

## Discussion Points

### Emergency Preparedness and Response

1. On October 22, 2014, Governor Christie took steps to establish a framework for the State's policy to limit the danger posed by the outbreak of the Ebola virus disease in West Africa by signing Executive Order Number 164, establishing the Ebola Virus Disease Joint Response Team (EVD-JRT), chaired by the Commissioner of Health. On October 31, Commissioner O'Dowd announced New Jersey's official mandatory quarantine and screening protocols<sup>1</sup>. The protocol calls for travelers arriving at Newark Liberty International Airport from Guinea, Liberia, or Sierra Leone who show symptoms during the flight to be immediately transported to a hospital. Other travelers are screened, including a non-contact fever check, a traveler declaration form providing contact information, and Ebola Virus Risk questionnaire, and an interview. A risk assessment based on this information would determine whether an individual would be subject to travel restrictions (some risk) or mandatory quarantine (high risk). All travelers from the three affected countries would be subject to active monitoring by a local health department for 21 days after their departure (whether in the low risk, some risk, or high risk categories). Individuals who would be subject to a mandatory quarantine would be quarantined in their own home, when reasonable. The policy indicates that "arrangements will be made for day-to-day necessities and comfort, as necessary," and that "the State will provide assistance to quarantined individuals if they are being denied compensation for lost time at work". The New Jersey Department of Human Services has assumed responsibility for designating suitable housing locations, should the need arise.

#### **Questions:**

- a. Pursuant to the protocol, how many travelers showing symptoms have been transported to a hospital?**

#### **Response:**

As of April 7, 2015, 21 travelers have been transported to a hospital for evaluation of symptoms. None developed Ebola Virus Disease.

- b. How many individuals have been screened and classified in each risk category?**

#### **Response:**

As of April 7, 2015, there have been 642 travelers who have been actively monitored by NJ local health departments. Of these, 639 fell in the "low risk" category, and 3 fell in the "some risk" category. In addition, 1,408 have been screened through the airport screening process.

- c. What costs has the State incurred in screening travelers and providing other services at Newark Liberty International Airport?**

#### **Response:**

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<sup>1</sup> <http://www.state.nj.us/health/news/2014/approved/20141031b.html>

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Under a unified command structure multiple agencies were and continue to be involved in Ebola response activities including NJDOH, NJDHS, NJSP, OHSP, and OAG.

Regarding the public health response, as of March 11, 2015, NJDOH obligated and expended \$2,616,409 (of which \$1,038,180 is personnel costs, \$1,188,411 is operational costs, and \$389,818 in grants).

**d. What costs have been incurred by the State and (to the extent information is available) by local health departments to conduct active monitoring of travelers?**

**Response:**

Since the inception of active monitoring on October 27, 2014, 62 Local Health Departments (LHDs) from 17 counties have been involved in active monitoring; each LHD has used existing staff and resources to varying degrees. Regarding costs to local health departments, we have not collected that information directly but through Federal grant funding have been able to assist in covering both active and direct active monitoring costs in the amount of \$140,000. Beginning in May, the DOH will be able to assist LHDs further as we have earmarked an additional \$1.55M in Federal Ebola-related funding to reimburse costs associated with Active Monitoring/Direct Active Monitoring.

**e. What costs, if any, have been incurred to provide assistance to quarantined individuals?**

**Response:**

LHDs are responsible for community quarantine as part of their regular public health activities. No costs to the state have been identified with housing quarantined individuals.

**f. What costs, if any, have been incurred to provide housing to quarantined individuals?**

**Response:**

The Department of Human Services is responsible for the coordination of housing for out-of-state residents subject to quarantine in the state. To date, there have been no out-of-state travelers subject to quarantine in NJ that have required housing support.

**g. What were lessons learned by the department during this response? What will the department do differently in the future should it face such a situation?**

**Response:**

The response is ongoing therefore a full after action analysis has not yet been conducted. Throughout the response we have worked to incorporate lessons learned as we continue to respond. For example, we have worked with our hospitals in sharing lessons learned in the triage, evaluation and treatment of persons under investigation of

## Discussion Points (Cont'd)

Ebola. Experiences have been shared among New Jersey hospitals and out of state hospitals that have treated patients for Ebola.

2. Furthermore, the department has taken many steps toward a comprehensive public health approach in response to Ebola. The department wants to ensure that the State prevents exposure, ensures health care system preparedness, and provides community education. The department provided outreach to multiple professional and community groups, purchased nearly \$1 million worth of additional personal protective equipment;<sup>2</sup> partnered with the Rutgers University School of Public Health to provide training for health educators, and ensured the ability of the DOH lab to test for the Ebola virus, among many other activities.<sup>3</sup>

### Questions:

**a. What equipment was purchased, and for what specific purpose (e.g. training, emergency reserve, or immediate distribution and use in the treatment of possibly infected patients)?**

#### Response:

\$1 million for Personal Protective Equipment (PPE) was ordered and distributed shortly thereafter to hospitals, EMS and public health partners for the purpose of ensuring that members of the healthcare continuum have the latest and secure gear for the safest provision of care possible.

**b. What was the cost of the training conducted in partnership with Rutgers University and the guidance provided to local health departments?**

#### Response:

Training costs provided by Rutgers were \$75,000. As of April 7, 2015, nearly 1400 individuals have been trained.

**c. What was the cost to enable the DOH lab to test for the Ebola virus?**

#### Response:

Scientific supply costs are \$12,000 along with associated salary charges.

**d. Were these costs paid through General Fund appropriations incorporated into the FY 2015 operating budget or federal dollars, or were funds diverted from other areas to support these activities?**

#### Response:

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<sup>2</sup> <http://nj.gov/governor/news/news/552014/approved/20141022e.html>

<sup>3</sup> [www.state.nj.us/health/newsletter/](http://www.state.nj.us/health/newsletter/) (October, 2014 edition)

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Initial purchase of PPE was done through the General Fund. Federal funding is being requested to reimburse the General Fund. Ebola operating costs, totaling nearly \$1.3M for SFY15 have been supported through a combination of State and federal funding, with as much as 86% of these operation costs tied to federal resources. To continue this unified effort, the Department of Health is working to leverage additional federal funding opportunities aimed at limiting any direct costs associated with SFY2015 State funds. To date, no funding has been diverted to support these activities.

3. A report by the federal Office of the Inspector General entitled "Hospital Emergency Preparedness and Response during Superstorm Sandy"<sup>4</sup> found that of 172 hospitals surveyed in the affected areas of New Jersey, New York, and Connecticut, 69 reported experiencing electrical utility outages, and for many of these backup generators were not a reliable power source. One New York City hospital reported that, although its power generator was safely located on the 13<sup>th</sup> floor, its fuel pumps were located in a flooded basement<sup>5</sup>.

### Questions:

**a. How does the department ensure that hospitals' backup power will be reliable in the event of a major disaster, such as widespread flooding?**

**Response:**

By administrative rule, hospitals are required to have emergency generators that are in full working order and ensure that they have ready access to back-up fuel supplies. Hospital licensing rules are in effect until 1/1/2018.

**b. Has the department conducted an analysis of current hospitals' emergency preparedness abilities?**

**Response:**

Yes, the DOH does this through regular on-site assessments and hospital surveys. The DOH assesses the effectiveness of these activities on an ongoing basis through in-depth evaluations pursuant to NJAC 8:43G-24.13 fire and emergency preparedness.

**c. Have these activities resulted in additional costs for the department?**

**Response:**

No, these activities are part of the general oversight of regulated healthcare facilities.

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<sup>4</sup> <https://oig.hhs.gov/oei/reports/oei-06-13-00260.pdf>

<sup>5</sup> [http://www.nytimes.com/2012/11/01/nyregion/belleuve-hospital-evacuates-patients-after-backup-power-fails.html?\\_r=0](http://www.nytimes.com/2012/11/01/nyregion/belleuve-hospital-evacuates-patients-after-backup-power-fails.html?_r=0)

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4. A report by Trust for America's Health and the Robert Wood Johnson Foundation,<sup>6</sup> found that "New Jersey scored three out of 10 on key indicators related to preventing, detecting, diagnosing and responding to outbreaks, like Ebola, Enterovirus and antibiotic-resistant Superbugs."

New Jersey is one of only four states that, from July 1, 2013 to June 30, 2014, did not report conducting an exercise or using a real event to evaluate the time it took for sentinel laboratories to acknowledge receipt of an urgent message from the state's laboratory.

Additionally, the report highlighted that New Jersey is one of a minority of states that does not require reporting of all CD4 and HIV viral load data to the State HIV surveillance program, and is also among a relatively few states that does not test at least 90 percent of reported *Escherichia coli* (*E. coli*) 0157 cases within four days.

### Questions:

- a. How does the department ensure that information about emergent public health threats is promptly communicated to front-line clinical laboratories and health care providers, and that these providers are prepared to take appropriate actions in response?**

**Response:**

Local Information Network Communications System (LINCS) /Health Alert Network (HAN), focused conference calls, Commissioner level conference calls, technical bulletins.

- b. What are the barriers to improving New Jersey's reporting and testing to be more in line with a majority of the states?**

**Response:**

Enhanced training of staff will bring us further along in order to align NJ with the majority of other states with respect to reporting and testing.

- c. What is the department's estimate of the cost to increase reporting of all CD4 and HIV viral load data?**

**Response:**

The CDC issued new directives in April 2014 recommending that CD4 levels be reported. Laboratories have been encouraged by DOH to voluntarily report all CD4 counts. As part of rulemaking activities, NJAC 8:57 will be updated prior to March 2016 to propose including this directive. At that time, the DOH will review the economic impact of this reporting requirement.

- d. What is the cost to test at least 90 percent of reported *E. coli* cases within four days?**

**Response:**

Costs needed to test at least 90 percent of *E.coli 0157I* cases within 4 days are related to staffing. The DOH is recruiting for a funded laboratorian position whose responsibilities

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<sup>6</sup> <http://healthyamericans.org/reports/outbreaks2014/release.php?stateid=NJ>

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will include, but not be limited to, performing this test at an estimated cost of \$117, 000 annually to meet and subsequently sustain the targeted 4 day turnaround time for reporting E. coli 0157 cases to CDC. Currently our average turnaround time is 5 days.

### **e. Are steps being taken to improve New Jersey's performance in these public health indicators?**

#### **Response:**

DOH continues to work to enhance our State's ability to detect, prevent, diagnose, or respond to outbreaks, to improve areas which are critical to our preparedness efforts.

### Contracting Procedures

5. A study released by Rutgers University Department of Labor Studies and Employment Relations in March 2014 entitled *Overlooking Oversight*<sup>7</sup> reported several problems with the State's procedures for contracting with private vendors. The report does not specifically identify that these are problems at the DOH, but it suggests that many problems may be endemic throughout State government. The report's major general findings are the following:

- (1) Oversight costs are typically not incorporated into contracts or the decision to
- (2) contract, resulting in insufficient allocation of resources to oversight and, in some cases, the contracting out of services that could be more efficiently provided in-house.
- (3) Contracts do not contain adequate performance requirements and standards, resulting in poor quality service provided to consumers.
- (4) A decline in the number of experienced contract managers and inadequate training and qualification of remaining contract managers, along with insufficient on-the-ground oversight capacity, generally as a result of attrition of experienced staff over time, results in an inability to effectively monitor vendors.

#### **Questions:**

- a. Which DOH contracts include oversight costs either as a standard policy or on a case by case basis? Are the parties responsible for oversight third parties acting as overseers or department staff? How are the necessary costs calculated? What percentage of contracts include oversight costs?**

#### **Response:**

Department staff performs the state contract manager function as part of their overall job duties and responsibilities. Since department staff handles the state contract manager duties there is no calculation of oversight costs as these are absorbed in the salaries they are already receiving. DOH primarily relies on a competitive grant process to award funds. These grants are administered by DOH staff.

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<sup>7</sup> <http://smlr.rutgers.edu/news-events/new-study-review-of-njs-oversight-of-third-party-contractors>

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**b. Which DOH contracts include performance requirements and standards? What are the consequences if these requirements or standards are not met?**

**Response:**

Performance deliverables are written into each contract/grant executed by DOH. Payments are withheld if deliverables are not met as a first step. In addition to contract managers, there are project management officers and grant management officers who provide day to day oversight. If performance deliverables are delayed or not met, DOH is following up with the contractor to discuss corrective action. If the situation is not remedied, DOH can file a complaint through the Department of Treasury, Division of Purchase and Property (DPP), which can lead to the removal of the vendor from the state contract.

**c. How many contract managers or other contract personnel does the DOH employ? Has this number been declining? If the issue is one of staff shortage, please indicate how many staff will need to be hired at what cost to improve the contracting procedures.**

**Response:**

As noted, the report does not specifically identify that these are problems at the DOH, but it suggests that many problems may be endemic throughout State government. It would be difficult for the department to speculate how best to correct a current process that the report does not specifically cite as deficient. If DOH were to incorporate the recommendations offered in the report, it could potentially reorganize its current programmatic staff to create an independent contract oversight unit would require additional staff of at least fifteen (15) at a total cost of no less than \$1.1 million in salaries.

**d. What percentage of DOH programs are provided by contracted employees and not department staff?**

**Response:**

A small percentage of DOH programs are supplemented or provided by contractors. DOH programs are supervised or managed by DOH employees.

### Community Provider Contractors – cost of living adjustment

6. Language in the FY 2015 Appropriations Act (page B-205 of the Appropriations Handbook) provides for Community Provider Contract Adjustments of \$13.2 million. Pursuant to the language, "amounts shall be transferred to departments and divisions contracting with community care providers in order to provide an upward contract adjustment effective January 1, 2015 for such providers, which shall be provided as payments to direct care workers." As of March 14, 2015, the payments to providers had not been completed. The language and the appropriation are not included in the FY 2016 Governor's Budget Recommendation for "Other Interdepartmental Accounts." Information

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provided to the OLS indicates that 152 community provider vendors contracted with DOH may be eligible for a contract adjustment pursuant to this language.

### Questions:

- a. How many direct care workers who are employed by community providers who contract with DOH does this increase affect?**

**Response:**

As noted, 152 Department grantees are eligible for COLA increase. The increase will be issued to the community grantees. The Department does not have information concerning the specific number of direct care workers employed by community providers.

- b. Were future contracts adjusted to incorporate this pay increase?**

**Response:**

No.

### Early Intervention Program

7. The Department of Health administers the Early Intervention Program (EIP) for infants and toddlers under age three who have developmental disabilities. On February 12, 2015, the department issued a notice of public comment period for its application for \$10.848 million in federal funds for continued participation in the Infants and Toddlers with Disabilities Program (part C of Individuals with Disabilities Education Act). According to the Directory of Department of Health Grant Programs, early intervention providers are reimbursed via a cost-reimbursement system, but information on specific providers' costs or average costs is not publicly available.

The Department of Human Services (DHS) is taking steps to establish a new payment system with standardized fee-for-service rates for community-based providers of services for individuals with developmental disabilities. These new systems are intended to encourage cost efficiencies by placing more financial risk on providers, and to provide equity in rates or "like rates for like services."

### Questions:

- a. How are State reimbursements to EIP providers currently determined?**

**Response:**

The New Jersey Early Intervention Program (EIP) provider rates were determined through a statewide cost and time study and are publicly reported at the following two locations:

[http://www.state.nj.us/health/fhs/eis/documents/service\\_rates.pdf](http://www.state.nj.us/health/fhs/eis/documents/service_rates.pdf)

[http://www.eikids.com/nj/matrix/docs/pdfs/NJServicesandRates\\_12012014.pdf](http://www.eikids.com/nj/matrix/docs/pdfs/NJServicesandRates_12012014.pdf)

- b. Do different providers receive different rates for the same services?**

**Response:**

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No, the DOH established statewide fee-for-service rates which are used to reimburse the EIPs based on type of practitioner and location of services. Of note, licensed practitioners, such as occupational therapists (OTs), physical therapists (PTs) and speech and language pathologists (SLPs), on occasion are called upon to provide Developmental Intervention services, which are a broad array of strategies to meet the needs of eligible children. Licensed OTs, PTs and SLPs are reimbursed the same rate for delivering that service, as they are for delivering OT, PT and SLP, whereas, other practitioners may be reimbursed at lower rates for providing Developmental Intervention services, according to their professional credentials.

**c. Is the department planning to adopt a similar fee-for-service rate for providers as the DHS is currently implementing?**

**Response:**

The DOH adopted a fee for service rate system in 2004 for the Early Intervention Program provider agencies and finds that the proposed DHS rates for individual Occupational, Physical and Speech & Language services are comparable to the New Jersey Early Intervention System (NJEIS) provider rates.

8. According to the Department of Health website,<sup>8</sup> the Early Intervention Program is not currently accepting new providers into the program. Prior to November 2014, the same webpage had indicated that the department was developing new provider enrollment procedures, but this text has since been removed. The website currently indicates that, “[t]here is no plan to open enrollment for the intent to increase competition.” Some Legislators have indicated that their districts have seen an increase in the early intervention population without a concurrent increase in provider capacity.

**Questions:**

**a. When does the department anticipate that the program will open to new providers?**

**Response:**

The DOH is working with a committee of the Governor-appointed State Interagency Coordinating Council to develop a competitive EIP Request for Application (RFA). This RFA is for EIP provider agencies – those that provide direct services.

**b. How does the department monitor and enforce quality of services, and under what conditions might a provider be terminated from the program?**

**Response:**

The DOH monitors to ensure quality of services using annual desk audits that review child records. Conditions under which a provider might be terminated from the program include but are not limited to failure to comply with auditing requirements, failure to

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<sup>8</sup> <http://nj.gov/health/fhs/eis/newenrollment.shtml>

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correct compliance issues, failure to adhere to timelines and not providing services in accordance with the plan and failure to meet procedural safeguards. Some components of a corrective action plan require an immediate correction and may have additional sanctions such as financial. A failure to correct timely, generally, leads to the agency being placed in at risk status and, at times, high risk status and can result in termination. Continued failures to make necessary corrections can lead to high risk status classification and sometimes termination.

9. According to the Directory of Department of Health Grant Programs, the Early Intervention Program contracts separately with 21 county-based agencies to provide care management services, and 10 child evaluation centers to assess children's needs. The State also contracts with Computer Services Corporation for information technology services, billing, and collection. Some other functions are performed directly by the department. By contrast, behavioral health services provided by the Department of Children and Families are managed by a single contractor (currently PerformCare)<sup>9</sup>, which performs a wide range of administrative functions, including eligibility determination, care management, and provider network management. (Unlike the managed care organizations that administer much of the Medicaid and NJ FamilyCare programs, PerformCare does not determine provider reimbursement rates.)

### Question:

**Could the performance of the Early Intervention System be improved, or its administrative costs reduced, by consolidating its administrative functions into a more unified system, either within the department or through a third party contractor?**

### Response:

The DOH, NJEIS has consolidated and unified administrative functions over the years and has been trying since 2007 to enhance the centralized data system to further unify and increase timely accessibility to information at all levels of the NJEIS. In 2004, the NJEIS established a Central Management Office (CMO), currently contracted with Computer Sciences Corporation (CSC), to unify a number of critical administrative operations and functions which have successfully increased accountability and generated revenue exceeding \$43 million (Medicaid and co-pays) in SFY14 to support the cost of early intervention services. The CMO does perform a wide range of administrative functions, including agency and practitioner enrollment and other provider network management including authorizations for providing and billing early intervention services; provider claims submission and payments; family explanation of benefits, billing, payment collection and suspension if needed due to non-payment and Medicaid claiming.

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<sup>9</sup> Contract number T-1932

## Discussion Points (Cont'd)

As a point of clarification, the DOH's contracts with 21 Special Child Health Case Management Units and 10 child evaluation centers are *not affiliated* with the NJEIS but instead serve as a broader pool of eligible residents Birth to Age 21. NJEIS currently contracts with 13 provider agencies to meet the federal service coordination requirements and 64 Early Intervention Program provider agencies to conduct developmental evaluations/assessment and deliver direct services agreed to through an Individualized Family Service Plan (IFSP). The DOH is working with a committee of the Governor-appointed State Interagency Coordinating Council to develop a competitive EIP Request for Application (RFA) for EIP provider agencies that provide direct services. This RFA is intended to increase the accountability and quality expectations of the EIPs.

10. Developmental services provided to children through the Early Intervention Program are subject to a family cost share in certain circumstances. Administrative regulations (N.J.A.C.8:17-9.2) provide that services to children in families whose income is at or below 350 percent of the federal poverty level are 100 percent subsidized through the program. Children in families with an income of above 350 percent of poverty are responsible to pay an hourly co-pay according to their family cost participation rate, as determined by the EIP.<sup>10</sup>

The FY 2016 Governor's Budget Recommendation estimates that \$6.2 million in revenue will be available from Early Intervention Program co-pays (page C-11). As copayments are paid to providers rather than the State, this revenue is never received by the State. However, the practice of requiring client co-payments offsets costs that would be paid by the State in the absence of the policy, and may also discourage frivolous or excessive utilization of services that could lead to higher State costs.

### Questions:

**a. Why does the budget anticipate this revenue, if it is never provided to the State, but rather is paid to providers?**

#### Response:

The state anticipates the \$6.2 million in Family Costs Participation co-pay revenues that are collected by the Central Management Office since these costs offset the total state liability to Early Intervention Program provider agencies. These revenues, identified as supporting costs associated with EIP services offset the total direct state need. (Note: Children in families with an income of above 300, not 350 percent, of poverty are responsible to pay an hourly co-pay according to their family cost participation rate.)

**b. Are other State and federal appropriations for the Early Intervention Program overstated based on this assumption of revenue?**

#### Response:

The Family Cost Participation collection is not overstated and is included in the overall budget as revenue against expenditures for early intervention services.

<sup>10</sup> [http://www.state.nj.us/health/fhs/eis/cost\\_participation.shtml](http://www.state.nj.us/health/fhs/eis/cost_participation.shtml), Contract number I-2211

## Discussion Points (Cont'd)

### Medical Research

11. The FY 2016 Governor's Budget Recommendation includes \$28 million for the Cancer Institute of New Jersey (CINJ) and \$15.4 million for the South Jersey Cancer Program – Camden (page D-148), consistent with the FY 2015 final appropriation. The FY 2014 and FY 2015 Appropriations Acts both added \$10 million each to the Cancer Institute of New Jersey and the South Jersey Cancer Program over the Governor's original recommendation.

#### **Questions:**

- a. What restrictions, if any, does the department impose on funds granted to CINJ or the South Jersey Cancer Program?**

#### **Response:**

The funds are used in accordance with the Budget Language at D-150 (Governor's FY 2016 Detailed Budget D-150).

- b. How have these two entities spent the additional funds provided in FY 2014 and FY 2015?**

#### **Response:**

CINJ expanded and maintained oncology research and clinical care during both fiscal years. South Jersey Cancer Program utilized FY15 funds for salaries and equipment related to clinical care of oncology patients and FY14 funds were used to complete the construction of their Cancer Center.

12. The Governor does not recommend a specific appropriation for the New Jersey Commission on Cancer Research (page D-147). Historically, the commission had been appropriated \$1 million each year, in accordance with N.J.S.A.54:40A-37.1. Beginning in FY 2011, the commission's appropriation has been inconsistent from year to year. (Final appropriations were \$94,000 in FY 2011; \$0 in FY 2012, \$1 million in FY 2013; \$0 in FY 2014; and \$1 million in FY 2015).

The commission was established in 1983, pursuant to the Cancer Research Act of 1983, P.L.1983, c.6 to promote significant and original research in New Jersey into the causes, prevention, treatment and palliation of cancer and to serve as a resource to providers and consumers of cancer services. The Cancer Research Act increased the tobacco tax to create an ongoing source of funds to support the high human and economic costs of cancer. Additional funds come from taxpayer donations on the state income tax return (Breast Cancer Research Fund and Prostate Cancer Research Fund), the Conquer Cancer License Plate, and from private donations. The NJCCR administers these funds and supports research projects through a competitive process for scientists across the state at a variety of universities, research centers, and other settings. According to the website, the commission has not issued an annual report since 2008.

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### Questions:

- a. How has this inconsistent funding affected the operations of the Commission on Cancer Research and its methodology for selecting research project to receive grant awards?**

**Response:**

The Commission awards funding allocated on a two year funding cycle so there has been no impact to operations.

- b. Have any long-term research projects supported by the Commission on Cancer Research been interrupted or terminated as a result of temporary unavailability of funds?**

**Response:**

To the Department's knowledge, no long-term research projects supported by the Commission on Cancer Research have been interrupted or terminated.

- c. When will the commission release its next annual report?**

**Response:**

The Commission is expected to issue its next report by the end of 2015.

13. The FY 2015 Appropriations Act included two new language provisions (both on page B-74 of the Appropriations Handbook), which are continued in the FY 2016 Governor's Budget Recommendation, that would appropriate funds from the New Jersey Spinal Cord Research Fund and the New Jersey Brain Injury Research Fund to clarify the Legislature's intent that these funds may be used to support research on either traumatic or non-traumatic injuries. According to the department's response to OLS discussion point #9 in the FY 2015 discussion points, the commissions had previously interpreted their mandates to be narrower. Specifically, the Brain Injury Research Commission had focused on traumatic brain injuries, and the Spinal Cord Injury Research Commission had focused on cellular level research of spinal cord injuries.

### Questions:

- a. How have the two commissions adjusted their criteria for assessing applications and awarding research grants?**

**Response:**

The criteria for assessing applications and awarding research grants remain the same.

- b. Has there been an increase in grant applications or awards due to this change?**

**Response:**

Both Commissions received approximately the same number of grant applications in SFY15 as in SFY16. Because the funding opportunity was broadened, we anticipate within funds available an increase in amount awarded.

## Discussion Points (Cont'd)

### AIDS Drug Distribution Program

14. The FY 2016 Governor's Budget Recommendation anticipates revenue from the AIDS Drug Distribution Program (ADDP) rebates of \$56 million in FY 2015 and \$56 million in FY 2016, \$16.57 million (23 percent) less than the \$72.572 million which was actually received in FY 2014 (page C-11). The Governor's Budget Recommendation in FY 2015 anticipated only \$56 million in FY 2014 (page C-12). It is noted that for the past several years total rebate collections recorded by the end of each year have consistently exceeded the amount originally budgeted and the adjusted estimate published during the fiscal year.

In response to an OLS discussion point in the FY 2015 budget process, the department indicated that there were two main causes for the increase in rebate revenue versus the projected revenue. First, the drug companies were paying the State faster than anticipated and second, that the number of clients transitioning to Medicaid (and thus out of the ADDP) was less than anticipated. Budget data supports this explanation as it includes an estimate that 4,496 individuals are anticipated to participate in the ADDP in FY 2015 and FY 2016, a decrease from the 7,396 individuals who were served in FY 2014 (page D-146).

Budget data indicates that the department will have 90 staff positions dedicated to providing AIDS services in FY 2016; this is 14 more than the 76 staff positions in FY 2015.

#### **Questions:**

- a. How many individuals are enrolled in ADDP thus far in FY 2015?**

#### **Response:**

Thus far the average monthly number of individuals enrolled in ADDP in FY15 is 4,815.

- b. Does the department anticipate other costs associated with AIDS programs to decrease as well?**

#### **Response:**

While the department has experienced a decrease in actual prescription costs through ADDP, it is expected that expansion of coverage for co-pays for ADDP eligible insured clients and health insurance premiums will result in a commensurate increase. Surveillance and prevention activities remain constant and have not been impacted by the new federal health care law as yet.

- c. Why is there an increase in staff positions dedicated to providing AIDS services?**

#### **Response:**

There has not been an increase in staff positions dedicated to AIDS services. The 90 staff positions shown in the position data are the 100% federally-funded positions that DOH is authorized to fill.

**Discussion Points (Cont'd)**

Federally Qualified Health Centers

15. The Governor’s FY 2016 Budget Recommendation allocates \$32.3 million for reimbursements to federally qualified health centers (FQHCs) for care they provide to uninsured patients. This is a decrease from the \$40 million authorized for the FQHCs in the FY 2015 Appropriations Act (page B-83). Funding for FQHC’s generally comes from the Health Care Subsidy Fund (page H-16) and any additional needs may be provided by the State General Fund through budget language (page D-150). The display for the Health Care Subsidy Fund decreases the FY 2015 appropriation for the FQHCs from the original appropriation of \$40 million (page H-16 in the FY 2015 Budget) to \$31.5 million (page H-16 in the FY 2016 Budget). The department asserts that the decrease is reflective of a decrease in the number of uninsured individuals being treated at the FQHCs due to the Affordable Care Act.

The Governor’s FY 2014 Budget Recommendation included a performance indicator that tracked FQHC uninsured visits, but that indicator was not included in the FY 2015 or FY 2016 budgets.

FQHCs provide comprehensive health services primarily to uninsured, underinsured, Medicaid and Medicare patients. Services are charged on a sliding scale based on patients’ income. In 2013, there were 1.73 million total FQHC encounters or visits in New Jersey and the majority of revenue received was through Medicaid (36 percent), State and local grants (23 percent), federal grants (23 percent) and self pay (8 percent), private insurance (3 percent) and Medicare (2 percent).<sup>11</sup>

**Question:**

- a. Please provide the performance data supporting the decrease in funding for FQHCs in FY 2015 and anticipated in FY 2016.**

**Response:**

The Uncompensated Care (UC) funding for FQHCs is based on volume not performance.

Year	#of Visits Reimbursed through UC	Reimbursed Expenditures
2014	405,949	\$41.0
2015	311,881	\$31.5
2016	319,802	\$32.3

- b. What is the likely reduction in State appropriations for the FQHCs due to a likely increase in Medicaid enrollment in FY 2017?**

**Response:**

As of January 1, 2014, uninsured adults with household incomes ≤ 138% of the FPL have been eligible to enroll in Medicaid and as such we have experienced a reduction in our

<sup>11</sup> <http://kff.org/state-category/providers-service-use/federally-qualified-health-centers/>

## Discussion Points (Cont'd)

original projection of patients to be served in SFY2015 through the Uncompensated Care Fund. We estimate 399,641 uninsured visits for FY2016. The impact of Medicaid expansion will continue to be monitored and trend data and analysis will be used to develop a FY 2017 budget next year.

### Tobacco Prevention

16. The 2014 "Monitoring the Future" report by the National Institute on Drug Abuse<sup>12</sup> indicates that teens' use of e-cigarettes containing nicotine now exceeds their use of traditional tobacco cigarettes. Anti-smoking advocates and health officials are at times conflicted regarding the role of e-cigarettes – with some arguing that e-cigarettes may be a safer alternative to traditional cigarettes, and others concerned that e-cigarettes may foster nicotine addiction that could lead to increased use of tobacco cigarettes or other addictive substances. Little research has been done to demonstrate the long-term health effects of e-cigarette use. The budget no longer includes specific budget line items for tobacco prevention and cessation, but the Directory of Department of Health Grant Programs indicates that approximately \$800,000 in federal funds are expected to be available for tobacco prevention programs.

#### **Questions:**

- a. How much does the State spend annually on tobacco prevention and cessation programs? Please clarify the source of this funding, State, federal or specific other fund.**

#### **Response:**

DOH spends \$3.8M on tobacco prevention and cessation programs. Federal funds in the amount of \$2.83M support the NJ Quitline, tobacco inspection compliance, school based programs and Mom's Quit Connection, a program for pregnant and parenting women, supported by \$75,000 from the Maternal Child Health Block Grant and \$464,000 from the Preventive Health Services Block Grant. Additional support from the Division of Taxation provides other revenue in the amount of \$500,000 to fund the TASE (Tobacco Age of Sale Enforcement) Program, a federal mandated inspection program (administered by the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention – SAMHSA-CSAP) to test the NJ Law of not selling tobacco to minors under the age of 19 years.

- b. Do any programs funded under these initiatives take a specific stance on e-cigarettes?**

#### **Response:**

The programs funded by the Department treat electronic cigarettes in a manner consistent with the Smoke Free Air Act, which prohibits the use of e-cigarettes indoors.

<sup>12</sup> <http://www.monitoringthefuture.org/>

## Discussion Points (Cont'd)

### Medicinal Marijuana Program

17. The FY 2016 Governor's Budget Recommendation includes a total General Fund appropriation of \$1.607 million for the Compassionate Use Medical Marijuana Act (page D-148) and estimates approximately \$170,000 in dedicated revenues in FY 2016 (page C-12). As of March 2015, only three alternative treatment centers (ATCs) were open and serving patients. A fourth, Breakwater Alternative Treatment Center, was granted permission to begin growing in November 2014, and anticipates beginning operations in the spring. As of March 2015, the actual opening date was still pending. An additional two organizations have applied to open ATCs, but still have not received all necessary approvals to do so. As of March 2015, the program has spent approximately \$590,000 and encumbered \$120,000 of its \$1.697 million appropriation for the current fiscal year.

#### **Questions:**

##### **a. What is the current status of the three ATCs that are not yet open?**

###### **Response:**

A background examination process for qualifying the ATCs was developed by the Department, in cooperation with Department of Law & Public Safety, Division of Gaming Enforcement. The purpose of the examination is to ensure the long-term integrity of the program by thoroughly reviewing all aspects of the ATCs' business, financial and personnel structures. Four of the six selected ATCs have completed the background examination process.

Breakwater ATC (Cranbury Twp., Middlesex County) has completed the background examination process and has been issued a permit to grow. DOH anticipates full permitting in summer 2015.

Compassionate Science ATC (Bellmawr, Camden County) has completed building its cultivation facility and will receive MMP inspection at the completion of the background examination which remains ongoing.

Foundation Harmony ATC (Secaucus, Hudson County) began the background examination process in December 2014.

##### **b. How many ATCs does the department anticipate will open during FY 2016?**

###### **Response:**

The Department anticipates full permitting of two additional ATCs in FY16

## Discussion Points (Cont'd)

- c. Given the generally low level of activity in the program, can the General Fund appropriation or the fees for participants, caregivers, or ATCs be reduced?**

**Response:**

The Department has been conservative in its hiring practices with the MMP. Requests to increase staff for the various units including Customer Service, ATC Monitoring, ATC Examination, Information Technology, Laboratory, and Legal and Regulatory are made at intervals where demand requires it. However, staff increases are anticipated in FY16. The Department anticipates FY15 revenue of \$400,000. 48% of patients and caregivers are afforded a reduction in the two year registration fee of \$200 to \$20. Currently the program costs are not met through the collection of fees.

- d. What services are supported by the current budget?**

**Response:**

Services supported by the current budget include equipment, cost and maintenance, and staffing

### Other Health Care Services

18. In November 2014, the Governor's Council for Medical Research and Treatment of Autism released requests for applications for clinical research pilot and translational research pilot projects and autism health needs medical homes pilot projects<sup>13</sup>. Total funding allocated to the two programs is \$6 million from the Autism Medical Research and Treatment Fund. The FY 2016 Governor's Budget Recommendation (page C-12) includes estimated revenue for these purposes to be \$3.8 million in FY 2016 and FY 2015 and actual revenue to be \$3.99 million in FY 2014.

This fund is the recipient of a \$1 surcharge on all fines and penalties paid for motor vehicle violations in the State, pursuant to P.L.2003, c. 144 (C.30:6D-62.2). As of March 16, 2015, the fund contained \$6.59 million in unexpended resources.

### **Questions:**

- a. How many responses were received from public entities, non-profit entities and for-profit entities, respectively, for each pilot program?**

**Response:**

The Department does not track responses by organization type. We received 30 grant applications for all the pilot projects, including 5 specifically for the Medical Homes Pilot Project.

- b. Has the department awarded funding to any respondents? If so, please list the respondent and amounts awarded.**

**Response:**

No. The responses are currently in review.

<sup>13</sup> <http://www.state.nj.us/health/grants/directory.shtml>

**Discussion Points (Cont'd)****c. Is there another source for funding these programs than the Autism Medical Research and Treatment Fund?****Response:**

The State funding for these research programs is the Autism Medical Research and Treatment Fund. Other non-State funding exists through organizations such as the National Institute of Health, Autism Speaks, and the Autism Science Foundation.

**d. How will the two programs interact with other programs serving individuals with autism, including those operated by local schools, the Department of Children and Families, and the Department of Human Services?****Response:**

The Governor's Council for Medical Research and Treatment of Autism funds research, not services. The Department of Human Services (DHS) is the lead agency for collaboration and coordination among state agencies that provide Autism services. In addition, the Autism Coordinating Center's annual symposium provides an opportunity for information and education.

19. The FY 2015 Appropriations Act included a new language provision (page B-74 of the appropriations handbook), which is continued in the FY 2016 Governor's Budget Recommendation (page D-150), appropriating \$140,000 from the New Jersey Brain Injury Research Fund to be transferred to the Department of Human Services to the Brain Injury Alliance of New Jersey for specialized community based services.

**Questions:****a. What specific services did this additional appropriation support?****Response:**

According to DHS, the specific services are:

Information & Resources Helpline: Assisted approximately 1,800 people per year through a toll-free Family Helpline that addresses the many questions families have following the trauma of brain injury at no cost to them.

Education: Provided constituents with brain injury, their families, and caregiving professionals the opportunity to increase their knowledge of brain injury issues.

Advocacy: Educated several hundred constituents with brain injury annually to become skilled self-advocates to address their needs.

Support Services: Provided for 20 county-based support groups that meet monthly and are attended by more than 1,000 people with brain injury and their caregivers, which offer mutual support, fellowship, and medical information about brain injury.

## Discussion Points (Cont'd)

**b. What regions and populations are being served?**

**Response:**

According to DHS, the appropriation was used to support individuals with Traumatic Brain Injuries and their families statewide.

**c. Please coordinate this question with the Department of Human Services, if necessary.**

**Responses:**

20. The FY 2015 Appropriations Act appropriated an additional \$750,000 (page B-75) to establish a Statewide registry of hospitalizations for traumatic injury, allowing for implementation of P.L.2013, c.223, which provides for the establishment of a formal Statewide Trauma System. The appropriation is not continued in the FY 2016 Governor's Budget Recommendation (page D-147).

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 Department of Health 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." As of March 2015, it does not appear that the department has appointed a director, nor have any of the funds in the account established for the Trauma System been appropriated or encumbered.

**Questions:**

**a. Has the department appointed a State Trauma Medical Director? If not, when does the department expect to appoint a State Trauma Medical Director?**

**Response:**

The Department is advertising in medical journals and newspapers for a consultant to serve as State Trauma Medical Director. We expect to appoint a State Trauma Medical Director in fiscal year 2015.

**b. Is the Statewide trauma registry operational, and if not, when is it expected to become operational?**

**Response:**

The Department evaluated existing data sources to conduct preliminary research and assess the requirements for a Statewide trauma registry. Additional, data elements and data contributors will be required. We expect a Statewide trauma registry to become operational in SFY16.

**Discussion Points (Cont'd)****c. What is the anticipated budget to operate the Statewide trauma registry and the cost to establish a formal State trauma system?****Response:**

The anticipated budget to implement the Statewide trauma registry is \$680,000. Approximately, \$450,000 annually will be required to operate the registry.

**d. How does the department plan to fund these activities in the absence of the \$750,000 appropriation?****Response:**

The department is requesting a Budget Resolution to carry forward funds.

21. The FY 2015 Appropriations Act added a new language provision (page B-76 of the appropriations handbook), which is continued in the FY 2016 Governor's Budget Recommendation (page D-150), that permits funds in the Hepatitis Inoculation Fund be used for hepatitis prevention activities.

The Hepatitis Inoculation Fund was established by P.L.1993, c. 227 to provide hepatitis inoculations to emergency medical technicians (EMTs), firefighters, and police officers. Priority is given to volunteers and employees of squads or departments with less than 100 members. Pursuant to State regulation, each municipality may receive up to \$5,000 in reimbursement for the cost of providing the immunizations and is restricted to use those funds only for the purposes of the act (N.J.A.C. 8:57B-1.5 and 8:57B-1.7). As of March 2015, the fund had encumbered or spent 90 percent of its \$821,968 resources for FY 2015.

**Questions:****a. How much does the department anticipate will be expended in FY 2015 from the Hepatitis Inoculation Fund for hepatitis prevention activities?****Response:**

We anticipate approximately \$256,000 will be expended prior to 6/30/15 for SFY15.

**b. What activities, if any, have been or will be funded?****Response:**

Reimbursements to municipalities for Hep B inoculations and two FTEs within the Communicable Disease Services program have been funded.

**c. What was the most recent year funding was expended to municipalities for inoculations?****Response:**

Funding for the municipalities was given in January 2015.

## Discussion Points (Cont'd)

- d. In the most recent year the funding was provided to municipalities for inoculations, how many municipalities were denied grants due to a lack of funding?**

**Response:**

None of the municipalities were denied grants due to lack of funding.

### Immunizations

22. The vaccine preventable disease program was awarded a two year federal grant of \$1.97 million in October 2014 by the Centers for Disease Control and Prevention for enhancements to the New Jersey Immunization Information System (NJIS). The funds will be used to implement infrastructure enhancements to NJIS to support interaction between NJIS and provider electronic health record systems, health information organizations participating in the New Jersey Health Information Network, pharmacies, and other organizations.

The NJIS is the official Immunization Registry per the Statewide Immunization Registry Act (P.L.2004, c.138). NJIS provides current recommended immunization schedules for infants, adolescents, and adults. All health care practitioners in the State who immunize children less than seven years of age are required by State regulations (N.J.A.C.8:57-3.16) to enroll as an authorized user in NJIS and to report all vaccinations in children under the age of seven to the NJIS. The NJIS then consolidates this immunization information for all providers into one record. Authorized users, including health care providers, child care centers, schools, colleges or universities, health plans, billing and practice management vendors, state or local public health and social services programs, and agencies or designated agents, may access the information contained in the NJIS.

### **Questions:**

- a. What is the current budget and funding source to administer the NJIS?**

**Response:**

The NJIS is supported by federal funding from the Centers for Disease Control and Prevention. The budget allocated for technical resources to administer NJIS during the 2014 budget year was \$1,159,994.00.

- b. How many users are registered with the NJIS? Please specify the users by type if possible.**

**Response:**

Currently, there are a total of 17,554 active (have logged into NJIS within the last three months) users registered with NJIS. Users include, but are not limited to, Healthcare Providers, Schools, Child Care Centers, Local Health Departments, and Audiological Facilities.

## Discussion Points (Cont'd)

**c. How many schools are registered to track immunizations through NJIIS?**

**Response:**

Currently, there are 3,401 schools registered with NJIIS.

**d. Does NJIIS conduct any outreach to schools or other organizations that are required to collect immunization data for their members/students?**

**Response:**

The NJIIS Trainers conduct school nurse trainings once or twice per month, based on the number of school nurses requests. Access to NJIIS is also available to staff from child care centers and social work agencies. Managed care organizations/insurance companies can also access NJIIS reports to review immunization data for their current or former plan participants. The NJIIS staff attends the annual school nurse conference, and other events and conferences throughout the year to promote NJIIS and to conduct outreach to schools and other organizations.

### Quality of Care at Regulated Facilities

23. A large percentage of New Jersey hospitals are being penalized by Medicare than hospitals in other states under two programs established under the Affordable Care Act intended to promote better hospital performance. Under the Hospital Readmissions Reduction Program, New Jersey had the highest percentage of hospitals penalized of any state (98 percent; 63 hospitals), with the seventh highest average penalty (indicating the difference between the appropriate readmission rate determined by federal officials and the actual readmission rate)<sup>14</sup>. Under a separate program, New Jersey had the fifth-highest percentage of hospitals penalized (37 percent; 23 hospitals) for high rates of hospital-acquired infections<sup>15</sup>. In apparent contrast, the Leapfrog Group rated New Jersey's hospital system as fourth safest in the nation in its fall 2014 report card.<sup>16</sup>

**Questions:**

**a. Has does the department regard the apparent conflict among various reports of the quality of care in New Jersey hospitals?**

**Response:**

Each quality report provides a unique perspective for various audiences over different time periods using at times multiple data sources for different purposes. Consumers and providers are encouraged to consider all of these sources when making decisions.

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<sup>14</sup> <http://kaiserhealthnews.org/news/a-guide-to-medicare-readmissions-penalties-and-data/>

<sup>15</sup> <http://kaiserhealthnews.org/news/hospital-acquired-condition-penalties-by-state/>

<sup>16</sup> <http://www.njspotlight.com/stories/14/10/29/hospital-safety-scores/>

## Discussion Points (Cont'd)

**b. What steps have New Jersey hospitals taken to improve their performance since the data collection periods that led to these penalties?**

**Response:**

Every hospital responds in different ways as part of their overall quality improvement, infection control and discharge planning programs. It is important to note that neither of these programs are sponsored by DOH or DHS.

**c. Are there regulatory, systemic, or cultural issues within New Jersey's hospital industry that might contribute to the State's hospitals being penalized more than hospitals in most other states?**

**Response:**

This is a program developed by CMS and the Medicare payment system. DOH is not aware of any reports issued by CMS that speak to state differences. DOH notes the great majority of hospitals nationally (over 75%) were penalized. Researchers from Johns Hopkins suggested social determinants and socio-economic factors may play a role.

**d. Is the department taking any steps specifically intended to improve performance on these metrics?**

**Response:**

The Department issues reports on Healthcare Associated Infections, Hospital Direct Care staffing ratios, Stroke Services, Cardiac Surgery, Cardiac Catheterization, Hospital Quality, Patient Safety, Inpatient Quality Indicators, Prevention Quality Indicators, and Patient Safety Indicators. The Department works with its Quality Improvement Advisory Committee (QIAC) to identify and address health care quality issues. In addition, our hospital Delivery System Reform Incentive Payments—or DSRIP program— rewards hospitals for achieving improved population health outcomes that will result in better health and reduced hospital admissions.

### Health Planning and Evaluation

#### Charity Care

24. Acute care hospitals in the State are required by State law to provide all necessary care to patients regardless of ability to pay, P.L.1992, c.160 (C.26:2H-18.52 et al.). Charity Care is free or reduced charge care that is provided to 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 through the Health Care Subsidy Fund (HCSF) administered under P.L.1997, c.263. The FY 2016 Governor's Budget Recommendation includes a \$148 million reduction in Charity Care

## Discussion Points (Cont'd)

grants to hospitals (page H-16). This reduction includes a decrease of \$100 million from federal funds and \$48 million from the HCSF.

The reduction is attributed by the Executive to anticipated downwards trends in the costs associated with individuals who do not have alternative forms of health insurance due to provisions of the Affordable Care Act (FY 2016 Budget Summary, page 16). However, enrollment data supporting this trend is still not official and the "Calendar Year 2013 Report of Documented Charity Care" prepared by the Office of Health Care Financing<sup>17</sup>, notes that documented charity care has demonstrated a six year (2008 through 2013) trend of variability but total incurred costs in 2013 of \$1.023 billion are slightly higher than the amounts paid in four of the previous five years. According to the department's press release, the department used "preliminary Documented Charity Care for calendar year 2014 of less than \$580 million, which represents more than a 40 percent reduction in care provided to the uninsured in New Jersey."<sup>18</sup> The preliminary Documented Charity Care for 2014, used by the department in its analysis, is not publicly available at this time.

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 the hospitals that serve the communities with the lowest median incomes to receive exactly 96 percent of the hospital's documented charity care, and it provides for a minimum reimbursement to each hospital of 43 percent of its documented charity care.

The proposed formula for FY 2016 (page D-154) differs from the statutory formula, and results in charity care subsidies that are less than the statutory minimum of 43 percent. 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.

### Questions:

- a. **Please provide the preliminary Documented Charity Care for calendar year 2014 of less than \$580 million that was used in the department's analysis. Please include in the table, each hospital's anticipated Documented Charity Care for FY 2014 as compared to the Documented Charity Care in FY 2013.**

### Response:

The preliminary DCC is considered incomplete, consultative and deliberative because it is still being audited. Final data will be shared as soon as it is available.

- b. **Please provide to the OLS in excel format, if the department has not already done so, each hospital's total gross revenue for all patients from the CY 2013 Acute Care Hospital Cost Report as defined by Form E4, Line 1, Column E data, according to the DOH advance submission request dated February 14, 2014, as**

<sup>17</sup> <http://www.state.nj.us/health/charitycare/hdcc.shtml>

<sup>18</sup> <http://www.nj.gov/health/news/2015/approved/20150306a.html>

**Discussion Points (Cont'd)**

**submitted by each acute care hospital by March 20, 2014, and source data used for Medicare Cost Report data from CY 2012.**

**Response:**

DOH provided this data to OLS.

- c. Please provide to the OLS in excel format, if the department has not already done so, each hospital's gross revenue for charity care patients, including all adjustments and void claims related to calendar years 2013 and any prior year submitted claims, as submitted by each acute care hospital or determined by the DOH.**

**Response:**

DOH has provided this data to OLS.

- d. Why are the components of the charity care formula not publicly available?**

**Response:**

The components of the formula are available at D-154 in the Detailed Budget and have been provided to OLS.

- e. Did the department analyze the amount of additional State or federal Medicaid funding anticipated by each hospital in FY 2014 and incorporate this information into its FY 2016 Charity Care analysis?**

**Response:**

The Proposed FY16 Charity Care Formula did not incorporate Medicaid funding into the distribution.

- f. To what extent does the department assess the financial condition of each hospital and hospital system before finalizing the Charity Care funding plan?**

**Response:**

The Proposed FY16 Charity Care Formula does not incorporate financial condition as a component of the distribution. The DOH Early Warning System is an on-going process that continually evaluates hospital financial condition.

- g. 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.**

**Response:**

The most recent available data is FY13. The hospital-specific distribution is available on our website. See [http://www.state.nj.us/health/charitycare/documents/cc\\_report2013.pdf](http://www.state.nj.us/health/charitycare/documents/cc_report2013.pdf)

## Discussion Points (Cont'd)

25. A portion of the Charity Care budget is drawn from federal funds under the Medicaid Disproportionate Share Hospital (DSH) program. However, it is not clear through the budget documents what portion of the DSH funding is being used for Charity Care in FY 2016.

DSH adjustment payments are federal funding intended provide additional help to those hospitals that serve a significantly disproportionate number of low-income patients. Under the formula provided by federal statute (42 U.S.C. 1396r-4(f)), the State's DSH allotment generally increases each year by the same percentage as the consumer price index, totaling approximately \$686.5 million in federal fiscal year 2014. (Individual hospitals are also subject to funding caps.) Due to the expanded access to health care coverage anticipated as a result of the Affordable Care Act, Congress included a reduction in DSH payments to begin in 2017.

The FY 2016 Governor's Budget Recommendation includes language indicating that there will be \$502 million allocated by the State to Charity Care. Historically, a portion of these funds have been reflected in the Health Care Subsidy Fund (page H-16) and has declined in recent years, from \$136.25 million in FY 2013 to \$0 in FY 2016. It appears that a portion of the DSH allotment, \$413.8 million, is recorded as general revenue by the Department of Human Services on Schedule 1, under the three "Medicaid Uncompensated Care" items displayed on page C-5 of the FY 2016 Governor's Budget Recommendation. The FY 2016 Governor's Recommended Budget is not clear with regard to where the remaining DSH allotment would be expended. The most recent information available indicates that DSH funding was distributed to 110 hospitals in the State (including psychiatric hospitals).

### Questions:

**a. What is the allocation of Medicaid DSH funds to Charity Care in FY 2016?**

**Response:**

According to the Office of Management and Budget (OMB), all federal reimbursements based on Charity Care spending are displayed as general State revenues on Schedule 1.

**b. How much of the total \$502 million FY 2015 Charity Care appropriation could potentially be supported with federal DSH funds, if not for the significant part of the allotment being dedicated to DHS?**

**Response:**

According to OMB, Federal Disproportioned Share Hospital (DSH) reimbursements may be allocated at the discretion of the State – therefore, the full DSH revenue amount of \$413.8 million as displayed on Schedule 1 could have been used to fund Charity Care. However, any such allocation would lower the total available general revenues and require replacement revenues or State funding cuts to maintain a balanced FY16 budget.

## Discussion Points (Cont'd)

- c. Please provide by entity, the amount of DSH funds distributed for the most recent year available.**

**Response:**

According to DHS, the federal government requires all states to conduct an annual independent certified verification of DSH payments. The annual report must identify each disproportionate share hospital that received a DSH payment and the amount of those payments.

NJ DHS follows the prescribed federal audit schedule and provides the following link to connect to the most recent years available on the CMS Medicaid.gov website:

<http://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/medicaid-disproportionate-share-hospital-dsh-payments.html>

### DSRIP

26. The Delivery System Reform Incentive Payments (DSRIP) program, a component of the Comprehensive Medicaid Waiver, took effect in FY 2014. The program 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. According to data published by the DOH<sup>19</sup>, of 64 eligible hospitals and systems, 51 are currently participating. Five hospitals initially chose to participate but then discontinued their participation after the second demonstration year. Non-participating hospitals can enter the program only under certain exceptional conditions. Pursuant to the program's rules, funding not allocated to non-participating hospitals is placed in a "universal performance pool," to be distributed to participating hospitals according to their achievement of certain performance goals.

The DSRIP program is currently in the third demonstration year and payments are made on a monthly basis.<sup>20</sup> The total target funding amount for FY 2015 is \$164.23 million, of which \$147 million is paid in a monthly amount to the participating hospitals and \$16.4 million is to be distributed through the Universal Performance Pool (UPP). The UPP will distribute \$20.1 million as it includes the current year's allocation and unused funds from the previous demonstration year from hospitals that withdrew from the program. The UPP contains is a portion of the total funding that is carved out each year and granted to hospitals for meeting certain performance requirements. The percentage of funding which is carved out and the performance measures vary from year to year.

This is a federally funded program and participating states must match the federal funding. States may use general fund dollars, but may also designate state dollars that are used for services that are similar to Medicaid services but are not currently matched with

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<sup>19</sup> <http://dsrip.nj.gov/>

<sup>20</sup> <http://dsrip.nj.gov/Home/Payment>

## Discussion Points (Cont'd)

federal dollars. The Governor's FY 2016 Budget Recommendation includes language stating that \$166.6 million are appropriated for the DSRIP (page D-155); however, analysis of budget data finds a total of \$175.78 million for the DSRIP, as follows: \$62.645 million from the General Fund (page D-153); \$28.835 million from the Health Care Subsidy Fund (page H-16); and \$84.3 million in federal funding (a portion of \$545.735 million on page D-154), a discrepancy of \$9.18 million.

### Questions:

- a. Which State-only funded programs are used for the federal DSRIP match? If more than one program, please indicate the amount of funding for each program.**

#### Response:

In SFY 2013 budget, the Hospital Relief Subsidy Fund (HRSF) was replaced with the Delivery System Reform Incentive Payments (DSRIP) at \$166.6 million. The funding level remains the same.

- b. What services are the additional \$9.18 million dedicated to?**

#### Response:

According to OMB, as discussed above, the \$9.18 million is in federal authority display only so no additional services have been identified relating to this amount. The department anticipates adjusting this display during the federal funds update as part of the annual budgetary process.

- c. Does the department anticipate that any currently non-participating hospitals may seek to enter the program?**

#### Response:

No. As of March 2013, 50 hospitals are eligible to receive funding under the DSRIP program during Demonstration Year (DY) 3 through DY5 are general acute care hospitals. The remaining hospitals have elected not to participate in the DSRIP program. Hospitals that did not submit a Hospital DSRIP Plan to the Department or have elected to withdraw from DSRIP will be precluded from participating in New Jersey DSRIP in subsequent demonstration years under the currently approved waiver.

- d. Does the department anticipate that any participating hospitals may exit the program prior to the end of the demonstration?**

#### Response:

The Department is not aware of any hospitals requesting to withdraw from the program at this time. Initially, seven hospitals declined to participate and subsequently six hospitals have withdrawn from the DSRIP program.

## Discussion Points (Cont'd)

27. Myers & Stauffer LC. was awarded the contract for the "Hospital Incentive Program" for the period 9/16/13 through 9/15/16. The original pricing of the contract equaled \$2.64 million for the completion of 20 specified objectives. However, on November 28, 2014 an amendment to the contract was approved which added "Year 2 price lines and funding in the amount of \$1.107 million" bringing the total contracted amount to \$3.75 million.

### Questions:

**a. Why was the contract increased by approximately 40 percent?**

**Response:**

The initial contract was developed before the program requirements were clearly defined by the Center for Medicare Services (CMS). The initial contract was intended to initiate the program and reach a point where the requirements are known. To continue implementation, the scope of services is considerably greater than those included in the initial contract.

**b. What additional duties are involved in the contract extension?**

**Response:**

The scope of services is considerably greater than initially contracted. The Department's contractor was required to review each hospital's specific plan, give feedback, and provide assistance to support every hospital which has resulted in CMS approval for all participating hospitals.

**c. What is the total cost to the Department of Health to administer the DSRIP? Are these costs covered by federal or State dollars? If the cost is shared, please indicate the required State match.**

**Response:**

The current contract with Myers & Stauffer is for \$3.1 million. There is a pending RFP for consultant services, which will receive 50% Federal match.

28. The Governor recommends a total appropriation of \$127.3 million for Graduate Medical Education (GME) (\$59 million State and \$68.3 million federal), an increase of \$27.3 million over the FY 2015 appropriation (page D-155). This increase continues a trend of growth for Graduate Medical Education since FY 2010, as follows: \$60 million in FY 2010 and FY 2011; \$90 million in FY 2012 and FY 2013; and \$100 million in FY 2014 and FY 2015.

Historically, Medicaid GME has been supported with 50 percent federal funds, but the Governor's FY 2016 Budget Recommendation anticipates a higher matching rate of approximately 67 percent due to the number of patients seen by the hospitals who are eligible for the higher 100 percent federal match from Medicaid. 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

## Discussion Points (Cont'd)

highly complex patients. In FY 2016, 42 hospitals will receive GME funding. Nonetheless, New Jersey struggles to maintain an adequate supply of practicing physicians in many specialties.

### Questions:

- a. Does the State anticipate receiving any additional GME funds for FY 2015 or any other previous years using the higher federal matching rate?**

**Response:**

The total matching amounts that will be received under the SFY 15 budget have increased from a 1 to 1 match to approximately 2 to 1.

- b. If the State does receive these additional funds, will they be distributed to hospitals? Please provide the amount the State anticipates allocating to each hospital.**

**Response:**

No additional funds will be distributed to hospitals.

- c. If the State does receive additional funds and does not allocate these funds to hospitals, for what purposes will the funds be used?**

**Response:**

The funds will be directed to the General Fund.

- d. How does the State encourage graduates from local medical training programs to remain in the State?**

**Response:**

The Department recognizes that training doctors is a partnership between our hospitals, medical schools and government. Governor Christie continues to increase his support and commitment to that partnership and the results are reflected in the continued investment and growth of our medical schools and expansion in the hospital based teaching programs. By funding this program, NJ Hospitals have been able to maintain or expand their training initiatives. In the absence of the State investment some of these programs may have been reduced or terminated.

- e. How does the State encourage international or out-of-State medical students to choose New Jersey to continue their training?**

**Response:**

This proposed budget continues Governor Christie's support of graduate medical education. The support has increased from \$60 million to \$127.3 million. The DOH does not have a program specifically dedicated to encourage international or out-of-state medical students to choose NJ.

## Discussion Points (Cont'd)

**f. Is it possible to set conditions on GME funding to more strongly encourage graduates to remain in the State?**

**Response:**

In order to set conditions, DOH would require a reliable data source and CMS approval.

29. P.L.2013, c.195 instructs the Commissioner to “undertake a review of New Jersey’s hospital financial reporting requirements and . . . report any findings and recommendations directly to the Governor no later than six months from enactment.” The law further instructs the Commissioner to “examine the impact of, and make recommendations on, the following areas for all entities receiving Health Care Subsidy Fund payments from the State: Internal Revenue Service filings, Securities and Exchange Commission filings, and audited financial statements.” The department’s report on hospital financial transparency<sup>21</sup>, issued in July 2014, includes several recommendations to make New Jersey hospitals’ finances more transparent, including requiring audited annual financial statements to be submitted to the department within 180 days of the close of the hospital’s fiscal year (rather than July 1<sup>st</sup>), making unaudited quarterly financial statements available within 60 days of a quarter’s end, and making the information available to the hospital’s website and at public meetings.

**Questions:**

**a. Does the department plan to write or implement regulations to increase hospital financial transparency based on any of its recommendations?**

**Response:**

On December 17, 2014, the Commissioner released guidance to Hospital CEOs encouraging adoption of her financial transparency recommendations for audited annual and unaudited quarterly financial statements as well as the provision of information on whether the hospital participated in insurance networks.

**b. What is the timeline for such regulations to be officially proposed?**

**Response:**

No specific timeframe has been determined; however, we have already begun meeting with stakeholders for input.

**c. Has the department estimated the possible increase in State costs related to oversight and enforcement resulting from any of its recommendations?**

**Response:**

The reporting will be the responsibility of the providers and enforcement would be incorporated into our general compliance program.

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<sup>21</sup> [http://www.nj.gov/health/documents/hospital\\_transparency\\_report.pdf](http://www.nj.gov/health/documents/hospital_transparency_report.pdf)

## Discussion Points (Cont'd)

- d. If the hospitals accept the recommendations to publish unaudited information on their individual websites, will the department consolidate this information and make it public on the department's website?**

**Response:**

No. Each hospital should provide their audited annual financial statements and the unaudited quarterly financial statements to the Department of Health and post them conspicuously on their websites. The Department recommends that each hospital post them conspicuously on their websites within 180 days of the close of the hospital's fiscal year. This is information of interest to the community and should be available on the hospital's website and at the annual public meeting.

Hospital realignment/closures:

30. On March 2, 2015, Navigant Consulting, Inc. (Navigant) released a report summarizing the current delivery of health care and providing recommendations to improve the provision of healthcare services in the Greater Newark, New Jersey area (referred to as the "Planning Area").<sup>22</sup> The New Jersey Health Care Facilities Financing Authority had engaged Navigant to evaluate the current inventory of healthcare services in the Greater Newark area to determine whether there is duplication of services, unused capacity, or an insufficiency of necessary services in this area, and if so, propose recommendations to the Commissioner of the Department of Health for consolidation or regionalization of services.

The analysis uncovered a certain amount of duplication of services, excess availability of underused services (such as in-patient beds), and under-availability of other services (such as emergent care and outpatient services). The report outlined goals to improve the delivery of health care in this region and made specific recommendations on how to achieve these goals, as follows:

Recommendation #1: Consolidate Inpatient Pediatrics and Cardiovascular Surgery Services at Newark Beth Israel Medical Center, starting in 2016 and fully implemented in 2017.

Recommendation #2: Expand Broadway House's role to include post-acute care, begin in 2015 and fully implemented by 2016.

Recommendation #3: Transform East Orange General Hospital and St. Michael's Medical Center into state-of-the-art ambulatory care facilities, beginning after the first two recommendations are well under way, and plan for completion by the end of 2017.

Recommendation #4: Develop a state-of-the-art regional medical center in Newark, complicated and including significant capital infrastructure, initial planning should begin in 2015 and will likely take at least until 2017 with full implementation of the recommendation being completed no earlier than 2019.

<sup>22</sup> <http://www.njhcfpa.com/njhcfpa/what/reports2.html>

## Discussion Points (Cont'd)

### Questions:

- a. What is the department's estimate for any fiscal impact of these changes on appropriations for Charity Care, Graduate Medical Education appropriations, and DSRIP in the future?**

**Response:**

The Department does not anticipate any fiscal impact to the SFY16 Budget.

- b. What is the department's estimate on the impact on licensing and regulation fees of these anticipated changes?**

**Response:**

The licensing and regulation fees are established by administrative rules. Should any filing occur, the applicants will be expected to file pursuant to existing fees and regulatory requirements.

- c. Does the department anticipate taking a lead role in creating linkages between the FQHCs and the medical facilities to facilitate an improved delivery system?**

**Response:**

The Department will work closely with any facility to improve the delivery system.

31. The FY 2016 Governor's Budget Recommendation includes \$19.841 million for the Hospital Asset Transformation Program (program), an increase of \$15.99 million over the total \$3.851 million which was appropriated for these purposes in FY 2015. The program was established by the "New Jersey Health Care Facilities Financing Authority Law," P.L.1972, c. 29 (C.26:2I-1 et seq.) for the purpose of providing financial assistance by the authority to nonprofit hospitals in this State in connection with termination of the provision of hospital acute care services at a specific location.

The program allows the Health Care Facilities Financing Authority (Authority) to issue State-backed bonds, secured by a contract with the State Treasurer, on behalf of a hospital meeting certain criteria. The bonds can be used by the hospital to facilitate the closure and realignment of services by a hospital. The Treasurer agrees to pay the principal and interest on the bonds when due and then the borrower enters into a loan agreement with the Authority to make payments equal to the principal and interest on the bonds plus other related costs and fees. The Authority then pays those funds directly back to the State.

### Questions:

- a. What are the reasons for the increased appropriation in FY 2016?**

**Response:**

The FY 2016 budget again includes debt service payments for both St. Mary's bonds and St. Michael's bonds. St. Michael's has a pending application requesting a transfer of license. If approved, the SFY16 includes the total due of about \$16.7 million.

## Discussion Points (Cont'd)

- b. Does the department anticipate a need for a supplemental appropriation in FY 2016? If so, in what amount?**

**Response:**

No. The Department does not anticipate the need for a supplemental appropriation in FY 2016.

- c. Due to the recommendations of the Navigant Report, does the department anticipate any costs to the program in FY 2016 that are not reflected in the recommended appropriation?**

**Response:**

No, the Department does not anticipate any costs in FY2016 that are not reflected in the recommended appropriation.