Discussion Points

Health Services

1. The FY2012 recommended budget included a 10% cut in per-visit reimbursements to federally qualified health centers (FQHCs), saving a projected $4.6 million. The appropriations act passed by the legislature restored this $4.6 million.

- **Questions:** Were FQHC reimbursements reduced in FY2012? Is the amount appropriated for FY2102 sufficient to reimburse the FQHCs for the level of service provided?

- **Answer:** The FY 2012 Budget contained $46.4 million from the Health Care Subsidy Fund; therefore a rate reduction was not necessary. At the current time, we believe that there are sufficient funds available to support the program.

2. The FY2011 and FY2012 appropriations acts eliminated State appropriations for family planning services. This led to the closure of five family planning centers during FY2011. The department indicated that many people who received services from family planning agencies would receive family planning services from FQHCs.

- **Questions:** Have any additional family planning agencies closed or curtailed services in FY2012? Has the department determined whether the reduction in family planning services has resulted in an increase in FQHC visits?

- **Answer:** No additional family planning sites have closed or curtailed their services during FY 2012. The Department has been monitoring the impact on FQHC’s closely. During CY 2011, 84,964 female patients received reproductive health care services at an FQHC. This amount is an increase of approximately 2 percent (1,790) in the number of new patients receiving these services over CY 2010. We will continue to assess and monitor this situation closely.

3.a. Some children who receive Early Intervention Program (EIP) services may be affected by the FY2013 budget recommendation that designates the Department of Children and Families (DCF) as the lead agency with respect to services for children with a developmental disability, including autism. However, the budget does not recommend shifting any funds related to EIP to DCF.

- **Questions:** Are EIP services provided to children with a developmental disability to be shifted to DCF? If not, what role will DCF play in the Early Intervention Program?

- **Answer:** The EIP Program is not being shifted to the Department of Children and Families (DCF) since 65% of referrals made to the EIS Program come through the healthcare system. Since 2006, DCF and the Department have benefited from successful collaboration on programs related to children's services. DCF and DOH
agree on the importance of working together to leverage existing resources within the current organizational structures to achieve better outcomes and identify opportunities for efficiencies and improved coordination. In fact, DOH works with DCF and other partners to encourage primary care physicians to consider the importance of mental health screening for children and youth which is currently part of the requirements for Medicaid’s Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

3.b. The budget recommends a reduction of $4.2 million in funding for the Early Intervention Program, from $92.6 million to $88.4 million, citing enrollment trends. However, available data indicates the number of infants receiving services will increase from 24,030 in FY2012 to 24,120 in FY2013.

- **Question:** What trends account for the reduced EIP appropriation?
- **Answer:** The $4.2 million reduction in the Early Intervention Program reduction will have zero impact on services or patients. The funding for this program comes from a variety of sources, Federal Part C, ARRA funds, state funds, client co-payments, insurance payments and federal Medicaid matching funds. The reduction in state funds will be offset by other funding sources. Also, recent information from our Center for Health Statistics shows an overall reduction in the birth rate.

4. Funding for the Worker and Community Right to Know Act is reduced $0.8 million, from $2.5 million to $1.7 million. No information has been provided regarding this reduction.

- **Question:** What accounts for this reduction?
- **Answer:** The budget line item for the Worker and Community Right to Know Program is funded from a dedicated Trust Fund. Receipts to that Fund have decreased over the last year; therefore a corresponding reduction was made in the departmental line-item. This reduction should have no impact on services.

5. The budget recommends a total of $1.4 million for implementation of the New Jersey Compassionate Use Medical Marijuana Act, including $0.8 million in State funds and $0.6 million in anticipated dedicated revenue.

- **Question:** How will these funds be spent?
- **Answer:** Funding will be used to cover the expenses of Medicinal Marijuana Program. The budget includes expenditures for staff salaries and benefits, including Director, responsible for policy development and program implementation; information technology development and software licenses related to the physician
registry and qualifying patient registry; contracted services with the AG’s Office to conduct investigations; and supplies and equipment.

6. The budget recommends State funding of $16.5 million for the Cancer Institute of New Jersey, South Jersey Program. This includes a continuation of its $5.4 million State appropriation in FY2012, and an additional $11.1 million. The FY2012 appropriations act provided $11.1 million through budget language for construction of the comprehensive cancer center in South Jersey. To date, none of the $11.1 million has been expended.

- **Questions:** What is the status of the proposed comprehensive cancer center and its total cost? What is the status of the $11.1 million made available by the FY2012 appropriations act?

- **Answer:** Construction of the comprehensive cancer center began this March. The estimated cost is projected at $80 million from all sources. Only $5.4 million will be made available in FY 2012, the balance of the funding of $11.1 million was allocated as a Language Supplemental that will not be used in FY 2012. However, this same amount is recommended for FY 2013 as a direct line-item appropriation.

7. The recommended budget includes over $0.5 million for a grant to the Poison Control Center operated by UMDNJ. As a portion of the center’s activities affects the State’s Medicaid/NJ FamilyCare population, it may be possible for the department to obtain federal Title XIX or Title XXI reimbursement for a portion of the center’s activities. Available information is that California receives federal Medicaid reimbursement on behalf of its poison control center.

   Similarly, the Department of Health obtains federal Medicaid reimbursement on behalf of the Office of the Public Guardian and the county offices on aging for administrative activities on behalf of Medicaid recipients.

- **Question:** Has the department discussed with the Department of Human Services whether it is possible to obtain federal Title XIX or Title XXI reimbursement on behalf of the Poison Control Center?

- **Answer:** We are in the discussion stages with DHS to determine if this cost is eligible for reimbursement under the Medicaid Program. If eligible, this activity would net about $35,000 annually in federal matching funds.

8. At the end of December 2011, nearly $350,000 in FY2011 AIDS Grants were still encumbered.

- **Question:** How much of the encumbered funds can be lapsed?
Discussion Points (Cont’d)

- **Answer:** The funds cannot be lapsed since there are still valid obligations on this account. It is not uncommon for final payments to be delayed for a variety of reasons; such as verification of information and/or receipt of a final expenditure report or they could be delayed due to a no cost extension for activities that could not be completed within the timeframe of the grant.

9.a. The FY2012 appropriations act had assumed $25 million in rebates for the AIDS Drug Distribution Program (ADDP) from drug manufacturers. Revised FY2012 estimates indicate that $44.0 million in rebates will be received. As there has not been a significant increase in the number of persons enrolled in ADDP, it is unclear why a $19 million increase in rebates is expected.

- **Question:** What accounts for the increase in rebates?

- **Answer:** Rebates are based as a percentage of drug costs and not just clients served. In FY 2010 the Department received $26.2 million in rebates and in FY 2011 the Department received $33.6 million. To date in FY 2012, we have collected $34.7 million. The increase is attributable to drug companies agreeing to pay the state faster and supplemental rebates that were negotiated with the AIDS Drug Assistance Program (ADAP) Crisis Task Force.

9.b. The FY2013 recommended budget estimates that ADDP rebates will increase by $4.0 million, to $49 million. The rebates received by the State are based on the number of prescriptions filled by ADDP plus Supplemental Rebates provided to the State by drug manufacturers.

- **Question:** How much of the $49 million in rebates represents Supplemental Rebates provided by manufacturers?

- **Answer:** Based on prior year experience, it is estimated that $4 million in these rebates will be received in FY 2013.

9.c. Funding for ADDP is subject to a payer of last resort requirement, which prohibits the use of funds to purchase drugs for an individual who is eligible to receive coverage for those drugs through public or private health insurance programs. A 2011 federal Inspector General report found that during the review period between 2003 and 2006 the AIDS Drug Distribution Program did not have adequate procedures for identifying when to bill other insurance providers for drugs when those plans had primary payment responsibility.

- **Question:** What processes does the department employ to ensure that ADDP funds are not used to pay for drugs that are covered by a patient’s health insurance? Have these processes been revised in light of the report’s findings and recommendations?
Discussion Points (Cont’d)

- **Answer:** The Department is in compliance with federal rules and has adequate procedures in place to comply with federal payer of last resort provisions. The characterization of the audit finding in the statement above is somewhat misleading. The federal Inspector General’s Report sampled 99 claims for compliance with federal law and concluded that the Department complied with the Ryan White Title II payer of last resort provisions. The audit report claimed that $2.5 million in costs were billed to Ryan White Title II and should have been covered by the Medicaid Program and therefore recommended that the amount in question be returned.

The Department provided documentation to correct this misunderstanding and the finding was retracted on April 26, 2011. However, we have just received notice that the finding has once again been reinstated by HRSA. The Department anticipates appealing this decision.

Health Planning and Evaluation

10.a. Nearly two years ago, the State submitted Medicaid State Plan Amendments (SPA) to the federal government related to the increase in the 0.53% hospital assessment and the increase in the ambulatory care assessment. The federal government approved the SPA related to the 0.53% hospital assessment, but did not approve the SPA related to the ambulatory care assessment.

- **Questions:** What explanation did the federal government provide for not approving the ambulatory care assessment? Can the SPA be resubmitted to address the federal government’s concerns?

- **Answer:** After significant conversations and analysis with CMS and the Department of Human Services it was determined that in order to comply with federal regulations on provider taxes that significant New Jersey Statutory changes would need to be made. The federal requirement details that all provider taxes be uniform and broad based. Based on that test, New Jersey could not obtain successful approval by CMS.

10.b. The federal government’s decision not to approve the ambulatory care facility assessment SPA will result in a $24 million loss in federal matching funds. Available information indicates that total federal funds for hospital related programs have increased from $347.5 million (FY2011) to $352.5 million (FY2013).

- **Question:** What accounts for the increase in federal funds despite the loss of $24 million from the SPA?

- **Answer:** Federal funding increased because the Governor’s Budget Recommendation used other sources of revenue to provide the State match within the Health Care Subsidy Fund in order to maximize federal matching revenues.
Discussion Points (Cont'd)

11.a. The FY2013 budget recommends a new formula for determining hospital-specific Charity Care disbursements. The new formula bases 90% of disbursements on FY2012 disbursements, and the remaining 10% on changes in the amount of uncompensated care provided by each hospital.

- **Question:** What would each hospital receive if the FY2012 formula were continued, but updated with more recent uncompensated care data?
- **Answer:** Due to Legislative and industry feedback expressing concerns with some components of the structure of the FY 2012 formula it was not modeled with updated data for FY2013.

11.b. The Department of Health conducts approximately 300 Charity Care audits each year.

- **Question:** How much has been recovered in each of the past several fiscal years?
- **Answer:** Charity care is not a claims payment system but rather only a claims documentation system. Charity care claims determined to be non-compliant upon audit are generally voided from the charity care system before the claims data is used for any subsidy payments. The audit serves the necessary function of enforcing documentation requirements and a deterrent against fraud.

12. Budget language in the FY2012 appropriations act created new formulas for determining distribution of Hospital Relief Offset Payments and Graduate Medical Education, which were to be phased in over a three-year period, from FY2012 to FY2014. The FY2013 recommended budget discontinues the phase-in process. Instead, recommended hospital-specific payments are identical to those for FY2012.

- **Question:** Why is the transition to new allocation formulas not continued in FY2013? Please provide a hospital-by-hospital breakdown of Hospital Relief Offset Payments and Graduate Medical Education if the three-year phase in were continued in FY2013.
- **Answer:** The transition to the new allocation formulas that began in FY2012 will not continue due to federal spending limitations. The continuation of these formulas would put in jeopardy the current federal match of $128.3 million. The Department of Human Services submitted a proposal to CMS to restructure the hospital subsidies into new funding pools that meet federal guidelines and are eligible for a 50% federal Medicaid match. It has been proposed that the new funding pools will remain at $256.6 million (same value as the current HRSF/GME). Contingent on CMS approval, the State will work with the industry to develop new formulas that will become effective in FY2014 and has already initiated these discussions. FY2013 is
designed as a transition year, in which the State anticipates that the federal government will allow the State to pay the subsidies in the same manner as the current year and receive a federal match.

13.a. The FY2013 budget recommends $30 million for the Health Care Stabilization Fund which provides assistance to licensed health care facilities to ensure continuation of access and availability of health care services in a community. The program is competitive in nature — health care entities submit applications to the department for funds. Health care entities which receive funds must meet both general and hospital-specific requirements.

- **Question:** To what extent are hospitals complying with the terms of both the general and hospital-specific requirements imposed by the department?
- **Answer:** Grant recipients have complied with both the general and hospital specific conditions periodically providing status reports, conducting meetings and conference calls with DHSS representatives. Reports prepared for the Legislature can be found at [http://www.state.nj.us/health/healthfacilities/hcsf.shtml](http://www.state.nj.us/health/healthfacilities/hcsf.shtml)

13.b. Available data indicates that between FY2009 and FY2011, nine hospitals received Stabilization Funds for two or more years. Providing ongoing financial assistance to certain hospitals may not have been what was envisioned when the Stabilization Fund was established, particularly as other hospitals that may need assistance have been denied funds.

- **Question:** Should the Stabilization Funds continue to be provided to a select group of hospitals that do not appear to be financially viable without such assistance?
- **Answer:** Stabilization funds should continue to be provided based on the RFA criteria. The climate under which hospitals operate in is constantly changing and often affects the health care delivery system. It is important in some instances to continue supporting hospitals to assure continuity of services and access to health care services for the community. Some hospitals that are financially troubled need several years to fully develop and implement financial improvement plans.

14. The FY2013 budget recommends $0.4 million for costs associated with the patient safety act.

A January 2012 federal Inspector General report concluded that “hospital incident reporting systems do not capture most patient harm.”

- **Questions:** To what extent are shortcomings identified in the federal Inspector General report present in reporting systems used by New Jersey hospitals? What steps are being taken to correct these deficiencies?
Discussion Points (Cont’d)

- **Answer:** The Department's Patient Safety Reporting System (PSRS) reviews adverse events and root cause analyses (RCAs) submitted by licensed health care facilities, including hospitals in accord with the New Jersey Patient Safety Act. The Department requires hospitals to develop and implement policies and procedures which identify adverse events and define the process for investigating and reporting such events. The OIG report specifically addresses the effectiveness of incident reporting systems, which is only one of the tools that New Jersey uses to identify adverse events. In addition to PSRS, the Department’s Health Facilities Evaluation and Licensing Division conducts investigations of complaints on adverse events as part of their role in regulatory oversight of licensed health care facilities.

The Department provides education and training workshops, periodic review of individual facilities’ reporting histories, disseminates information about reportable adverse events to facility staff, and encourages facilities to review internal policies/procedures for identifying and reporting adverse events.

### Health Administration

15. The FY2013 budget recommends $1.5 million for the Office of Minority and Multicultural Health. In each of FY2010 and FY2011 the office expended less than $1.4 million.

- **Question:** Can the $1.5 million appropriation be reduced as the program does not expend its entire appropriation?

- **Answer:** No, the Department’s current year spending plan anticipates spending all funding. Prior year expenditures were less due to staff vacancies.

### General Departmental Question

16. The Chairman of the Assembly Budget Committee requests that each department report to the committee the proportion of women and minorities among the senior staff of the department.

- **Question:** Please provide the racial and gender breakdown of your senior staff.

- **Answer:** The Department’s senior staff is 27 percent male and 73 percent female. The overall minority representation is 32 percent.