May 12, 2016

Honorable Gary S. Schaer
Chairman Assembly Budget Committee
c/o Frank Haines
Legislative Budget and Finance Officer
Office of Legislative Services
State House Annex
P.O. Box 068
Trenton, New Jersey 08625-0068

Dear Chairman Schaer:

I am writing in response to your request for additional information to issues raised by committee members.

Chairman Schaer:

Q1. Please provide to the committee the name of the hospitals in the State about which the department is concerned with their financial condition.

Response
The Department monitors the financial condition of all hospitals with a view toward ensuring continued access to quality care. If financial issues are identified, the Department engages individual hospitals in determining reasons for those problems and what can be done to address them. Routinely, hospitals are successful in making adjustments to effectively restore financial stability. To publish a hospital’s financial position could lead to incorrect conclusions about its condition, putting it at a competitive disadvantage with vendors and payers, and further destabilize a situation that could negatively impact quality of care.

Assemblyman Burzichelli:

Q2. Please provide to the committee the amount from the sale of St. Mary’s Hospital to Prime Health Care services which was put in escrow to pay down the $45.4 million in outstanding bonds still owed by the State on behalf of St. Mary’s Hospital. Please detail the repayment schedule for these bonds, including the amounts paid from escrow and from State appropriations.

Response
Prime Healthcare Services paid $15,000,000 to acquire St. Mary’s Hospital. As required by the Internal Revenue Code, in order to keep the remaining bonds tax-exempt, all $15,000,000 was deposited into an escrow account to pay a portion of the interest on the bonds in SFY 2015, 2016 and 2017 and to call approximately 48.91% of the bonds outstanding pro rata from SFY 2018 through 2027.
<table>
<thead>
<tr>
<th>State Fiscal Year</th>
<th>Payment from Escrow from Purchase Price</th>
<th>Payment from Treasury Subject to Appropriation</th>
<th>Total Bond Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>$316,662.50</td>
<td>$2,285,465.00(^1)</td>
<td>$3,690,822.00(^1)</td>
</tr>
<tr>
<td>2016</td>
<td>$633,725.00</td>
<td>$3,056,534.00</td>
<td>$3,690,259.00</td>
</tr>
<tr>
<td>2017</td>
<td>$14,283,725.00</td>
<td>$3,060,442.00</td>
<td>$17,344,167.00</td>
</tr>
<tr>
<td>2018</td>
<td>$2,423,295.76</td>
<td>$1,891,350.00</td>
<td>$2,314,645.76</td>
</tr>
<tr>
<td>2019</td>
<td>$1,891,350.00</td>
<td>$1,891,350.00</td>
<td>$1,891,350.00</td>
</tr>
<tr>
<td>2020</td>
<td>$1,889,582.00</td>
<td>$1,889,582.00</td>
<td>$1,889,582.00</td>
</tr>
<tr>
<td>2021</td>
<td>$1,889,332.00</td>
<td>$1,889,332.00</td>
<td>$1,889,332.00</td>
</tr>
<tr>
<td>2022</td>
<td>$1,890,832.00</td>
<td>$1,890,832.00</td>
<td>$1,890,832.00</td>
</tr>
<tr>
<td>2023</td>
<td>$1,888,832.00</td>
<td>$1,888,832.00</td>
<td>$1,888,832.00</td>
</tr>
<tr>
<td>2024</td>
<td>$1,889,656.00</td>
<td>$1,889,656.00</td>
<td>$1,889,656.00</td>
</tr>
<tr>
<td>2025</td>
<td>$1,892,718.00</td>
<td>$1,892,718.00</td>
<td>$1,892,718.00</td>
</tr>
<tr>
<td>2026</td>
<td>$1,890,750.00</td>
<td>$1,890,750.00</td>
<td>$1,890,750.00</td>
</tr>
<tr>
<td>2027</td>
<td>$1,890,000.00</td>
<td>$1,890,000.00</td>
<td>$1,890,000.00</td>
</tr>
<tr>
<td>Total</td>
<td>$15,234,312.50</td>
<td>$27,838,788.76</td>
<td>$44,161,595.76(^1)</td>
</tr>
</tbody>
</table>

\(^1\) Includes payments made by St. Mary's totaling $1,088,494.50 in SFY 2015.

Assemblyman Singleton:

Q3. For the past five years, please indicate how many children each year were screened for elevated blood lead level. For each of these years, please indicate what percentage of total children this represents.

Response
Children in New Jersey are required to be screened at 12 and 24 months of age. Any child older than 3 years of age must be tested at least once before their sixth birthday. Annual distribution of children screened by their sixth birthday, therefore, is not as significant as knowing the percentage of children who have been screened before their sixth birthday at the conclusion of each state fiscal year (SFY).

The table below demonstrates: the number of children in New Jersey less than six years of age screened each of the last five SFYs; and the percentage of children who had at least one blood lead level screen prior to their sixth birthday by the conclusion of each SFYs.

<table>
<thead>
<tr>
<th>SFY</th>
<th>Children (&lt; 6 years) Screened</th>
<th>% screened by 6th birthday</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>178,429</td>
<td>97%</td>
</tr>
<tr>
<td>2012</td>
<td>183,617</td>
<td>99%</td>
</tr>
<tr>
<td>2013</td>
<td>176,520</td>
<td>99%</td>
</tr>
<tr>
<td>2014</td>
<td>171,271</td>
<td>97%</td>
</tr>
<tr>
<td>2015</td>
<td>172,859</td>
<td>95%</td>
</tr>
</tbody>
</table>
Assemblywoman Muoio:

Q4. Please identify State and Federal funding provided by the State for the prevention and detection of sexually transmitted infections in FY 2016 and anticipated in FY 2017.

Response

<table>
<thead>
<tr>
<th></th>
<th>FY 2016</th>
<th>FY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>State</td>
<td>$1,455,013</td>
<td>$1,444,272</td>
</tr>
<tr>
<td>Federal</td>
<td>$2,951,099</td>
<td>$2,742,994</td>
</tr>
<tr>
<td>Total</td>
<td>$4,406,112</td>
<td>$4,187,266</td>
</tr>
</tbody>
</table>

Q5. How many children have been tested twice for elevated blood lead levels before their seventh birthday? What percentage of all children in this age range does this represent?

Response
Children in New Jersey are required to be screened at 12 and 24 months of age. Any child older than 3 years of age must be tested at least once before their sixth birthday (not their seventh birthday). As of the end of SFY 15 (June 30, 2015) 93% (1.62 million) of children born in NJ had at least one test before their sixth birthday. Of these children, 56% (913,514) had a second test prior to their sixth birthday.

Assemblyman Johnson:

Q6. Please provide information to the committee on the impact of bad debt on hospitals' financial solvency. Please identify any specific hospitals for which the department has concerns over the amount of accrued bad debt.

Response
The Department does not track bad debt at hospitals

Q7. Does the department think the $100,000 in funding should be continued for Adler Aphasia Center?

Response
The Department's understanding is that no funding for the aforementioned item is included in the FY 2017 budget.

Sincerely,

Cathleen D. Bennett
Acting Commissioner
November 21, 2016

Honorable Gary S. Schaer
Chairman Assembly Budget Committee
c/o Frank Haines
Legislative Budget and Finance Officer
Office of Legislative Services
State House Annex
P.O. Box 068
Trenton, New Jersey 08625-0068

Dear Chairman Schaer:

I am writing in response to your request for additional information about issues not raised during the hearing due to time constraints.

Q1. Certificate of Need (CN) approval letters have generally listed a series of conditions for the approval, which set forth continuing obligations on the hospital. Often included in the conditions are requirements to use “commercially reasonable best efforts to negotiate in good faith for in-network HMO and commercial insurance contracts...” What efforts will the DOH undertake to enforce the conditions in a CN letter, particularly the requirements around good faith contracting? What power does the DOH have to enforce these types of requirements?

Response

The Department monitors compliance with all CN conditions. In recent years, Department staff has met with several hospitals to review issues arising in contract negotiations with insurers, and has asked for written documentation that describes the number and subject of telephone calls, correspondence and meetings with existing HMO and commercial insurance carriers, as well as follow-up telephone calls, correspondence and meetings. In addition, if insurers fail to respond to requests to negotiate with the hospital, the hospital is to notify the Department and the Department of Banking and Insurance to request assistance.
Q2. Some hospitals appear to be out of network with a number of carriers. They also tend to be for-profit hospitals. Can you comment on why that may be?

Response

Hospitals may not be part of an Insurer’s provider network for some or all products the Insurer offers to its subscribers. In some cases, hospitals may elect to not contract with an Insurer or the Insurer may elect to not contract with the hospitals for reasons endemic to the hospital or the Insurer’s business plans. The Department has no evidence to support a higher incidence of for-profit hospitals out of network than not for-profit hospitals out of network. The Department of Banking and Insurance may be able to offer more insight on this topic.

Q3. What can we learn from other states as far as Graduate Medical Education (GME) spending? Are other states more effective in using the funds to train and retain residents? How does our level of funding compare to other states and their number of GME slots and the physicians they retain?

Response

The Department does not have data from other states on Graduate Medical Education spending, resident retention data or the number of GME funded positions.

Q4. Regarding state funding for hospitals, what exactly is meant by “specialized care” and how is it different from charity care? What are the differences in the formulas for the two categories of funding?

Response

The Department is unfamiliar with a hospital funding formula for specialized care. The Department does not use the term or have a designation of “specialized care” in any of its funding pools.

Q5. Please provide a chart with the breakdown of direct and indirect GME funding.

Response

See the table below:

<table>
<thead>
<tr>
<th>SFY 2017 Budget</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct GME</td>
<td>$ 83,009,570</td>
</tr>
<tr>
<td>Indirect GME</td>
<td>$ 104,990,430</td>
</tr>
<tr>
<td>Total</td>
<td>$ 188,000,000</td>
</tr>
</tbody>
</table>
Q6. Annual Reports showing aggregate data for preventable adverse events under the Patient Safety Act are outdated. The most recent report is dated 2010. When will you publish a report?

**Response**

The 2012 Patient Safety Report has been completed and will be published in the 2016 calendar year. The Department has begun developing a combined 2013-2015 report.

Q7. The 2010 law requiring ambulatory surgical care facilities to report infections rates does not seem to be implemented. No regulations appear to have been promulgated, and no reports showing infection rates by facility is available. Why not?

**Response**

The 2010 law (P.L. 2009, c. 263) has been implemented. The regulation (N.J.A.C 8:56) has been in place since 2012 and requires that ambulatory surgery facilities report data on infection control rates to the Department.

The Department has been collecting this infections data since 2012. In March 2016, the Department shared data with each of the reporting facilities for review. A system to report facility-level data on a quarterly basis to facilities has been developed to assist them in monitoring their performance. Facility-level annual reports will be posted on the Department’s website, once the facilities have had an opportunity to review their data.

Q8. The Department of Health is responsible for inspecting nursing facilities and assisted living facilities. It does so on behalf of both the department and the Centers for Medicare and Medicaid Services (CMS). The purpose of these inspections is to assure compliance with federal and state requirements covering areas such as resident rights, quality of life, nursing services and infection control, to name a few. State survey teams issue a deficiency for individual item when a facility is out of compliance. These deficiencies are graded for level of severity based on the number of times a facility may have been out of compliance—from isolated to widespread—as well as the potential for harm to residents—from no actual harm to immediate jeopardy to resident health or safety. Deficiencies range from level A to level L, with Level L being the most egregious. When a facility disagrees with one or more survey findings—a deficiency—they are entitled to “informal dispute resolution,” or IDR. This is a process whereby facility representatives and members of the State survey team present their points of view regarding the accuracy of survey findings with representatives of the Department of Health. Assuming funding were to be made available, would the Department support the establishment of a truly independent informal dispute resolution process utilizing third-party arbitrators rather than
DOH staff to make the final determination with regard to a survey team’s findings when they are disputed by a facility?

Response

The Department is opposed to the establishment of an independent informal dispute resolution process utilizing third-party arbitrators rather than Department staff to conduct IDRgs because it would not excuse the Department from oversight of the IDR process. CMS provides in Chapter 7 of the State Operations Manual:

States should be aware that CMS holds them accountable for the legitimacy of the informal dispute resolution process including the accuracy and reliability of conclusions that are drawn with respect to survey findings. This means that while States may have the option to involve outside persons or entities they believe to be qualified to participate in this process, it is the States, not outside individuals or entities that are responsible for informal dispute resolution decisions. So, when an outside entity conducts the informal dispute resolution process, the results may serve only as a recommendation of noncompliance or compliance to the State. The State will then make the final informal dispute resolution decision and notify the facility of that decision. CMS will look to the States to assure the viability of these decision-making processes, and holds States accountable for them.

Informal dispute findings are in the manner of recommendations to CMS and, if CMS has reason to disagree with those findings, it may reject the conclusions from informal dispute resolution and make its own binding determinations of noncompliance.

State Operations Manual, §7212.3 (italics in original). Thus, the State would still be responsible for reviewing the panel’s recommended decision and making the final IDR decision, which would then be subject to CMS review. It should also be noted that the Department currently offers an Independent Informal Dispute Resolution (IIDR), which “provide[s] facilities, under certain circumstances, an additional opportunity to informally dispute cited deficiencies through a process that is independent from the State survey agency or, in the case of Federal surveys, the CMS Regional Office.” State Operations Manual, §7213.2. If a facility qualifies for an IIDR, it is conducted by the New York State survey agency.

Q9. Governor Christie has twice vetoed bipartisan legislation establishing a state dental director. Prior to 1993, NJ had a full time dental director but that spot has been left vacant by the department and now a non-dentist serves in an acting capacity in that position. Data indicates that NJ lags behind the nation in oral health literacy which is directly linked to oral health utilization. Why hasn’t the
The New Jersey Department of Health (NJDOH), through its Children’s Oral Health Program (COHP), works in concert with the dental community to implement model programs that improve the oral health of children. In accordance with policy recommendations (2014) established by the American Academy of Pediatrics, the NJDOH has partnered with the Dental Trade Alliance to co-fund a model program to promote early dental literacy development for infants and children leading up to kindergarten.

The program, called “Bedtime Bytes”, is being implemented in the State’s federally qualified health centers. The overarching goal is to improve the oral health status of children by assisting families in securing a dental home for consistent dental care and providing family-focused activities that promote the importance of a dental visit by age 1. This health promotion/literacy initiative is implemented in conjunction with the Dean and faculty at the School of Nursing, Health and Exercise Science at the College of New Jersey and the NJ Department of Children and Families in the NJ Home Visiting Programs for first time families.

The "Treat Your Family to a Healthy Smile" health literacy library initiative was implemented at libraries throughout the State in the summer of 2016 to enhance literary skills while emphasizing the importance of good oral health and nutrition practices. These and other initiatives implemented by COHP focus on providing oral health education to school age students throughout the State. They are conducted by and target a multi-disciplinary staff of health care providers (doctors, dentists, nurses, health educators and other health care professionals) who can coordinate multiple health disciplines and reach large numbers of children and families.

State oral health programs do not provide direct clinical dental services that require a licensed dentist to administer. The Association of State and Territorial Dental Directors reports that over half of the state oral health programs are administered by non-dental professionals with a variety of backgrounds including Masters in Public Administration, Title V Maternal Child Health Program Managers, Certified Health Education Specialists and dental hygienists.

New Jersey’s program is led by a doctoral prepared nurse with 30 years of public health experience, who for the past 15 years has administered the COHP and coordinated its collaborative initiatives with the dental and healthcare communities.
Office. Please provide detailed information about the funding and activities of this office and the impact of its activities and programs on promoting greater health equity in the state.

Response

OMMH Funding:

<table>
<thead>
<tr>
<th></th>
<th>OMMH Funds SFY16 &amp; Project SFY17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>State SFY16</td>
</tr>
<tr>
<td>Salaries</td>
<td>$490,000.00</td>
</tr>
<tr>
<td>Grants</td>
<td>$1,010,000.00</td>
</tr>
<tr>
<td>Total</td>
<td>$1,500,000.00</td>
</tr>
</tbody>
</table>

OMMH Major objectives:
- Achieve health equity & Reduce health disparities by:
  - Targeted funding to community & faith based organizations and other partners to implement health promotion & disease prevention activities in vulnerable populations;
  - Conducting health surveillance through data collection & monitoring;
  - Provide Health education & outreach;
  - Build Strategic partnerships and coalitions with non-traditional as well as traditional partners;
  - Promote cultural competence & best practices in the delivery of health care services

OMMH Major Activities:

Community & Faith-Based Grant Funding
- Over 1 million in funding provided to build capacity to improve health among vulnerable and high risk populations statewide
  - $890,000 (FY 2016-2018) in Community Health Disparity and Prevention grant funding to 25 community-based/faith-based organizations to investigate ways in which health equity can be advanced through research or promising practices, demonstration and evaluation projects, and continued support of existing program models.
  - $180,000 (FY 2016) to five (5) grantees awarded Chronic Disease Self-Management Program / Diabetes Self-Management in Spanish and Languages Other Than English.
- Raise community awareness and build community capacity to identify and prevent associated risk factors of chronic illnesses by targeting OMMH health disparity priority areas (i.e., asthma, cancer, diabetes, heart disease, hepatitis C/B, HIV/AIDS, infant mortality, immunization kidney disease, obesity, unintentional injuries, or violence).
• Annual Minority Health Month implementation which promotes health equity through a month-long series of forums, events and activities across the state.

Strengthen Community Relationships through strategic collaboration & coalition building

• **NJ HepB Coalition.** OMMH partnered with the DOH Infectious and Zoonotic Disease program to lead efforts to recognize and address Hepatitis B as a health disparity among Asian Americans.

• Active participation with the following organizations/coalitions:
  o Pediatric Asthma Coalition of New Jersey
  o NJCEED Statewide Cancer Coalition,
  o Chronic Disease Coalition (Heart Disease and Stroke Coalition),
  o NJ Immunization Network
  o New Jersey Chapter American Academy of Pediatrics,
  o New Jersey Statewide HIV/AIDS Planning Group
  o New Jersey Statewide **Network for Cultural Competence**
  o Rutgers School of Nursing
  o March of Dimes
  o Association of Lesbian, Gay, Bisexual, Transgender Addiction Professionals and Their Allies
  o Hetrick-Martin Institute (HMI)
  o National Association of Social Workers- NJ Chapter in 2015

• **Local public health equity initiative.** Creating a strategic partnership with the Newark Department of Health and Community Wellness (DHCW) to advance health equity. Participating organizations include: a) Mahoney Health Women’s Health Clinic, b) Designing health center for South and North wards of Newark, c) ShopRite Supermarket Urgent Care Center, d) West Ward Diabetes Specialty Clinic.

• **Region 2 Community Advisory Committee (R2AC) Member.** R2AC is an educational training collaborative to provide visionary and strategic direction and critical information related to changes in public health workforce development in general and adult learning in particular.

Access to Health Care Services & Cultural Competence

• Work collaboratively with colleges of medicine and dentistry and other health care professional training programs to develop cultural and language competency courses.

• Pilot a Cultural Competence and Linguistic Competence Policy Assessment (CLCPA) in 13 of New Jersey’s long-term care facilities in July 2015, in conjunction with the DOH Division of Health Facility Survey & Field Operations.

• In FY2016-2017, OMMH will conduct a webcast on the National CLAS Standards Blueprint to ultimately reach all 364 facility management teams.

• NJDOH Cultural Competency policy development.
Workforce Development
- In SFY16 awarded the $6,000 Rutgers University Cook Rutledge Fellowship to a graduate student, who was matched to a Community Health Disparities Prevention grantee to lead the effort to provide the CLCPA and developed the pre/post cultural competency assessments.
- OMMH and the Rutgers School of Public Health student internship program collaboration to match 10 Master of Public Health students with OMMH grantees.

Data Collection, Analysis, and Reporting
- Conduct surveillance and monitoring of priority health disparity areas statewide.
- Produce publications to inform the public about the health status of New Jersey’s racial/ethnic and vulnerable populations statewide.

Q11. The four private companies that inspect hospitals as part of the accreditation process for CMS do not assess a hospital’s compliance with state laws and regulations, such as those relating to staffing, workplace violence prevention and safe patient handling. What does the DOH do to objectively assess whether or not a hospital is in compliance with state laws and regulations designed to protect patients and employees, beyond requiring hospitals to self-certify that they are in compliance? Does DOH ever conduct any spot checks?

Response

The Department (DOH) conducts a full State survey each time it conducts a full Federal survey or a CMS validation survey. At that time, hospitals are inspected for compliance with all State regulations. In addition, all general hospitals come under inspection at least every two years. Most those surveys are complaint investigations, approval surveys, and monitoring visits. The facilities are also then assessed for compliance with the State licensure regulations.

When DOH staff conducts a full survey at a hospital, it is labor intensive. A survey team consists of at least two registered professional nurses, a pharmacist, a Life Safety Code inspector, a dietician and an additional nurse who solely functions as a sanitarian reviewing the processing and sterilization of surgical equipment. The number of nurses and the days spent on site depends on the size of the facility, but typically there are at least three nurses and the team is on site for at least 3 days. Inclusive of supervisory reviews and travel, on average a full survey takes almost 300 staff hours.

In October 2015, DOH issued a memo to all licensed healthcare facilities reminding facilities they are to be in compliance with the regulations in NJAC 8:43E, which includes Safe Patient Handling and Violence Prevention. Since the memo was issued, 43 hospitals have been monitored for compliance with 8:43E. Eleven were cited for deficient practice.
Q12. Hospitals are not required to submit their full accreditation inspection reports to the DOH; hospitals only have to submit a letter stating that they have passed accreditation, although DOH has the authority to request the hospital submit the full report. In the past three years, how often has the DOH asked a hospital to provide the full inspection report from the accreditation company?

Response

The Department has not asked hospitals to submit full inspection reports from the accreditation organizations.

Q13. What outreach to the Department of Human Services has the Department of Health undertaken to address the many licensure and other regulatory barriers to integrated care that face community based providers of mental health and substance use treatment services who wish to integrate physical healthcare without needing to invest hundreds of thousands of dollars in physical plant?

Response

In 2015, the Department, working with the Department of Human Services (DHS), prioritized efforts to remove regulatory barriers to allow the integration of primary medical care services and primary behavioral health services. Representatives of both agencies have been meeting routinely to sort through the complex issues surrounding the provision of primary care services in facilities operated by community-based behavioral health centers. Unlike primary care facilities, most behavioral health centers do not currently have physical space that complies with the Department’s physical plant requirements, including infection control requirements. Both Departments are continuing to work together and meet with potential providers to review physical plant issues to determine if compliance can be achieved with appropriate waivers and without significant physical plant expenditures. This has become an ongoing priority and will continue to be so.

Q14. When will the department implement the menu-labeling law for which calories are required to be listed on the menus of food establishments (P.L. 2009, c. 306)? The law applies to chain restaurants with 20 or more locations in the state of New Jersey. The department was supposed to implement it within one year of passage – the law was signed on January 17, 2010. In response to previous inquiries, the department said they were waiting for Federal regulations to be adopted so as not to cause confusion or unnecessary expense for NJ restaurants. The Feds adopted final regulations on July 10, 2015 and those regulations go into effect December 1, 2016. Why has the department not issued
or begun to enforce the State law ever since they have known what the final Federal Regulations say?

Response

The federal menu labeling requirements will pre-empt New Jersey's menu labeling law and the Food and Drug Administration will be the primary enforcement agency of the federal menu labeling regulations. There are differences between New Jersey's law and the federal regulations. The Department's position remains the same in this regard; enforcing the State law will create confusion in the retail food industry. The Public Health & Food Protection Program, within the Department, has incorporated the federal menu labeling regulations in the upcoming revisions of retail food rules found at N.J.A.C. 8:24-1 et. seq. The revisions are currently under review.

Q15. What is the protocol when a person tests positive for hepatitis C? Is it reported by the provider, e.g., doctors, nurse practitioners, hospitals?

Response

N.J.A.C. 8:57-1.5(b) requires that health care providers and administrators report any new case of hepatitis C to the Department within 24 hours of diagnosis (i.e., previously diagnosed "chronic" cases are not reportable). This administrative code defines a health care provider as a physician, physician assistant, advanced practice nurse, or certified nurse midwife. An administrator is defined as the person having control or supervision over a health care facility, correctional facility, school, youth camp, child care center, preschool, or institution of higher education. In addition to mandatory reporting by health care providers and administrators, N.J.A.C. 8:57-1.7(b) requires that clinical laboratory directors report all positive hepatitis C lab tests to the Department within 72 hours of the result.

Q16. What is the schedule and frequency of hospital and nursing home inspections? It's our understanding that due to staff shortages, these facilities are not inspected on a normal timeline. How often are they inspected outside of an inspection due to a reported incident or complaint?

Response

There is not a standard schedule for hospital inspections. However, all general hospitals come under survey at least every two years. In addition to complaint investigations, approval surveys, and monitoring visits, hospitals are inspected for compliance with all State rules each time they are surveyed for Full Federal surveys and CMS Validation surveys.
In October 2015, the Department issued a memo to all licensed healthcare facilities reminding facilities they are to be in compliance with the rules at NJAC 8:43E, which includes Safe Patient Handling and Violence Prevention. Since the memo was issued, 28 hospitals were monitored for compliance with 8:43E.

Nursing homes are inspected annually within nine to fifteen month intervals. The Department has consistently met the CMS required standard of a statewide average interval of 12.9 months between consecutive standard surveys.

Q17. We have been told there will be efforts made to streamline and make the integration process between physical and mental health facilities more efficient, but there is no reference to this in either the Core Mission Summary on page D-143 of the budget or elsewhere. Please elaborate on the department’s efforts to date and plans for FY 0217 to streamline and make the integration process between physical and mental health facilities more efficient.

Response

As noted above, working in conjunction with the Department of Human Services (DHS), the Department prioritized efforts to promote the integration of primary medical care services and primary behavioral health services in 2015. Those efforts persist in FY2017. Staff from both Departments are actively engaged in assisting licensing applicants who propose to integrate primary medical and primary behavioral health services. Department staff will continue to meet with applicants and, where appropriate and feasible, work with them and DHS staff to find ways to streamline the integration process.

Q18. Is the State laboratory equipped to test for the Zika Virus? What updates can the Commissioner provide with regard to coordinating surveillance with the Federal Government of this burgeoning disease? There is no increased funding to the State laboratory budget; does the Administration recommend updating the budget in light of growing knowledge about the threat posed by the emergence of the Zika Virus?

Response

Effective May 18, 2016, the New Jersey Public Health and Environmental Laboratory (PHEL) began testing for the Zika virus.

NJDOH reports de-identified cases of confirmed human arboviral diseases, including Zika, to the Federal government (CDC) as the cases are confirmed. The Department is also participating in CDC’s US Zika Pregnancy Registry, and health care providers of pregnant women who meet criteria for the registry will be contacted to provide additional surveillance data regarding their clinical status and the clinical status of their infants.
NJDEP works with local mosquito control agencies regarding mosquito surveillance and control; NJDOH provides de-identified human arboviral case data to NJDEP/local mosquito control to assist with their efforts.

Currently the Department is scheduled to receive funding from the CDC as part of national funding initiative for the Zika virus.

Q19. Vaccination rates among school aged children have reduced as a result of the Attorney General’s determining that school systems may not determine whether a request for exemption on the basis of religion is legitimate (97% compliance in 2014 to 93% expected compliance in 2016). What types of diseases have begun to reemerge, or are anticipated to reemerge, as a result of the increase in non-compliance?

Response

We are always monitoring reportable vaccine-preventable diseases to understand trends in these diseases. From time to time, we see outbreaks of vaccine-preventable diseases here and nationwide, but it is hard to predict if there is a direct relationship with exemptions.

According to data which appears in the August 28, 2015 MMWR titled, Vaccination Coverage Among Children in Kindergarten – United States, 2014 – 2015 School Year, the median percentage of nonmedical exemptions was 1.5% (range: 0.5% - 6.2%) for states where they are allowed and reported separately. Despite the increase in the nonmedical exemptions in New Jersey, the total number of students fully immunized remains high. However, in New Jersey and within the United States, there might be a geographic clustering of people who are not fully vaccinated and therefore susceptible to vaccine-preventable diseases. It is important to ensure that everyone receives timely age-appropriate vaccination.

Percentage of children meeting all immunization requirements and claiming religious exemptions (RE) for each of the years noted

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total immunized</td>
<td>95.0%</td>
<td>88.5%</td>
<td>95.3%</td>
</tr>
<tr>
<td>Total RE</td>
<td>1.9%</td>
<td>1.7%</td>
<td>1.7%</td>
</tr>
</tbody>
</table>

Percentage of children in kindergarten meeting all immunization requirements and claiming religious (RE) exemptions for each of the years noted

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Kindergarten – immunized</td>
<td>96.3%</td>
<td>92.5%</td>
<td>96.8%</td>
</tr>
<tr>
<td>Kindergarten - RE</td>
<td>1.6%</td>
<td>1.5%</td>
<td>1.4%</td>
</tr>
</tbody>
</table>

The immunization rates for 2014 – 2015 were lower due to a change in methodology which is described on the Communicable Disease Service website at
http://www.nj.gov/health/cd/stats.shtml. In short, a change in reporting resulted in a greater number of children with “unknown” vaccination status for the 2014 – 2015 academic year. With greater follow-up by the program staff, the number of students with “unknown status” decreased from 7.6% in 2014 – 2015 to 0.8% in 2015 – 2016.

Q20. Why do you predict a reduction in the number of people tested and counseled by AIDS Services (page D-146)?

Response

We expect a reduction in the number tested as a result of focusing our testing efforts on a smaller number of higher risk people. This is referred to as targeted testing. Targeted testing is more labor intensive as we have to seek out people at higher risk in their environments.

Q21. Why are no funds recommended in FY 2017 for the Statewide Trauma Registry (budget page D-148)?

Response

Approximately $1.4 million from FY 2016 will be encumbered and fully committed before June 30, 2016. These funds will be used in FY 2016 and FY 2017.

Q22. We received notification that certain insurance companies would no longer cover certain HIV medications, including the medications which are single pill regimens. Does the budget for the AIDS drug distribution program take into account these changes in coverage (is it private insurance or Medicaid managed care)? If not, how much additional funding must be allocated? Will ADDP assist beneficiaries in obtaining prior authorization?

Response

ADDP has sufficient funding to cover necessary HIV medications for patients. DHSTS does comply with HRSA requirements that ADDP funding is to be used as payer of last resort.

Division of HIV, STD and TB Services (DHSTS) is not aware of health insurance companies having a policy not to cover single pill regimens. We are encouraging providers to submit written appeals and complaints to the insurance company as the situation arises.
Q23. Given the fact that there was no increase to the vital records budget with additional regulations regarding adoption going into effect in January 2017, can the department handle the additional inquiries with the staff and budget as recommended? How many birth parents have filed thus far to maintain privacy and how many have filed contact preference forms?

Response

The Department believes it will be able to handle additional inquiries associated with implementation of the adoption law, utilizing current budget levels. As of June 6, 2016, 120 birth parents have filed forms pertaining to privacy, contact preference, and/or family history.

Sincerely,

[Signature]

Cathleen D. Bennett
Commissioner