered by a shortage in mental health care professionals? Are there plans in place to ensure the number of mental health care professionals is sufficient to meet patient demand?

No applicant in the last psychiatric bed CN batch suggested that there might be a shortage of appropriate professionals to staff these beds or necessary outpatient services. The Department believes that the increased number of beds and the increased public perception of the need for behavioral health services will encourage more programs to train professionals. The Department will work with behavioral health providers to monitor this situation and cooperatively address any issues.

Community Programs

16. The department has completed the process of transitioning community-based mental health and addiction services from a system of cost-reimbursement contracts to fee-for-service reimbursement. Most providers were required to do so by June 30, 2017, while those providing services in the Community Support Services (CSS) program were permitted to extend their cost-reimbursement contracts through December 2017. The State appropriated $136 million under Behavioral Health Rate Increase to assist providers with the transition in FY 2018. The amount is continued in the Governor's FY 2019 Budget Recommendation (page D-169). However, some providers have warned that the transition will be detrimental to their financial stability, and may force them to curtail services or close down. The Mental Health Coalition has urged the department to keep a reserve of $90 million to maintain a safety net to ensure continuity of care for current service consumers.

- **Questions:**

a. Has the transition to the fee-for-service reimbursement system been completed for providers of mental health and addiction services? What categories of providers, if any, remain on cost-reimbursement contracts, and what is the total number of providers that continue on cost-reimbursement contracts? Does the department have plans to transition the remaining providers to fee-for-service reimbursements?

The transition to fee for service has been completed for all DMHAS contracted providers of mental health and addiction services that were targeted to move to the new reimbursement approach with the exception of Community Support Services. Services that remain in cost reimbursement at this time include: psychiatric emergency screening, Projects for Assistance in Transition from

Discussion Points (Cont'd)

Homelessness (PATH), Intensive Family Support Services, Legal Services and Self Help centers. At this time, there are no active plans to transition these to fee for services.

b. Please comment on the performance of the fee-for-service reimbursement system. Has the transition been mostly seamless for providers and their clients? How many provider agencies terminated or curtailed their operations in FY 2017 and FY 2018? Does that number differ from FY 2014, FY 2015, and FY 2016? Have providers cited the transition to the fee-for-service reimbursement system as a contributing factor to their decision to terminate or curtail operations? Has the quality and effectiveness of services provided to clients increased or decreased as a result of the transition?

The DMHAS has worked and continues to work extensively, both internally and with providers, to ensure that the transition to fee for service was as seamless as possible. We successfully developed and implemented the New Jersey Mental Health Application Process (NJMHAPP), which is our claims entry system. We have engaged providers with significant training around NJMHAPP, including weekly webinars and technical assistance that have been well-received. In addition, we created dedicated teams to serve as the main points of contact for both programmatic, information technology and fiscal issues; this has helped to expedite our responses to questions and concerns from providers each week. Additionally, NJMHAPP contains a ticket management system where providers enter questions and complaints for response. The dedicated team responds to each entry submitted. Feedback received from providers has been overwhelmingly positive in this regard.

In addition, early on in the transition, in response to provider comments, we increased the billable rates for certain outpatient services significantly. More recently, we instituted a policy change (again in response to provider concerns) that would effectively increase the quantity of Supported Employment contacts that are billable to DMHAS, which has resulted in increased billings in that service category.

During FY17 and FY18, a total of 16 distinct service programs were eliminated or curtailed by contracted providers. Providers advised that they made business decisions to target particular programs for reduction or elimination based upon their individual analyses of the impact the conversion to FFS would have for these particular programs. DMHAS did not maintain specific comparable records for the prior years. DMHAS worked with these providers to transition consumers into available services to minimize impact to consumers. In several cases, it is necessary to re-procure services to replace the lost capacity. However, we are confident that there has been no detrimental impact of the transition on the quality and effectiveness of services delivered. Additionally, the Office of Licensing continues to license new treatment providers.

c. Are the billings for services by providers that have transitioned to fee-for-service generally keeping pace with projections? Have billings exceeded or fallen short of projections?

In assessing provider billings, it is important to consider both Medicaid and non-Medicaid claims. While non-Medicaid claims in DMHAS are falling somewhat short of what we had initially predicted, we believe there is an offsetting impact in Medicaid. In other words, the actual mix of clients (Medicaid vs. Non-Medicaid) has varied from our initial projection

DMHAS will build on the experience in FY18 in setting projections for non-Medicaid billings in FY19. Additionally, the DMHAS is meeting with every provider individually whose NJMHAPP billing is significantly lower than projected to understand the reason for the low billing for state dollars.

Discussion Points (Cont'd)

d. Please provide a list of all DMHAS contracted providers, indicating (1) the provider's status with respect to the fee-for-service transition; (2) the types of service provided under the contract; (3) the annual contract funding (if currently still on a cost-reimbursement contract); and (4) the annual amount of fee-for-service payments for the most recent year for which data are available.

Please see attached analysis summarizing the payments for both cost-based and fee for service mental health and substance use disorder providers.

e. Please describe efforts by the department planned for FY 2019 to assist providers in the transition to fee-for-service, including both technical and financial assistance.

The Division has provided both technical and financial assistance to providers in FY 18 and will continue to provide this service in FY 19. We conduct a weekly webinar with providers to review any issues, problems, and concerns that they have related to finances, systems or programmatic areas. Also, providers are able to submit tickets via the NJMHAPP system with any questions / problems they may have and these tickets are answered within 24 hours. The Fiscal Office works very closely with both the Financial and executive management staff of the providers to ensure that all parties are aware of their billing activity and how it compares to budgeted amounts. A monthly financial analysis is prepared for each provider analyzing actual billing versus budget for each of their programs.

f. Does the department anticipate expending the full $136 million Behavioral Health Rate Increase appropriation in FY 2018? What is the basis for the $136 million recommended appropriation for FY 2019?

Yes – we do anticipate spending the full $136 million appropriation, which consists of about $20 million of State funds with the balance reflecting enhanced federal match in Medicaid/DMAHS. The amount reflects an estimate of the impact of higher billable rates on spending in both DMHAS and DMAHS. As such, the $20 million will support higher State costs for such programs and services that have been impacted significantly by higher rates such as residential services. The $116 million of federal budget authority is being spent at Medicaid, reflecting the increase in federal share of behavioral healthcare costs.

17. Expenditures for mental health and substance use disorder services programs are split across two divisions in two departments, DMHAS in the DOH and the Division of Medical Assistance and Health Services (DMAHS) in the Department of Human Services (DHS). In brief, payments eligible for federal Medicaid matching funds in the DHS are administered by DMAHS/NJ FamilyCare, while "State-only" payments and federal block grants are administered by the DMHAS in the DOH. Recent efforts to move the system into fee-for-service and increase reimbursement rates are associated with a push to increase claims of federal Medicaid matching funds – which means spending shifts from the DMHAS to DMAHS/NJ FamilyCare.

The Governor's FY 2019 Budget recommends retaining an annually recurring language provision that allows for the transfer of appropriations between the DMHAS and DMAHS/NJ FamilyCare in order to permit flexibility in the handling of appropriations and ensure the timely payment of claims to providers of mental health and substance use disorder services. In particular, the Behavioral Health Rate Increase appropriations in the DMHAS, being mostly federal matching funds, may need to be transferred to Medicaid in order to be expended.

Discussion Points (Cont'd)

- **Question:**
  Please provide data on total spending for community-based mental health and substance use disorder treatment across the DMHAS and DMAHS/NJ FamilyCare for each year from FY 2016 (actual) through FY 2019 (recommended). Please disaggregate mental health from substance use disorder spending, and disaggregate State General Fund, federal Medicaid, federal block grant, and other State funds.

DMAHS/Medicaid Spending: FY16-FY19					
Actual & Projected	Federal $		State $		Total Fed and State
	Mental Health	Substance Use Disorder	Mental Health	Substance Use Disorder	
Actual SFY16	$ 115,604,790	$ 17,548,643	$ 64,672,400	$ 2,735,123	**$ 200,560,956**
Actual SFY17	$ 183,429,101	$ 24,571,792	$ 100,583,776	$ 5,503,447	**$ 314,088,115**
Projected SFY18	$ 231,608,951	$ 31,295,798	$ 116,453,398	$ 7,583,095	**$ 386,941,243**
Projected SFY19	$ 244,629,097	$ 33,419,397	$ 123,960,915	$ 8,121,906	**$ 410,131,314**
TOTAL FY16-19	**$ 775,271,939**	**$106,835,631**	**$ 405,670,489**	**$ 23,943,570**	**$ 1,311,721,629**

DMHAS Spending: FY16-FY19					
Actual & Projected	Federal/Other $		State $		Total Fed, State and All Other
	Mental Health	Substance Use Disorder	Mental Health	Substance Use Disorder	
Actual SFY16	$ 25,160,656	$ 75,727,799	$ 380,648,879	$ 66,448,652	**$ 547,985,986**
Actual SFY17	$ 34,486,596	$ 73,789,045	$ 373,060,770	$ 72,213,083	**$ 553,549,494**
Projected SFY18 [1,2]	$ 31,494,000	$ 78,317,594	$ 410,377,000	$ 104,271,000	**$ 624,459,594**
Projected SFY19 [2,3]	$ 33,565,000	$ 76,233,594	$ 390,377,000	$ 176,671,000	**$ 676,846,594**
TOTAL FY16-19	**$ 124,706,253**	**$304,068,032**	**$ 1,554,463,649**	**$ 419,603,735**	**$ 2,402,841,668**

Total DMHAS/DMAHS Spending: FY16-FY19					
Actual & Projected	Federal/Other $		State $		Total Fed, State and All Other
	Mental Health	Substance Use Disorder	Mental Health	Substance Use Disorder	
Actual SFY16	$ 140,765,446	$ 93,276,442	$ 445,321,280	$ 69,183,775	**$ 748,546,943**
Actual SFY17	$ 217,915,697	$ 98,360,837	$ 473,644,545	$ 77,716,529	**$ 867,637,609**
Projected SFY18 [1,2]	$ 263,102,951	$109,613,393	$ 526,830,398	$ 111,854,095	**$ 1,011,400,837**
Projected SFY19 [2,3]	$ 278,194,097	$109,652,991	$ 514,337,915	$ 184,792,906	**$ 1,086,977,909**
TOTAL FY16-19	**$ 899,978,192**	**$410,903,663**	**$ 1,960,134,138**	**$ 443,547,305**	**$ 3,714,563,297**

[1] FY18 reflects Adjusted Appropriations as per Governor's Budget Message, inclusive of Drug Court funding from AOC; includes $27.6 million from Governor's Expansion of Opioid Initiatives

[2] FY18 and FY19 figures exclude $116 million transferred to Medicaid to reimburse for the impact of the fee for service rate increase for behavioral health services; FY17 amount was $106 million. These amounts are embedded in the Medicaid figures above.

[3] FY19 reflects Recommended amount as per Governor's Budget Message, inclusive of Drug Court funding from AOC; includes $100 million for Governor's Expansion of Opioid Initiatives .

In addition to above, for each of FY16-19, DMHAS has transferred, or will transfer, $7.9 million of State funds to the Department of Children and Families for Addictions services provided in that agency.

Discussion Points (Cont'd)

18. In November 2017, New Jersey received a waiver from the federal rule prohibiting Medicaid reimbursement for treatment of non-elderly adults for mental health or substance use disorders in residential facilities with more than 16 beds – the so-called "Institutes for Mental Disease" or "IMD exclusion." However, the federal Centers for Medicare and Medicaid Services (CMS) have not yet allowed federal funds to be used to pay for such treatment, the full cost of which is currently being paid by the State. In answering an FY 2018 OLS Discussion Point, the Department of Human Services indicated that at the time 24 facilities with Short Term Residential and Detoxification services in New Jersey exceeded 16 beds and that more than 5,000 clients treated in these facilities were eligible for Medicaid.

- **Questions:**

a. How many facilities currently operating in New Jersey, and how many patients, became eligible for Medicaid reimbursement under the waiver?

DMHAS data indicate that between 5,000 and 6,000 individuals will become eligible for Medicaid reimbursement under the waiver.

b. Has the federal government begun to provide funds for treatment under the waiver? If not, by what date does the department expect to receive federal Medicaid funds for that purpose?
The Division of Medical Assistance and Health Services (Medicaid) will begin receiving federal Medicaid reimbursement for short-term residential services and detox services on July 1, 2018 and for long-term residential services on October 1, 2018.

c. What were the costs to the State in FY 2017 of providing treatment to newly-eligible patient classes under the waiver? What are the anticipated total expenditures for treatment to newly-eligible patient classes under the waiver in FY 2018 and FY 2019, and the State and federal components thereof?

Total costs to fund services for the clients (in DMHAS) were approximately $23 million in FY17. This primarily reflects costs in the DMHAS Addictions Fee for Service Network and covers clients in initiatives such as Drug Court, Mutual Agreement Program and the Substance Abuse, Prevention and Treatment Initiative. The FY18 and FY19 gross costs in the Division of Medical Assistance and Health Services (Medicaid) are expected to be around $30-40 million, split between State and Federal shares.

Health Planning and Evaluation

Dementia Care Homes

19. P.L.2015, c.125 (N.J.S.A.55:13B-5.1 et al.) transferred responsibility for the oversight of rooming or boarding houses for persons with dementia from the Department of Community Affairs (DCA) to the DOH, which is to license these facilities as dementia care homes. After having operated under temporary regulations, on November 21, 2017, the DOH promulgated final regulations, R.2017, d.246, which took effect December 18, 2017.

The DOH is empowered to exercise such authority with respect to a dementia care home as is granted with respect to any other DOH licensed health care facility. However, section 22 of P.L.2015 c.125 (N.J.S.A.26:2H-153) permits the department to issue a temporary or permanent waiver of licensing standards to dementia care homes which are operating and licensed by DCA on the effective date of the act (June 1, 2016).

Discussion Points (Cont'd)

According to the DOH's responses to FY 2018 OLS Discussion Points, provisional licensure had been granted to 28 dementia care homes and 14 dementia care homes submitted requests for waivers or clarification of the DOH licensing regulations, which were then under review.

- **Questions:**

a. How many dementia care homes have applied for licensure under the current regulations? How many applications has the DOH approved and rejected? How many licensure determinations remain pending?

25 were licensed on June 1, 2016, two more in July 2016 and one additional in December 2016. None were denied a license and none are pending.

b. How many dementia care homes are currently operating under a provisional license granted prior to the effective date of the current regulations?

Until recently, all 28 were operating under a provisional license. Twenty-seven still are and these will be issued a full license on their next licensure renewal date, since new rules for these homes became effective in November 2017. However, one licensed entity, Selah Care Center in Belvedere, was found to have serious and repeated significant licensing deficiencies, including locked resident rooms, insufficient staff, poor medication administration, and resident abuse. Due to this, the DOH revoked the license of this facility on February 21, 2018. The facility appealed this decision. Since subsequent inspections after revocation indicated the facility was still in serious violation of standards and to require the facility to close until the revocation hearing is held, a Summary Suspension of the license was issued on March 28, 2018. The facility did not appeal this decision and subsequently transferred all its residents.

c. How many boarding homes that were licensed by the DCA prior to June 1, 2016 have requested a waiver of some or all DOH dementia care home licensing standards? How many waivers have been approved? Are any requests still under review?

Two facilities have formally requested a waiver. Both of the requests were subsequently withdrawn after DOH staff pointed out the requirements for which a waiver was requested were statutory requirements which the Department could not waive.

Telemedicine

20. Telemedicine is the remote delivery of health care services and clinical information using telecommunications technology. This includes a wide array of clinical services using internet, wireless, satellite, and telephone media. Currently, more than 30 states and the District of Columbia require that private insurers cover telehealth services the same as in-person services. Many other insurers cover at least some telehealth service.[5]

New Jersey authorized the use of telemedicine pursuant to P.L.2017, c.117 (N.J.S.A.45:1-46 et al.). The law requires telehealth and telemedicine organizations to annually register with the department and to report certain encounter data; including the total number of encounters, the types of technology being utilized to provide services, the categories of medical condition for which services are sought, the region where the

[5] http://www.americantelemed.org/main/about/about-telemedicine/telemedicine-faqs

Discussion Points (Cont'd)

patient was located, the patient's age and sex, and any prescriptions issued. As of January 2018, the reporting requirement expanded to include the patient's race and ethnicity, diagnostic codes, evaluation management codes, and the source of payment for the encounter.

- **Questions:**

a. How many telehealth and telemedicine organizations are currently registered with the department?

None at this time. The Department is in the process of developing the registration process and reporting system contemplated by the statute. Since the program is still in development, the data requested below has not been compiled.

b. What types of services are being provided via telehealth and telemedicine and how many patients are receiving telehealth and telemedicine services?

The expansion and utilization of available telehealth and telemedicine services by patients is increasing in New Jersey. These services range from telestroke, teleneurology, telecardiology to telemedicine consultations by providers in tele-psychiatry and tele-pediatrics. The Division of Mental Health and Addiction Services designates psychiatric emergency screening services (PES). This service assesses if an individual meets commitment criteria because they are a danger to themselves or others due to mental illness. The service operates 24/7. There is one PES in every county except Essex, where there are three PES. Ten of the 23 designated PES use telepsychiatry to determine if someone meets the commitment criteria. At this time, the Department does not have data on the number of patients who are receiving telehealth and telemedicine services.

c. What has been the increase in the number of patients receiving services in medically underserved areas that is attributable to the availability of telehealth and telemedicine services?

The Department currently has no data available to report.

d. What has been the increase in the number of patients receiving services in connection with substance use disorder treatment that is attributable to the availability of telehealth and telemedicine services?

The Department currently has no data available to report.

e. What has been the annualized cost to the department of administering the provisions of P.L.2017, c.117? How many full-time equivalent positions, by title, are assigned to the implementation of P.L.2017, c.117? Does the department expect the number to increase in the next three fiscal years?

The Department anticipates that the cost to establish, monitor and analyze data collection for implementation of P.L. 2017, c.117 (telehealth/telemedicine) would be approximately $500,000. Four full-time equivalents, which would include a Program Manager, Health Data Analyst and two Information Technology Developers, are needed.
The Department does not anticipate a significant increase in the next three fiscal years.

Discussion Points (Cont'd)

Charity Care

21. Acute care hospitals are required by State law to provide all necessary care to patients regardless of ability to pay, pursuant to P.L.1992, c.160 (N.J.S.A.26:2H-18.52 et al.). Charity Care is free or reduced charge care that is provided to uninsured patients who receive their inpatient and outpatient services at acute care hospitals throughout the State. To offset the costs to hospitals of uncompensated care delivered to low-income uninsured patients, the State provides subsidies through the New Jersey Hospital Care Payment Assistance Program (Charity Care Program). The source of funding for hospital care payment assistance is the Health Care Subsidy Fund (HCSF) administered under P.L.1997, c.263. The FY 2019 Budget Recommendation includes expenditures of $252 million from the HCSF for Charity Care, which is the same as the adjusted FY 2018 appropriation (page H-11).

The current statutory Charity Care distribution formula, established pursuant to subsection b. of N.J.S.A.26:2H-18.59i, ranks hospitals according to the percentage of each hospital's gross patient revenue attributable to Charity Care patients, and pays hospitals with a higher rank a larger subsidy in proportion to their total documented Charity Care. Notably, the statutory formula provides for the hospitals that provide the most Charity Care and serve the communities with the lowest median incomes to receive 96 percent of the hospital's documented Charity Care. The formula also provides for a minimum reimbursement to each hospital of 43 percent of its documented Charity Care. The current statutory formula has never been implemented precisely as enacted, as appropriations language has overridden it in each Appropriations Act since the current formula was established in 2004.

The proposed formula for FY 2019 (page D-161) differs from the statutory formula, and results in Charity Care subsidies for certain hospitals that are less than the statutory minimum of 43 percent. The recommended FY 2019 formula is substantively identical to the FY 2018 formula, except that the years of the source data are updated.

Uncompensated care claims by New Jersey hospitals have decreased significantly since calendar year 2013. Claims approximated $1.0 billion annually from calendar year 2010 through calendar year 2013. They plunged to $570 million in calendar year 2014 and then slid to $480 million in calendar year 2015 and $451 million in calendar year 2016. New Jersey Charity Care appropriations mirror this trend: in FY 2015, for example, Charity Care expenditures were $650 million while the adjusted FY 2018 appropriation stands at $252 million.

The continued downward trend in the costs associated with individuals who do not have alternative forms of health insurance is due to two elements of the federal Affordable Care Act (ACA): the health insurance purchase mandate imposed on individuals in conjunction with federal premium tax credits and cost-sharing subsidies, and the State's decision to opt into the ACA's optional expansion of Medicaid coverage to individuals with household incomes up to 138 percent of the federal poverty level.

Federal health insurance policy changes in 2017, however, may halt or reverse the declining trend. In October 2017, the federal government ceased to make cost-sharing reduction subsidy payments to health insurance carriers. These payments effectively lowered the cost of qualified insureds for health insurance policies purchased through the health insurance marketplace. In December 2017, the "Tax Cuts and Jobs Act," Pub.L.115-97, then repealed the individual mandate penalty under the ACA as of tax year 2019. The ACA currently requires taxpayers to pay a penalty on their tax returns if they do not have minimum essential health insurance coverage or qualify for an exemption. All other factors being equal, the elimination of the individual mandate and cost-sharing reduction subsidy payments has the potential to increase hospitals' annual uncompensated care claims.

- **Questions:**
  - **a. Please provide a table displaying the hospital-specific distribution that would result from the statutory Charity Care distribution formula, using the most recent available cost and documented charity care data available**.

Discussion Points (Cont'd)

HOSPITAL NAME	SFY2019 Statutory Subsidy
AtlantiCare Regional MC - City	7,095,918
AtlantiCare Regional MC - Mainland	4,392,428
Bayshore Community Hospital	292,686
Cape Regional Medical Center	346,432
Capital Health Medical Center - Hopewell	4,470,413
Capital Health Regional Medical Center	15,668,252
CarePoint Health - Bayonne Medical Center	3,711,674
CarePoint Health - Christ Hospital	12,680,209
CarePoint Health - Hoboken University Medical Center	11,647,087
CentraState Medical Center	1,421,949
Chilton Medical Center	276,737
Clara Maass Medical Center	1,091,005
Community Medical Center	1,221,357
Cooper Hospital/University MC	13,667,770
Deborah Heart and Lung Center	1,151,100
East Orange General Hospital	3,474,427
Englewood Hospital and Medical Center	3,568,586
Hackensack UMC - Mountainside	581,464
Hackensack UMC - Palisades	9,284,108
Hackensack UMC - Pascack Valley	130,268
Hackensack University Medical Center	6,418,120
Hackettstown Regional Medical Center	196,347
Holy Name Medical Center	1,445,418
Hudson Regional Hospital (Meadowlands)	110,403
Hunterdon Medical Center	1,057,737
Inspira Medical Center - Elmer	191,297
Inspira Medical Center - Vineland	2,189,039
Inspira Medical Center - Woodbury	405,649
Jefferson Cherry Hill Hospital	674,179
Jefferson Stratford Hospital	599,555
Jefferson Washington Twp Hospital	658,156
Jersey City Medical Center	20,329,708
Jersey Shore University Medical Center	3,727,726
JFK Medical Center	4,958,228
Lourdes Medical Center of Burlington Cty.	1,172,278
Memorial Hospital of Salem County	121,285
Monmouth Medical Center	3,586,368
Monmouth Medical Center - Southern	2,020,446
Morristown Medical Center	3,591,182
New Bridge Medical Center (Bergen Regional)	14,164,959
Newark Beth Israel Medical Center	5,130,356
Newton Medical Center	374,070
Ocean Medical Center	961,658
Our Lady of Lourdes Medical Center	3,452,290

Discussion Points (Cont'd)

Overlook Medical Center	2,191,668
Raritan Bay Medical Center - Old Bridge	536,786
Raritan Bay Medical Center - Perth Amboy	4,930,164
Riverview Medical Center	1,096,070
Robert Wood Johnson University Hospital	12,679,279
RWJ University Hospital - Hamilton	1,068,227
RWJ University Hospital - Rahway	447,493
RWJ University Hospital - Somerset	1,433,861
Shore Medical Center	461,687
Southern Ocean Medical Center	409,801
St. Barnabas Medical Center	1,573,349
St. Clare's Hospital - Denville	952,417
St. Clare's Hospital - Dover	2,157,542
St. Francis Medical Center	5,442,116
St. Joseph's Regional Medical Center	34,933,829
St. Joseph's Wayne Hospital	448,562
St. Luke's Warren Hospital	275,432
St. Mary's General Hospital	3,705,699
St. Michael's Medical Center	6,589,572
St. Peter's University Hospital	12,630,051
Trinitas Regional Medical Center	30,235,923
University Hospital	46,043,835
University MC of Princeton - Plainsboro	1,927,516
Valley Hospital	1,096,139
Virtua-Mem. Hospital of Burlington County	2,289,817
Virtua-West Jersey Health Sys. - Berlin *	0
Virtua-West Jersey Health Sys. - Marlton	568,910
Virtua-West Jersey Health Sys. - Voorhees	1,344,613
TOTAL	351,180,682

b. To what extent does the recommended FY 2019 Charity Care appropriation take into account the effects of the 2017 federal health insurance policy changes on hospitals' uncompensated care claims?

The FY 2019 Charity Care appropriation is maintained at $252 million, rather than continuing the trend of funding reductions, demonstrating continued support of hospital funding and anticipated increases in documented charity care. The department continues to monitor trends of uninsured throughout the State and we will recommend adjustments accordingly and work with other State departments to improve access to quality care throughout the State.

c. Has the department studied the likely impacts of the 2017 federal health insurance policy changes on the finances of New Jersey hospitals? If so, please detail the findings of the analysis.

The Department continues to monitor trends that affect the uninsured population and charity care provision throughout the State. The Department also closely monitors the financial health of acute care hospitals throughout the State and will continue to do so as federal policies change.

Discussion Points (Cont'd)

d. Please project the likely impact over the next five fiscal years of the 2017 federal health insurance policy changes on uncompensated care services provided by New Jersey hospitals and, in turn, the State's Charity Care Program.

The Department is monitoring trends that affect the uninsured population to ensure that all individuals in the State continue to have access to quality care.

e. Please discuss any policy responses the department is currently developing to the 2017 federal health insurance policy changes.

The Department monitors the charity care claims activity and anecdotal feedback from acute care hospitals throughout the State to determine what, if any, actions the department should take to ensure access to quality care for all citizens. Executive Order (EO) #4 issued by Governor Murphy, states that a primary goal of his administration is to ensure that every New Jerseyan has access to affordable health insurance and no New Jersey residents are unable to see a doctor when they are sick. Furthermore, EO4 directs all State entities that regularly interact with the public to undertake reasonable measures to provide information to the public regarding the Affordable Care Act marketplace and ways to enroll. The DOH has taken action to provide health insurance coverage information to the public through our website, http://nj.gov/health/getcovered.

Graduate Medical Education

22. The Governor's FY 2019 Budget Recommendation includes an appropriation of $218.0 million for Medicaid Graduate Medical Education (GME), which is unchanged from FY 2018. The budget displays the FY 2019 recommendation as a General Fund appropriation, but only $79.8 million of the total represents State funding. The remaining $138.2 million comes from federal funds. Notwithstanding the unchanged recommended combined State and federal FY 2019 appropriation for GME, the program's funding level has experienced a long-term trend of growth. Appropriations for GME were: $60.0 million in FY 2010 and FY 2011; $90.0 million in FY 2012 and FY 2013; $100.0 million in FY 2014 and FY 2015; $127.3 million in FY 2016; $188.0 million in FY 2017; and $218.0 million in FY 2018 and FY 2019.

Historically, Medicaid GME was supported with 50 percent federal funds, but beginning in FY 2015, the State received a higher federal matching rate under the federal Affordable Care Act for certain patients seen by the hospitals. The recommended FY 2019 appropriation anticipates a 63.7 percent federal match, virtually unchanged from FY 2018. Medicaid GME pays hospitals under two related systems: direct GME which makes payments to hospitals to cover the costs directly related to educating residents; and indirect GME, which is payments to teaching hospitals intended to account for higher costs of providing specialized care to highly complex patients.

The FY 2019 Governor's Budget recommends retaining language that was included in each of the FY 2017 and FY 2018 Appropriations Acts requiring each hospital receiving a GME allocation to provide a report to the DOH indicating the total number of physicians who completed their training during the preceding calendar year, and the number of those physicians who plan to practice medicine in New Jersey. The department replied to an FY 2018 OLS Discussion Point that it was still reviewing and compiling the data hospitals had submitted in accordance with the FY 2017 language.

Discussion Points (Cont'd)

- **Questions:**

a. Has the general upward trend in GME funding been associated with an increased number of residents in hospitals? Please provide the number of residents for FY 2010 through the most recent year for which such data are available.

Analysis of the data indicates an increase in the number of residents that is associated with the increased trend in funding over the previous five years of data.

The number of full time residents for NJ hospitals (source -Medicaid Cost report):

2011	2012	2013	2014	2015	2016
FTEs	FTEs	FTEs	FTEs	FTEs	FTEs
3,082	3,106	3,225	3,377	3,443	3,522

b. Please report, in the aggregate and by hospital, the data that Medicaid GME-receiving hospitals submitted, in accordance with the language included in the FY 2017 and FY 2018 Appropriations Acts, regarding the number of physicians who completed their training and the number of those physicians who planned to practice medicine in New Jersey. What conclusions does the department draw from these numbers? Please describe any policy responses the department has implemented, or plans to implement, based on the data.

Hospital	Complete Residency Training in FY 2018	Physicians Practice in NJ FY 2018	Complete Residency Training in FY 2017	Physicians Practice in NJ FY 2017
AtlantiCare Regional Medical Center	11	1	11	4
Bergen Regional Medical Center	8	1	7	3
Capital Health Regional Medical Center - Hopewell	0	0	0	0
Capital Health Medical Center	13	2	15	2
CarePoint Health - Bayonne Hospital New in SFY 2018	0	0		
CarePoint Health - Christ Hospital	6	3	6	3
CarePoint Health - Hoboken University Medical Center	13	4	11	2
CentraState Medical Center	7	6	7	0
Cooper Hospital/University MC	115	22	106	33
Deborah Heart and Lung Center	11	1	13	3
Englewood Hospital and Medical Center	14	8	13	Don't Know
Hackensack UMC - Mountainside	14	8	16	Don't Know
Hackensack UMC - Palisades	30	3	11	1
Hackensack University Medical Center	11	3	200	Don't Know
Hunterdon Medical Center	6	4	6	4
Inspira Medical Center - Vineland	33	0	16	5
Inspira Medical Center - Woodbury	5	0	4	1
Jersey City Medical Center	34	4	24	8
Jersey Shore University Medical Center	37	0	30	Don't Know
JFK Medical Center/A M Yelencsics	22	4	4	Don't Know

Discussion Points (Cont'd)

Kennedy Health System	58	0	63	23
Lourdes Medical Center of Burlington Cty.	1	0	1	Don't Know
Meadowlands Hospital Medical Center	3	0	6	5
Monmouth Medical Center	38	10	36	9
Morristown Medical Center	55	18	41	16
Newark Beth Israel Medical Center	77	19	56	21
Our Lady of Lourdes Medical Center	18	8	4	Don't Know
Overlook Medical Center	21	7	23	5
Raritan Bay Medical Center	8	1	8	0
Robert Wood Johnson University Hospital	125	40	65	Don't Know
RWJ University Hospital - Somerset	7	3	7	3
St. Barnabas Medical Center	61	13	44	15
St. Francis Medical Center	12	4	10	4
St. Joseph's Medical Center	90	30	57	30
St. Luke's Warren Hospital	6	3	6	4
St. Mary's General Hospital	1	1	1	0
St. Michael's Medical Center	17	1	19	5
St. Peter's University Hospital	28	2	29	8
Trinitas Regional Medical Center	16	9	10	1
University Hospital	160	39	178	28
University MC of Princeton - Plainsboro	29	0	5	Don't Know
Virtua - Burlington Cty - Combined in FY 2017	7	0	0	Don't Know
Virtua -West Jersey - Combined in FY 2017	9	8		
Total	1237	290	1169	246

The department has analyzed the numbers of individuals who are planning to stay in New Jersey after their residency and it appear that approximately 23.4 percent of individuals do plan to stay. The department is still determining the best policy response to this, but plans to support the Governor's goal of building a stronger and fairer economy in New Jersey to continue to make New Jersey an attractive place to live for all residents.

Delivery System Reform Incentive Payments

23. The Delivery System Reform Incentive Payments (DSRIP) program, a component of the Comprehensive Medicaid Waiver, was established as a five-year federally co-funded demonstration project to be completed on June 30, 2017. In 2017, the federal Centers for Medicare and Medicaid Services (CMS) approved a two-year extension of the DSRIP program, plus a one-year transition period, thus fully funding a continuation of the program for FY 2018 through FY 2020 at $166.6 million per fiscal year.[6] The DOH is currently awaiting CMS comments and final approval of its Funding and Mechanics Protocol for the extension period.

DSRIP provides subsidies to participating hospitals that carry out approved projects designed to improve the quality of care provided, the efficiency with which care is provided, or population health. DSRIP disbursements are linked to the achievement of specific performance objectives. Forty-six hospitals have submitted reapplications for the program's first extension year.

The FY 2019 Budget Recommendation includes language stating that an unchanged $166.6 million is appropriated for DSRIP (page D-161). The appropriation has three funding sources: $62.6 million from the General Fund (page D-160); $20.7 million from the Health Care Subsidy Fund (a portion of the

[6] https://dsrip.nj.gov/

Discussion Points (Cont'd)

recommended $287.0 million FY 2019 All Other Funds appropriation on page D-160 and referenced on page H-11); and $83.3 million in federal funding (a portion of the recommended $89.0 million FY 2019 Federal Funds appropriation on page D-160 and referenced on page H-11). The Budget Recommendation also includes contingency language that authorizes the DOH to transfer the recommended $166.6 million FY 2019 DSRIP appropriation to the Charity Care or Graduate Medical Education programs if CMS rejects the State's waiver extension request for the DSRIP program so as to ensure that payments to hospitals continue to include federal matching funds.

- **Questions:**
  - **a. Please provide the distribution by hospital of the recommended $166.6 million FY 2019 DSRIP appropriation.**

Table III Participating DSRIP Hospital	Annual DY6-DY8 Funding Target
AtlantiCare Regional Medical Center	6,676,138
Bergen Regional Medical Center	14,046,927
Capital Health Medical Center – Hopewell	1,898,860
Capital Health Regional Medical Center	3,535,341
CarePoint Health - Bayonne Medical Center	250,000
CarePoint Health - Christ Hospital	2,203,816
CarePoint Health - Hoboken University Medical Center	1,053,708
CentraState Medical Center	425,804
Chilton Medical Center	250,000
Clara Maass Medical Center	2,755,066
Community Medical Center	452,606
Cooper Hospital/University MC	6,122,062
East Orange General Hospital	2,687,750
Englewood Hospital and Medical Center	404,564
Hackensack UMC – Palisades	897,627
Hackensack University Medical Center	1,479,694
Inspira Medical Center – Elmer	250,000
Inspira Medical Center – Vineland	4,350,233
Inspira Medical Center – Woodbury	763,136
Jersey City Medical Center	7,596,119
Jersey Shore University Medical Center	3,529,681
JFK Medical Center/A M Yelencsics	408,104
Kennedy Health System	6,402,389

Discussion Points (Cont'd)

Lourdes Medical Center of Burlington Cty.	2,047,576
Monmouth Medical Center	7,642,526
Monmouth Medical Center – Southern	4,969,597
Morristown Medical Center	451,595
Newark Beth Israel Medical Center	12,336,508
Newton Medical Center	250,000
Our Lady of Lourdes Medical Center	2,428,853
Overlook Medical Center	264,483
Raritan Bay Medical Center	2,444,506
Robert Wood Johnson University Hospital	3,927,127
RWJ University Hospital – Hamilton	250,000
St. Barnabas Medical Center	462,214
St. Clare's Denville / Dover	5,530,996
St. Francis Medical Center	1,250,987
St. Joseph's Medical Center	10,705,204
St. Mary's General Hospital	2,302,211
St. Michael's Medical Center	6,635,156
St. Peter's University Hospital	4,532,171
Trinitas Regional Medical Center	9,421,729
University Hospital	13,516,857
University MC of Princeton – Plainsboro	298,872
Virtua - West Jersey Health	887,512
Virtua-Mem. Hospital of Burlington County	710,516
Total Statewide Target Funding	161,706,819
Non-Participating Hospitals*	4,893,181
Total Annual DSRIP Funding	166,600,000
* Non-Participating Hospitals Amount to be redistributed to participating hospitals at fiscal year end.	

This information is based on target funding and does not include the distribution of the UPP pool and the redistribution of funding of hospitals who have chosen not to continue with the DSRIP program. These two amounts cannot be determined until the projects have been complete for the year and the evaluation of metrics has been performed.

Discussion Points (Cont'd)

b. Please provide an evaluation of the performance of the five-year DSRIP demonstration program. What outcomes made the program a success and what outcomes did not meet initial department expectations?

The Rutgers Center for State Health Policy is currently conducting an evaluation of the DSRIP program. The due date for the draft of that report is April 30, 2018 and it will be shared once it is final.

c. Please provide, in the aggregate and by hospital, the number of DSRIP performance objectives that participating hospitals met during the initial five-year DSRIP demonstration period and the number of DSRIP performance objectives that participating hospitals failed to achieve. Does the department notice significant variations in each hospital's ability to meet performance objectives?

The Rutgers Center for State Health Policy is currently conducting an evaluation of the DSRIP program. Once that evaluation is complete, it will be made public.

d. Has the CMS approved the Funding and Mechanics Protocol for the extension period? If not, what is the status of the CMS review and by what date does the department anticipate a CMS decision?

Yes, the Funding and Mechanics Protocol was approved in March, 2018 and can be accessed at the State DSRIP page, https://dsrip.nj.gov/Documents/NJ%20DSRIP%20DY6-DY8%20Funding%20and%20Mechanics%20Protocol.pdf

24. Following a competitive bidding process (Bid Solicitation/Request for Proposal 17DPP00119), Public Consulting Group Inc. was awarded the contract to provide management, oversight, and education services to the DSRIP program from February 2, 2018 through September 15, 2020. During a transition period through September 15, 2018, the previous "Hospital Incentive Program" contractor, Myers & Stauffer LC. will continue to serve as a co-program administrator. Myers & Stauffer LC. has held the contract since September 16, 2013. Notwithstanding the contract, the DOH performs certain DSRIP administrative functions. In response to an FY 2018 OLS Discussion Point, the department noted that, for the prior five fiscal years, 13 full-time and part-time staff were assigned to the design, implementation, and administration of the DSRIP program.

- **Questions:**

a. How many full-time and part-time staff does the department have dedicated, or plans to have dedicated, to the design, implementation, and administration of the extended DSRIP program in FY 2018 and FY 2019? What is the total amount of DSRIP administrative expenditures the department anticipates for FY 2018 and FY 2019?

The Department has three DOH staff who are responsible for DSRIP activities, and the contracted partner, Myers and Stauffer for DY 6 has seven staff, and the contracted partner, PCG, for DY7 an DY8 has ten staff. The department anticipates spending approximately $225,000 for department staff for salaries and fringe benefits.

Discussion Points (Cont'd)

b. What was the number of submissions to Solicitation/Request for Proposal 17DPP00119? How many bids met the criteria established in the RFP? Was Myers & Stauffer LC one of the bidders?

Two submissions were received. Myers and Stauffer was one of the bidders.

c. What is the estimated total amount, broken out by State and federal cost share, that Public Consulting Group Inc. will receive for services provided under its "Hospital Incentive Program" contract? What is the vendor anticipated to be paid in FY 2019? How do the totals compare to Myers & Stauffer LC's compensation under the previous contract?

PCG's contract was awarded for approximately $8.5 million, (about $2.8 million per year) for the three-year contract. Myers and Stauffer will receive approximately $5.4 million under the last three years of their contract. Fifty percent of the costs are reimbursed by federal funding.

Federally Qualified Health Centers

25. P.L.2005, c.237 allocated $40 million annually from the surcharge on each general hospital and each specialty heart hospital to federally qualified health centers (FQHCs). The FY 2019 Budget Recommendation includes language which overrides this statute and allocates only $32 million for reimbursements to FQHCs for uncompensated care provided to uninsured patients (page D-175). This funding level is identical to the funding provided to FQHCs in FY 2018.

In response to FY 2018 OLS Discussion Points, the department reported 301,066 uncompensated care visits to FQHCs in FY 2016 and estimated 294,160 uncompensated care visits in FY 2017 and 303,043 such visits in FY 2018.

FQHCs provide comprehensive primary health care services primarily to uninsured, underinsured, Medicaid, and Medicare patients. Services are charged on a sliding scale based on patients' income. In 2016, there were 24 FHQCs operating 134 healthcare delivery sites in New Jersey and Medicaid funds accounted for 44.0 percent of FQHC budgets, while State uncompensated care accounted for 8.9 percent.[7]

- **Question:**
  Please provide the actual or estimated number of visits to FQHCs which were or are estimated to be reimbursed through uncompensated care funding in FY 2017, FY 2018, and FY 2019.

  The number of Uncompensated Care Fund reimbursed visits by year are as follows:
  FY2017 (Actual) – 304,873
  FY2018 (Estimated) – 315,953
  FY2019 (Estimated) – 333,330

Health Care Facilities

26. N.J.A.C.8:43E establishes the general licensure procedures and standards applicable to all licensed long-term care and acute care facilities. The department, or its designee, may conduct periodic or special inspections of licensed health care facilities to evaluate the fitness and adequacy of the facility and to ascertain whether the facility complies with all applicable State and federal licensure regulations and statutes.

[7] NJPCA 2018 Edition, New Jersey's Federally Qualified Health Centers, Quick Facts.

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The Department, or its designees, may also conduct surveys of facilities on behalf of the U.S. Department of Health and Human Services for purposes of evaluating compliance with all applicable federal regulations or Medicare and Medicaid certification regulations.

Ten days after conclusion of the survey, or inspection, the department will provide a facility with a written summary of any factual findings which indicate a violation of licensure. The regulations outline the process for informal dispute resolution (N.J.A.C.8:43E-2.3), implementing a plan of correction (N.J.A.C.8:43E-2.4), and enforcement remedies available to the department (N.J.A.C.8:43E-3.1). Enforcement remedies include a civil monetary penalty; curtailment of admissions; appointment of a receiver or temporary manager; provisional license; suspension of license; revocation of a license; order to cease and desist operation of an unlicensed health care facility; and other remedies for violations of statutes as provided by State or federal law or regulations.

- **Questions:**

a. What is the total revenue anticipated to be collected by the department from fines and penalties in FY 2018 and FY 2019? If possible, please detail these amounts by type of facility.

The Office of Program Compliance (OPC) estimate of penalties to be imposed and collected for FY 2018: $280,250. OPC estimate of penalties to be imposed and collected for FY 2019: $195,099.* This information is not available by facility type.
**Note: The FY 2019 estimate is based on an average of penalties imposed in 2013, 2014, 2015 and 2017; 2016 was excluded as an outlier.*

b. Has the department had to take action against a long-term care or acute care facility's license in FY 2018? If yes, please indicate the number of actions taken and the number of licensees that were subject to department action.

The Department took the following action against licensees in FY 2018:

- 3 cease and desist orders against 3 licensees;
- 1 summary suspension of license against 1 licensee;
- 5 curtailment of admissions against 5 licensees;
- 5 directed plans of correction against 5 licensees;
- 1 revocation of license against 1 licensee; and
- 4 penalty actions against 4 licensees.

Totals:

- Total number of enforcement actions issued: 19
- Total number of licensees issued enforcement actions by DOH: 14*

**Note: The total number of licensees which were issued enforcement actions is less than the total number of enforcement actions because the Department issued several types of enforcement actions against certain licensees.*

27. The DOH surveys long-term care facilities on behalf of the U.S. Department of Health and Human Services for purposes of evaluating compliance with all applicable federal regulations, including Medicare and Medicaid certification regulations. If during these surveys the DOH identifies violations by the facility, it may recommend to the federal department Civil Monetary Penalties (CMPs).[8] CMPs are imposed for either the number of days or for each instance a facility is not in substantial compliance with one or more Medicare and Medicaid participation requirements for long-term care facilities. A portion of CMPs

[8] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/CMP-FAQs.pdf

Discussion Points (Cont'd)

collected from facilities is returned to the state in which the CMPs were imposed. State CMP funds may be reinvested to support activities that benefit nursing facility residents and that protect or improve their quality of care or quality of life. Each state has its own process for facilities to request funding from CMPs.

The department replied to the FY 2018 OLS Discussion Points that it received about $9 million in cost reimbursements from the U.S. Department of Health and Human Services in each of FY 2014 and FY 2015, and that it received $176,000 in CMP funding in FY 2016.

- **Questions:**

a. What was the amount of federal funds received by New Jersey from CMPs for allocation to requesting long-term care facilities in FY 2017 and FY 2018 to date?

In FY 2017, New Jersey received $532,648 from civil monetary penalties collected by CMS. Through April 2, 2018, New Jersey received $305,322. CMS designates these funds for projects that benefit the residents of federally certified nursing homes.

b. What was the amount of funding provided to approved long-term care facilities from federal CMP revenue in FY 2017 and FY 2018 to date?

The Department manages the funding approved by CMS for each proposal. Proposals may be submitted by a single nursing home, or by an industry/professional association, university, or other sponsor for the benefit of residents in many nursing homes. Project funding also varies by project scope and length. In SFY 2017, projects approved by CMS received $46,640 from civil monetary penalties and through March 2018, $70,840.

c. How many facilities requested funding from CMPs in the State in FY 2017 and FY 2018?

CMS designates CMP funds for projects that benefit the residents of federally certified nursing homes. Projects may be sponsored by organizations other than nursing homes, such as industry associations or universities. As a result, consistent with previous years, we report the number of proposals received per year.

FY 2017: 9
FY 2018 through March 2018: 3

d. How many facilities were granted funding from CMPs in the State in FY 2017 and FY 2018?

Projects may be sponsored by organizations other than nursing homes, such as industry associations or universities, provided that the project benefits nursing home residents. As a result, consistent with previous years, we report the number of proposals funded per year.

FY 2017: 5
FY 2018 through March 2018: 1

e. What is the amount of cost reimbursements that the DOH received in FY 2016 and FY 2017 from the U.S. Department of Health and Human Services for surveying long-term care facilities for compliance with all applicable federal regulations?

The Department received the following cost reimbursements from US DHHS:

FY 2016: $9.2m (not finalized)
FY 2017: $9.96m (not finalized)

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Emergency Medical Services

28. P.L.2017, c.116 (N.J.S.A.26:2K-66 et seq.) establishes certain data reporting requirements for emergency medical service (EMS) providers and dispatchers. The law requires the department to create an enhanced system to accept and process the reported data, which, to the extent possible, is to be compatible with existing systems used by EMS providers and dispatchers. The department is additionally required to provide the system software to EMS providers and dispatchers without charge. The requirements of this enactment took effect January 17, 2018.

- **Questions:**

a. What is the implementation status of the enhanced EMS reporting system? Is it being developed or upgraded internally or by a third-party entity? What are the total system development or upgrade costs?

The EMS enhanced reporting law has two major components: ePCR (electronic Patient Care Record) data and dispatch data.

ePCR Data:

- Background: In New Jersey, emergency medical services (EMS) providers collect data on patient encounters using a standardized form called a pre-hospital care report (PCR). Historically, electronic PCR data (ePCR) was reported to the NJDOH Office of Emergency Medical Services (OEMS) on a voluntary basis, and OEMS analyzes data using software from Image Trend. The new EMS enhanced reporting law codifies ePCR reporting to OEMS, requires OEMS to make software or programs available to EMS providers for reporting, and requires OEMS to publish data.
- Implementation: The implementation of the ePCR component has been on schedule. OEMS held education sessions for EMS agencies, provided free iPads and access to Image Trend for ePCR reporting, and publishes monthly data on the DOH website.
- Software Costs: Image Trend costs were $96,000 in 2018 and are covered through a preexisting federal grant with the National Highway Traffic Safety Administration (NHTSA). EMS agencies who choose to use another vendor must cover their own costs.
- Staffing Costs: OEMS has two FTEs dedicated to the implementation of the ePCR component at a total of $266,000
- Total cost of ePCR data component: $386,000.

Dispatch Data:

- Background: Public Safety Access Points (PSAPs, or dispatch centers) receive and collect information on 91 calls. The new EMS reporting law requires PSAPs to report EMS related 911 calls to OEMS; to make dispatch software or programs available to PSAPS for reporting; and requires OEMS to publish data.
- Implementation: The implementation of the dispatch component has been on schedule. OEMS notified all PSAPs of the new law, provided free spreadsheets for dispatch data reporting, and publishes monthly data on the DOH website.
- Software Costs: Unlike ePCR data, there is no national requirement to compel PSAPs to report standardized data. As such, instead of using software, PSAPs submit electronic spreadsheets to OEMS.
- Staffing Costs: One FTE at $130,000.
- Total cost of dispatch data component: $130,000.

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b. If the department contracted with a third-party entity to develop or upgrade the system, what are the project milestones and the terms of vendor compensation? Has the vendor met the project milestones?

ePCR Data: No third parties were contracted for ePCR reporting beyond the Department's current vendor, Image Trend. In 2018, this annual fee was $96,000; in 2019, the fee will increase to $120,000. Image Trend/DOH has met all project milestones to date, as ePCR data is being collected and posted on the DOH website.

Dispatch Data: No third parties were contracted for dispatch data reporting; OEMS uses spreadsheets to receive and analyze data. OEMS has met all project milestones to date, as dispatch data is being collected and posted on the DOH website.

c. What are the anticipated annual costs of operating and maintaining the enhanced system?

Total annual costs: $506,000

d. What are the anticipated costs of providing the system software to EMS providers and dispatchers?

ePCR Data: OEMS receives a preexisting federal grant from NHTSA which covers costs associated with Image Trend. EMS agencies may use this software free of charge; if they select another vendor, they must incur that expense.

Dispatch Data: OEMS provides spreadsheets to PSAPs free of charge.

e. Does the department anticipate the need to hire additional staff in connection with the EMS reporting requirements or the operations and maintenance of the enhanced EMS reporting system? If so, how many additional staff will be hired and at what annual cost?

ePCR Data: OEMS has an FTE dedicated to ePCR data that predates the new EMS law. In addition to continuing with this FTE, OEMS hired an additional FTE to work on ePCR data. The annual cost is $266,000.

Dispatch Data: OEMS will need one FTE to assist with the collection and compilation of dispatch data. The annual cost is $130,000.

Family Planning Services

29. P.L.2018, c.2 made a supplemental appropriation of $7.5 million for Family Planning Services. The Governor's FY 2019 Budget recommends maintaining the appropriation in FY 2019. These appropriations restore funding that was eliminated in FY 2011.

- **Questions:**

a. What is the total amount of federal funding that the DOH anticipates receiving in FY 2018 and FY 2019 that the DOH intends to direct to Planned Parenthood, either directly or indirectly?

Discussion Points (Cont'd)

$2,100,000 in federal funding is allocated to Family Planning in FY 18 and in FY 19, and a portion of that is indirectly contracted to Planned Parenthood.

b. What is the total amount of State funding that the DOH anticipates directing to Planned Parenthood in FY 2018 and FY 2019, either directly or indirectly?

$7,453,000 in state funding is allocated to Family Planning in FY 18 and in FY 19, and a portion of that is indirectly contracted to Planned Parenthood.

c. What is the total amount of State funding that the DOH anticipates providing for family planning services in FY 2018 and FY 2019, either directly or indirectly?

$7,453,000 in state funding is anticipated for Family Planning in FY 18 and in FY 19.

d. What is the total amount of federal funding anticipated to be provided through the DOH for family planning services in FY 2018 and FY 2019, either directly or indirectly?

$2,100,000 in federal funding is anticipated for Family Planning in FY 18 and in FY 19.

e. Please detail the funding anticipated to be provided for family planning services through the DOH by grantee for FY 2018 and FY 2019.

Funds are awarded to the New Jersey Family Planning League as its sole grantee for FY 18 and FY 19. Total amount is $9,553,000 ($7,453,000 state, $2,100,000 federal) for each year.

f. Please provide the FY 2010 distribution of family planning services grants. How many service providers that received an allocation in FY 2010 have since ceased operations? Does the department anticipate that the FY 2018 supplemental appropriation and the recommended FY 2019 appropriation will increase the number of family planning and reproductive health care service providers in New Jersey?

Bayonne Department of Health, $404,143
Burlington County Health Department, $325,468
Planned Parenthood Southern NJ $2,036,568
Cape May Department of Health, $201,085
Planned Parenthood Metro NJ, $1,391,392
FamCare, $1,026,475
Hoboken Family Planning, $299,902
Horizon Health Center, $931,520
Planned Parenthood Mercer, $900,114
Planned Parenthood Central NJ, $993,196
Newark Beth Israel Medical Center $317,686
North Hudson Community Action Corporation, $548,722
Planned Parenthood Greater Northern NJ, $1,859,874
Family Planning Ocean County, $763,274
Women's Health, $240,528
UMDNJ-University Hospital, $215,159
Rutgers University, $25,680
UMDNJ- Y Fathers, $18,070

Discussion Points (Cont'd)

4 providers, Bayonne Health Department, Burlington County Health Department, University Hospital and Beth Israel ceased providing family planning services since 2010.

The Department's Family Planning sole grantee, New Jersey Family Planning League (NJFPL), is currently conducting a needs assessment throughout the state as well as reviewing the Guttmacher Women in Need data, to determine the need for an increased number of family planning and reproductive health care service providers in New Jersey.

g. Please provide any available data series going back to FY 2015 that illustrate the anticipated effects of the $7.5 million FY 2018 and FY 2019 appropriations on clients of family planning service providers.