

## Discussion Points

## DEPARTMENT OF HEALTH AND SENIOR SERVICES (GENERAL)

1. The FY 2006 recommended budget includes \$4.9 million in Direct State Services efficiencies and \$1.5 million in Grants-in-Aid efficiencies.

- **Question:** What specific efficiencies will achieve \$4.9 million in Direct State Services savings and \$1.5 million in Grants-in-Aid savings?
- **Answer:** Under the federal government's recently enacted Medicare Modernization Act of 2003, the PAAD program will receive federal transitional grant funding to help educate PAAD beneficiaries about Medicare Part D. The Medicare Transitional Assistance Grant will offset \$5.3 million of PAAD State administrative costs. The balance of the reduction represents a \$1 million reduction in the salary recommendation in Health Care Systems Analysis, which will be achieved through attrition.

## HEALTH SERVICES

2. In FY 2005, the Legislature appropriated \$5 million for a new Women's Health Awareness Program to provide a public health campaign concerning preventative care. Funding for the program has been eliminated in the proposed FY 2006 budget. Virtually all of the monies appropriated to the program in FY 2005 were expended on a professional services contract with Fleishman Hillard/GMMB Inc., a communications consulting firm.

- **Question:** How did the department solicit bids and determine which firm should be awarded the professional services contract? Specifically, what services did the firm provide for the campaign?
- **Answer:** The department solicited bids through the Treasury Department's Purchase and Property Division. It was a comprehensive bid process launched in late 2003. Of the 15 bids submitted, the Evaluation Committee based its selection on the strength of the proposal and depth of talent and resources available through the bidding agency. The three-year contract was awarded to Fleishman-Hillard/GMMB in February 2004 to develop and execute all advertising and public relations campaigns for the department.

For the Women's Health Awareness campaign, the contractor provided the following advertising components:

- Created, produced and placed one 30-second television ad which aired over a three-week period (August 30 – September 19) statewide on New York and Philadelphia stations.
- Created, produced and placed one 60-second radio spot which aired over the same three-week period (August 30 – September 19) statewide on New Jersey, New York and Philadelphia stations.
- A second flight of television and radio advertising for the Women's Health Awareness campaign, scheduled for November 8 – December 12, was cancelled following Governor McGreevey's resignation.

The balance of these funds, \$2.5M will be used for the Post Partum Depression awareness campaign.

3. The recommended budget includes a new \$2 million grant for Post Partum Screening to cover the cost of treating postpartum depression among uninsured women.

- **Question:** How many women throughout the State are estimated to be suffering from Post Partum depression? How many women does the department anticipate serving with this grant? Who will provide the screening services?

**Answer:** Approximately 10-15 percent of all pregnant women experience post partum depression. In New

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Jersey, there are approximately 110,000 births annually which would result in an estimated 11,000 to 16,620 women who may suffer from Post Partum Depression. Ultimately, all pregnant and parenting women should be screened and educated regarding post partum depression. Resources will be targeted to those women without health insurance. The Commissioner's Working Group on Post Partum Depression is in the process of finalizing recommendations for implementation of this initiative. The Screening and Referral subcommittee has made specific recommendations regarding the use of standardized screening tools during the prenatal and post partum period and as part of pediatric services.

Training for implementation of a wide scale screening initiative will likely be through the regional Maternal and Child Health Consortia. They will provide training to physicians (obstetric s/gynecology, family practice, pediatrics), Midwives, Nurses etc. who will be the practitioners that will actually conduct the screenings.

Resource and referral information will be part of the education for screening. It is anticipated once clinicians identify women in need of service to address PPD, they will be referred to mental health agencies for care and treatment. This may be to one of New Jersey's 125 licensed behavioral health agencies, located in each of the states 21 counties or to private clinicians working throughout the State.

4. The President's proposed FY 2006 budget recommends a national funding increase of \$304 million to establish more health centers in medically underserved areas. Similarly, the Governor's proposed budget increases Funding for Federally Qualified Health Centers - Services to Family Care Clients, by \$5 million, to establish new service locations in medically underserved areas.

- **Question:** In consideration of the proposed increase in federal funding which would allow for more services in medically underserved areas, is additional State funding necessary?
- **Answer:** Yes, State funding is still necessary. To receive federal funding the proposed service area must be in whole, or in part, designated by the US Department of Health and Human Services as a Medically Underserved Area (MUA) or Medically Underserved Population (MUP). Many needy New Jersey communities cannot meet the rigorous MUA/MUP standards. In areas that are considered MUAs or MUPs the advance State support to the Centers adds a competitive advantage in obtaining available federal funding

5. The FY 2005 budget appropriated \$36 million to the Cancer Institute of New Jersey (CINJ). Language required the South Jersey Program and the University of Medicine and Dentistry of New Jersey (UMDNJ) - Newark to each receive \$9 million, with the rest, approximately \$18 million, for the New Brunswick facility. CINJ also received a \$6 million supplemental appropriation in FY 2005. The FY 2006 proposed budget reduces CINJ funding to \$18.25 million, and eliminates language concerning funding for the South Jersey Program and UMDNJ - Newark. Available information indicates that a large portion of the funding the New Brunswick facility and the South Jersey Program received was used to support salary lines.

- **Question:** How were the CINJ appropriations for Newark used? What will be the effect of the proposed elimination of funding for the Newark and the South Jersey programs?
- **Answer:** For Fiscal Year 2005 the CINJ appropriation for Newark in the amount of \$9M was used to support the construction and infrastructure of the new building housing the New Jersey Medical School-University Hospital Cancer Center. The new Cancer Center is anticipated to open in 2006 and will provide comprehensive state of the art cancer care in Newark with the focus on serving the surrounding communities to aid in diagnosing and treating patients at an earlier stage of the disease in order to improve overall quality of life and survival rates. Of the \$9 million, approximately \$6.1 million was used to build the infrastructure including scientific equipment, furnishings, IT computer and telephone hardware. \$1.8 million was used to recruit the

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essential personnel to oversee the operations of the Cancer Center and the balance of \$1.1 million was used to relocate of existing faculty and start up costs of new faculty to further enhance the Cancer Center.

The proposed effect of eliminating funding for Newark is the suspension of building the infrastructure including scientific equipment, furnishings, IT computer and telephone hardware. Additionally, the Newark facility will not be able to recruit the essential personnel to oversee the operations of the Cancer Center, or support the relocation of existing faculty and start up costs of new faculty to further enhance the Cancer Center.

For CINJ at Cooper University Hospital an amount of \$9M was appropriated in SFY 2005. The breakdown of that amount is as follows:

Faculty support and recruitment of new faculty - \$768,510  
 Creation and support tumor site-specific programs – 258,310  
 Development of Cancer Center Building - \$5,375,000  
 Support for the School of Osteopathic Medicine/Network Development - \$400,000  
 Outreach, Education and Communication – \$2,090,680  
 Development of Research Infrastructure – \$107,500

The proposed effect of eliminating this funding is faculty recruitment will be halted; support services for patients will be lost; new programs will not be developed; the development of treatment facilities will be halted; network development will be limited; and outreach and education activities will be dramatically curtailed.

6. a. The proposed budget decreases funding for the AIDS Drug Distribution Program (ADDP) from the FY 2005 adjusted amount of \$14 million to \$9 million in FY 2006. Budget documents indicate that this recommendation assumes that \$5 million in savings will be achieved through changes to the program's drug formulary.

- **Question: What specific changes will the formulary undergo to achieve these savings? When are these changes expected to be implemented?**
- **Answer:** DHSS would convene a meeting of its Ad Hoc Committee on ADDP, a group of infectious disease physicians and consumers, to obtain their input on a reduced formulary. This group would provide recommendations on a reduced formulary that includes all of the HIV anti-retroviral medications, those medications that treat opportunistic infections, and those that treat side effects. The anticipated savings would be \$5 million.

DHSS would begin notifying pharmacies and patients by mail starting in July 2005. The target effective date for the formulary reduction is anticipated to be on or about October 2005.

6. b. Under Section 340B of the Public Health Service Act, discounted outpatient drugs are available to certain federally funded grantees, including ADDP. Through 340B, a state can opt to use a point-of-purchase system whereby it receives an up-front discount at the time it purchases drugs, or a rebate system whereby it purchases drugs and receives a rebate later from manufacturers. ADDP currently participates in 340B and operates under the rebate model. The federal government encourages states to adopt the point-of-purchase model, claiming that states using the point-of-purchase model realize more savings than those receiving a rebate.

- **Question: Has the department looked into adopting the point-of-purchase model for ADDP? Would changing to the point-of-purchase model generate more savings for the program?**

**Answer:** The Division has examined a number of systems for purchasing and distributing medications under the ADDP. While the price of medications is a key cost component, other important factors were considered in

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deciding to utilize the reimbursement model. While the direct purchase model may achieve a slightly lower cost for medications, other associated costs far outweigh these savings. For example, under a direct purchase system, the Division would need to hire pharmacists and rent regional warehouse space across the state in order to distribute and store medications. The cost of shipping medications to clients would further increase expenditures.

Under the reimbursement model, the Division utilizes the existing Medicaid infrastructure to distribute medications and to pay claims at more than 2,000 pharmacies statewide. The Medicaid infrastructure is a centralized and fully integrated system utilized by all state pharmaceutical assistance programs, including PAAD and Senior Gold. New Jersey's system of administering the ADDP has been viewed as exemplary by our funding source and has served as a model for other states.

6. c. The "Medicare Prescription Drug, Improvement and Modernization Act of 2003," Pub. L. 108-173, establishes a voluntary prescription drug benefit, effective January 2006, known as Medicare Part D. It is possible that as a result of this law, ADDP may be able to achieve savings by shifting Medicare-eligible clients from ADDP to Part D coverage.

- **Question: How many ADDP clients are Medicare eligible? Will these clients be encouraged to enroll in the Medicare Part D Prescription Drug Benefit program which begins January 2006? If so, what steps is the program taking to encourage enrollment?**

- **Answer:** Approximately 500 ADDP clients are Medicare eligible. These clients will be urged to enroll in Medicare Part D. The Division will send a letter to all Medicare eligible ADDP clients offering to cover all cost sharing expenses including the payment of Part D premiums.

6. d. Depending on a Medicare beneficiary's income and assets, persons who enroll in Medicare Part D may have to pay a monthly premium and be subject to an annual deductible and a coverage gap.

- **Question: In the event that an ADDP client enrolls in Part D, will the program cover drugs not included in a Part D plan? Will it subsidize Part D's deductible and cost sharing requirements? Can federal Ryan White Title II funds be used for these purposes?**

- **Answer:** The ADDP will cover drugs not included in a Part D plan (wrap around coverage). As with all ADDP clients who have existing partial insurance coverage, the ADDP will bill the other insurance at the point of sale (cost avoidance system), with any remaining balance being billed to the ADDP. Federal Ryan White Title II funds can be used to pay the Part D premiums on behalf of ADDP clients.

6. e. As an interim measure before the drug benefit is implemented, Medicare beneficiaries are able to enroll in the voluntary Medicare Prescription Drug Discount Card program through December 2005 and thereby purchase drugs at a reduced cost. For those Medicare beneficiaries with incomes below 135% of the federal poverty level, the discount card also provides a total of \$1,200 in transitional assistance in 2004 and 2005 to be applied towards the purchase of prescription drugs.

- **Question: How many ADDP clients are Medicare eligible and have income below 135% of the federal poverty level? Has the program been able to get those clients to enroll in the Medicare Prescription Drug Discount Card program and take advantage of transitional assistance subsidies? If so, how much savings did the program realize?**

- **Answer:** There are approximately 20 ADDP clients who are Medicare eligible and have incomes below 135% of the federal poverty level. These eligibles have not been enrolled in the discount card program to date but we

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continue to outreach them and urge them to enroll in the Medicare D program. Theoretical savings could be as much as \$12,000 (20 clients times \$600 discount per client) for the 2005 calendar year.

7. a. Recent amendments to the Child Abuse Prevention and Treatment Act (CAPTA) require states to refer children under three years of age involved in substantiated cases of abuse or neglect to certain federally funded Early Childhood Intervention Program services.

- **Question: How many children are expected to be referred to the program as a result of changes to CAPTA? What is the estimated expense for fulfilling this mandate? Are any federal funds available for this purpose?**

*Answer:* We expect the law to cost NJ \$1 million, just to evaluate an estimated 2,000 children for eligibility. The federal government has not provided any new resources for this effort.

7. b. In 2004, the Early Childhood Intervention Program entered into a contract with the vendor Covansys to provide a new electronic financial management system to reimburse providers on a fee-for-service basis. Switching to this system created delays in authorizations, limiting the ability of some providers to submit claims and receive accurate and timely reimbursement. As a short-term solution, the department issued more than \$25 million in advance payments to providers.

- **Question: Has Covansys corrected this problem? Have any providers left the program as a result of difficulties in obtaining reimbursement? Has Covansys upheld the terms of the contract?**
- *Answer:* The delay created in the switch to a new electronic central management system did not stem from the vendor (Covansys) but was mostly caused by the need to enter back data on approximately 15,000 children served by the system. The state, working in conjunction with the Regional Early Intervention Collaboratives (REIC's) and provider agencies has implemented a variety of solutions to correct the delays in the billing system. We are not aware that any providers have left the Early Intervention System for this reason. Covansys has not only upheld the terms of their contract but has gone beyond the terms to accommodate the State's needs.

7. c. The FY 2005 budget estimated \$7 million in revenue for the Early Childhood Intervention Program through implementation of a family cost share plan, and \$5 million in federal Medicaid reimbursement. However, FY 2005 adjusted amounts reflect cost share revenues of only \$3.5 million. In addition, Medicaid reports through February 2005 indicate that only \$300,000 in federal Medicaid reimbursement has been realized.

- **Question: How will the potential \$8 million shortfall, from lower than expected family cost sharing and Medicaid revenues, in the Early Intervention account be addressed?**

*Answer:* At this time we do not anticipate a shortfall in the Early Intervention Program

The original revenue projection of \$7million was revised downward due to changes in the family cost share formula after significant concerns were raised during public hearings. The shortfall in revenues is being offset by the one time deferral associated with the new billing system which effectively shifted payments 1 month into the future.

The temporary Medicaid revenue shortfall will be corrected once the all pending retroactive Medicaid claims adjustments are processed. Medicaid claims for July 1, 2004 forward were pending approval of a rate adjustment for inflation.

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**HEALTH PLANNING AND EVALUATION**

8. Additional staff to increase oversight of Residential Health Care Facilities is proposed (p. D-134). However, there is an overall reduction in the various Direct State Services accounts and the number of State supported positions. Further, Governor Codey has recommended that the licensing/inspection function be transferred to the Department of Community Affairs.

- **Question: As overall State funding and the number of State supported positions are reduced, where are the additional funds to increase staff reflected?**
- Answer: There is an overall reduction in the Health Care Systems Analysis category of \$1M which offsets the \$200,000 increase in the Criminal Background Checks line item.

9. The Health Care Systems Analysis Program is recommended to receive \$40.3 million in Other Funds which primarily represent monies received from the 0.53% assessment on hospital revenues (capped at \$40 million), a \$10 per hospital admission assessment and other fees such as Certificate of Need fees. These revenue sources generate about \$50 million annually. The program also retains any unexpended balances realized, which at the end of FY 2004 totaled \$18.8 million.

- **Question: As recommended appropriations are less than the amount of revenues from Other Funds that will be available, how will the additional revenues be used?**
- Answer: There are no additional revenues. The carry forward balances which represent the balances in the Health Care Planning Fund and Certificate of Need account, cited above are incorrect. These correct balances total \$11.2M. Funds from the .53 percent balances roll back to the Health Care Cost Reduction Fund, which is a component within the Health Care Subsidy Fund, and are therefore not available for Departmental use.

The Health Care Planning Fund (\$10 per hospital admission assessment) brings in \$14.4 million annually. One half of these funds go to the General Fund and one half is retained by the Department. In FY 2004, eighteen months of revenue were collected and deposited in FY 2004, or \$7.2 million more than anticipated, which inflated the carryforward into FY 2005 and will result in less revenue in FY 2005 for Departmental use. Therefore, in FY 2005 and FY 2006 the carryforward balances are fully needed to fully support the annual \$9 million cost of this program.

The Certificate of Need program carryforward into FY 2005 was \$2.1 million. The revenue from this program is collected in a manner that is consistent with the life cycle of the projects being reviewed, and therefore fluctuates from year to year as the chart below indicates. Therefore, carryforward balance is needed to fully support the annual \$2 million expenditures for this program.

FY 1999	1,636,670.72	Actual
FY 2000	1,549,486.85	Actual
FY 2001	577,467.23	Actual
FY 2002	757,618.20	Actual
FY 2003	483,285.17	Actual
FY 2004	1,311,194.44	Actual
FY 2005	1,300,000.00	Estimated
FY 2006	537,000.00	Estimated

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SENIOR SERVICES

10. a. The FY 2005 appropriations act provided the department with additional staff to increase nursing home recoveries by approximately \$0.5 million (State).

- **Question: How much in recoveries has been and will be realized?**

- **Answer:** For the period of July 1, 2004 to March 31, 2005, 42 rate recalculations were completed. The results of these recalculations were a total of overpayments and interest of \$2,060,828.
 

12 Facilities - cash collected	\$ 323,383
5 Facilities - withholding agreements in place	362,642
4 Facilities - payment agreements being finalized	490,271
2 Facilities -in bankruptcy (may not be collectable	281,824
5 Facilites - contesting	508,310
3 Facilities – covered by prior settlement agreement (precludes recovery )	94,398
<u>11 Facilities</u> – no overpayments or interest due	<u>0</u>
42 Facilites	\$ 2,060,828

10. b. The department contracted with Myers and Stauffer LC to conduct 40 per diem audits of nursing homes and 5 patient income audits annually, at an average cost of around \$750,000.

- **Question: How many audits annually are being completed? How much have these audits identified as potential recoveries, and how much has actually been recovered to date?**
- **Answer:** In SFY 2005, the department contracted with the firm to audit 42 facilities at a cost of \$722,400. It is estimated that potential recoveries will total \$1.4 million. To date, only six audits have been finalized and the total estimated amount of recoveries is \$373,790. However, the department still projects achieving the \$1.4 million recovery target.

10. c. While the Budget in Brief identifies \$6.0 million in savings to be achieved by an "enhancement" of the rate setting methodology used to determine county nursing home reimbursement, the actual budget document does not reference these savings. Also, no budget language is proposed to implement an "enhancement" to the county nursing home rate setting methodology.

- **Question: Where is the \$6.0 million in savings reflected? What "enhancement" to the county nursing home rate setting methodology is proposed to achieve this savings? Will this result in an increase in county expenditures?**
- **Answer:** The \$6.0 million savings are reflected in the Payments for Medical Assistance Recipients-Nursing Home account. The enhancement is that for federal claiming purposes, (the calculation of Peer Rates), we will use unscreened, i.e. 100% of the county nursing home's costs. There will be no additional county expenditures required. The amount represents the annualization of the enhancement which was initiated in FY 2005. In total, the enhancement will earn approximately \$24M in additional federal revenues. This is part of a State Plan Amendment currently being reviewed by CMS.

10. d. Proposed budget language would freeze reimbursement to Special Care Nursing Facilities at FY 2005 levels. Savings may be included as part of the \$23.4 million in savings anticipated by not providing an inflation adjustment to the Medicaid FY 2006 reimbursement rates.

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- **Question:** How much reimbursement will Special Care Nursing Facilities lose by freezing rates at FY 2005 levels?

- **Answer:** This initiative applies to all nursing facilities, not just Special Care Nursing Facilities. A budget resolution will be submitted to correct the budget language. As in the past, nursing facilities rates will be rebased, however the customary inflationary factor will be deferred. This proposal results in a reimbursement reduction for all nursing homes of \$46.8 million. The estimated annual state share savings are \$23.4 million.

11. The FY 2005 appropriations act provided the Medical Day Care Services account with \$48.4 million (State). Implementation of a prior authorization system and maintaining rates at FY 2004 levels were expected to save \$12.7 million. At present, State program costs are projected at around \$65 million due to delays in implementing a prior authorization system. Projected expenditures would increase by at least \$1.8 million if pending legislation that would lift the rate freeze is enacted.

- **Question:** How will the potential shortfall in the Medical Day Care Services account be addressed?
- **Answer:** The legislation referenced above was recently signed by the Governor. The shortfall will be covered with balances in other entitlement program accounts.

12. a. Various language provisions are proposed to coordinate PAAD with the new Medicare Part D Prescription Drug Program. One provision would provide the department with the "authority to coordinate [PAAD] benefits" with Medicare Part D.

- **Question:** Will the cost of any monthly premium, deductible, copays (in excess of \$5.00), coverage gap and prescription drugs not covered by Medicare Part D be assumed by PAAD?
- **Answer:** Yes, the intent is that the beneficiary will not experience any reduction or change in services.

12. b. There is no proposed budget language that addresses Senior Gold and the Medicare Part D program.

- **Question:** Will the department seek to coordinate Senior Gold with Medicare Part D? To what extent will the State assume the out-of-pocket expenses of Senior Gold beneficiaries?
- **Answer:** DHSS is not recommending that Senior Gold beneficiaries enroll in Medicare Part D plans. The State only pays 40% of the price of the beneficiary's prescription drug claims, so paying premiums on behalf of Senior Gold beneficiaries would not be cost effective. The catastrophic cap for Senior Gold is \$2,000 per year for a single person and \$3,000 per year for a married couple. The catastrophic cap under Medicare Part D is \$5,100 per person.

12. c. The Medicaid program will transfer responsibility for the prior authorization process from a private vendor that currently handles this function to the Rutgers School of Pharmacy. This will save \$1.0 million. The PAAD/Senior Gold program proposes to continue to use the private vendor until January 2006 when the Medicare Part D program takes effect.

- **Question:** Could PAAD/Senior Gold transfer responsibility for prior authorization to the Rutgers School of Pharmacy? If so, how much would PAAD/Senior Gold save through December 2005 by transferring the prior authorization function to the Rutgers School of Pharmacy through the end of the year?

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- **Answer:** PAAD began reducing its dependency on the private vendor for prior authorization through its mandatory TPL cost avoidance and the use of the Medicare Discount Card Transitional Allowance program. When PAAD/SR. Gold programs are the secondary payers, the claim is subject to the program rules of the primary payer and the primary payer provides the prior authorization and drug utilization review. As of March 17, 2005, the Medicare Transitional Assistance Program has saved PAAD \$62.4 million for 1.1 million claims, which were not subject to the review of the State's private vendor. DHSS, from June 2004 to February 2005 was responsible for \$2,079,232. It would not be cost effective to change vendors at this point as the savings realized between now and Medicare Part D commencement on January 1, 2006 would be minimal. In addition, all possible personnel and resources must be devoted to the Part D implementation to realize the fullest savings to the State.

13. Funding for the New Jersey Caring for Caregivers Initiative is discontinued for FY 2006 and the persons receiving services from this program will in all likelihood be transferred to the federal National Family Caregiver Program. As the program is being discontinued, counties may not need all of the remaining \$1.8 million in encumbered funds.

- **Question: How much of the \$1.8 million of encumbered funds may be lapsed?**
- **Answer:** It is anticipated that all the encumbered funds will be expended.

14. State Aid funding to the County Offices on Aging is reduced by \$433,000 based on the receipt of federal Medicaid reimbursement for a portion of the offices' administrative costs. However, there is no identifiable federal Medicaid reimbursement account within the overall program.

- **Question: Where is the Medicaid reimbursement to the county offices reflected?**
- **Answer:** The funding was not reflected in the Department of Health and Senior Services budget. The Department will update this during the federal funds update process later this spring.