Fiscal Year 2021 Revised Budget Proposal
Questions for the Department of Health

Long-Term Care

In a press release from August 10, 2020, the Governor's Office announced $25 million in new funding to assist the State's long-term care facilities with the cost of newly required weekly COVID-19 testing of all staff. In addition, the Governor's August 25 "FY 2021 Revised Budget Proposal" announced the State will dedicate $10 million in federal Coronavirus Relief Fund monies for long-term care facilities and their oversight, and to support the facilities' efforts to implement more robust infectious disease control programs and protocols. The revised budget proposal also includes a recommended $1.1 million appropriation for a new Office of Long-Term Care Resiliency.

Questions:

1. **Please detail how the $10 million in federal Coronavirus Relief Fund funding will be used. Will it finance any new positions, and will the new positions be permanent? How much will be allocated toward infection control supplies, programs, and protocols? Does the department anticipate the need to support long-term care facilities in their efforts to implement and adapt their infectious disease control programs beyond FY 2021? If so, how does the department plan to fund these programs in future years?**

The NJDOH used $1,995,225 for an initial contract with CertiSurv to conduct Focused Infection Control surveys per CMS requirements on all CMS certified facilities and $2.8 million of CRF funding to meet additional recommendations in the Manatt report. Specifically, NJDOH will expand their current contract with CertiSurv to conduct both Infection Control focused surveys of non-Medicare certified facilities as well as complaint investigations at both Medicare certified nursing homes and non-Medicare certified long term care facilities including assisted living facilities. The purpose of this contract is to have a baseline Infection Control survey for all long-term care facilities in the state by the end of October. The remainder of the funds will be used to advance additional infection control supports for facilities.

Long Term Care	**2020**
Salaries	7,075
Materials / Supplies	87
Services	1,081
Maintenance	99
Additions, Improvements & Equipment	210
Special Purpose	
Background Checks	979
Implement Patient Safety Act	400
TOTAL DSS	**9,931**

2. The FY 2021 General Fund appropriation for the Division of Long-Term Care Systems Development and Quality Assurance is $10.6 million, about 6.8 percent higher than in FY 2020. Will this level of funding be enough to accomplish the goals established in the department's directive on the phased reopening of LTC facilities? If not, how large a shortfall does the department anticipate?

The NJDOH does not expect a need for an additional appropriation to respond to the requirements imposed on facilities in the Executive Directive: Directive for the Resumption of Services in all Long-Term Care Facilities Executive Directive NO. 20-026, licensed pursuant to N.J.A.C. 8:43, N.J.A.C. 8:39, N.J.A.C. 8:36 and N.J.A.C. 8:37 (https://www.state.nj.us/health/legal/covid19/8-20_ExecutiveDirectiveNo20-026_LTCResumption_of_Svcs.pdf), the Department has identified staff to review the attestations being submitted by facilities in order to advance phases towards reopening. The NJDOH has used CRF funding to contract with a CMS certified consultant survey company as described in question 1 above.

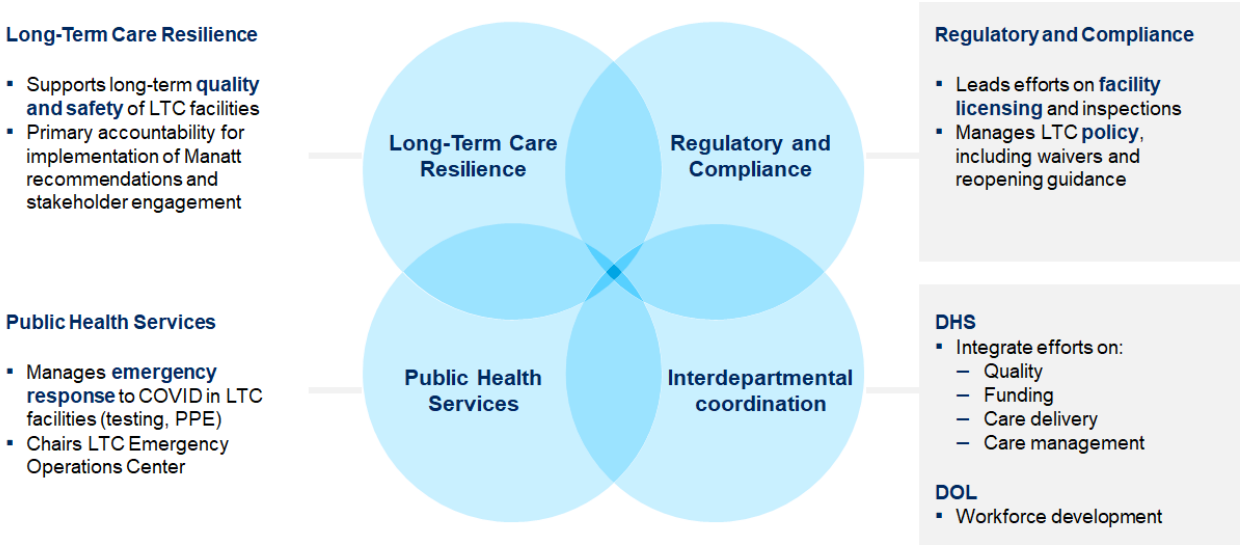
a. Does the Administration plan to supplement these State appropriations with federal CRF funds? If so, by how much, and what specific activities will these funds support?

CRF Funds must be spent by the end of December. As such, we will focus on testing in DOC, DCF, DHS, and long-term care facilities. As mentioned above, the CRF funds will be utilized to conduct infectious controlled focused surveys at LTC facilities per CMS and DOH reopening guidance.

3. Please describe the department's role in overseeing the quality of long-term care facilities in the State.

Currently, the NJDOH inspects nursing homes every 9-15 months to ascertain compliance with both State and Federal regulations, assess minimum quality and safety standards, and to assess access to health care for all citizens. The Division assesses Medicare Certified facilities for compliance with CMS requirements under an agreement with HHS. HHS uses the results of annual surveys among other data inputs to give facilities quality ratings.

The NJDOH has established the Office of Long-Term Care Resiliency (LTCR) within the Integrated Health Services Branch to support the overall resiliency, health, safety, and quality of our state's long-term care facilities via data-driven and expert guidance. Additionally, the department developed a joint workgroup with the Department of Human Services to foster interdepartmental coordination and collaboration as it relates to quality, care delivery and management, and the varying funding and rate setting initiatives. The below depicts a high-level presentation of these efforts.



4. **Please describe the department's role in in overseeing the financial health of long-term care facilities in the State.**

The Department has no role in the financial oversight of long-term care facilities. This function falls under the purview of the Department of Human Services which has addressed this question.

5. How many infection control-focused long-term care facility inspections has the department conducted in calendar year 2020 to date?

All 370 CMS certified nursing homes have received at least one infection control survey. In addition, DOH has conducted infection control focused surveys at 60 assisted living facilities, 6 specialty hospitals, 6 dementia care homes, 36 End State Renal Dialysis, 6 Ambulatory Surgical Centers, and 7 Acute Care Hospitals.

a. Does the department have enough staff to conduct these surveys, as well as review and approve each facility's application for advancement to a higher stage of the department's re-opening directive? If not, how many additional staff would be required to conduct the required number of facility inspections and review long-term care facility Phase Reopening attestations? How much additional funding would be required to fill these inspection positions?

The NJDOH has expanded their current contract with CertiSurv to augment survey capacity in order to meet federal survey requirements and complete a baseline infection control survey of every long-term care residential facility licensed by the NJDOH by the end of October 2020. Long-term care facilities do not need to "apply" for advancement to a higher phase of the departments reopening

directive, but instead need to attest to their compliance with specified requirements prior to advancing. There are no additional expenses incurred by the Department due to the directive. The Department is collecting all the attestations submitted by facilities in order to advance phases according to E.D. 20-026, and continues to conduct infection control focused surveys in accordance with CMS guidance, within 3 to 5 days of a newly identified outbreak. The Department is also taking enhanced enforcement actions in accordance with CMS guidance: https://www.cms.gov/files/document/qso-20-31-all.pdf. The NJDOH monitoring data entered the NHSN and the NJHA.

6. **How will the $25 million in new funding to assist the State's long-term care facilities with the cost of newly required weekly COVID-19 testing of all staff be distributed among long-term care facilities?**

The Department of Health is directing up to $25 million in CDC Epidemiology and Laboratory Capacity (ELC Enhanced) Funding to assist long-term care (LTC) facilities. LTC facilities will have priority access to Rutgers University saliva testing to cover $25M in costs for the weekly COVID-19 testing of all staff. The Department continues to work with stakeholders to develop a comprehensive plan for the funds.

a. Would the $25 million come out of the Coronavirus Relief Fund?

No, the funding will come from the CDC Epidemiology and Laboratory Funding.

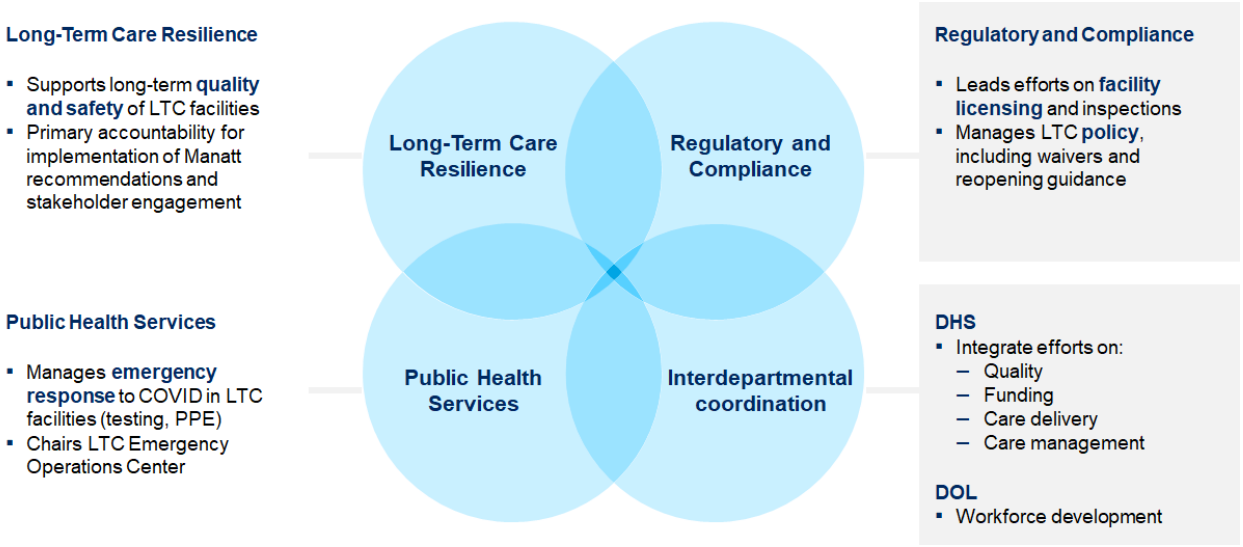
b. If so, given that only expenses incurred through December 30, 2020 are eligible for federal Coronavirus Relief Fund reimbursement, how will the State assist long-term care facilities with the cost of adhering to COVID-19 protocols after that date?

As noted above, the testing supports are not from the CRF, and thus are not limited by the December 30 end date. In any case, the NJDOH expects that long term care facilities will be able to cover the costs associated with new COVID-19 protocols using state enhanced rates and federal funding.

c. If so, how much supplemental State funding do you anticipate would be required?

At this time, the Department will utilize funding received from the ELC - Centers for Disease Control and Prevention to support the COVID-19 testing of staff at LTC facilities.

7. **Please describe the responsibilities and general organizational structure of the new Office of Long-Term Care Resiliency that a recommended $1.1 million appropriation is supposed to support. How are these responsibilities different from the department's current responsibilities?**



Office of Long-Term Care Resiliency (LTCR)

The mission of the Office of LTCR is to improve the resilience and quality of medical care and services for the residents of Long-Term Care Facilities in the state of NJ by providing a dedicated team to support health, safety and quality via data-driven guidance. The Office, which will be led by an Executive Director, will report to the Deputy Commissioner of the Integrated Health Services Branch.

The appropriated $1.1 million will be used for the salaries of the office's staff (Executive Director, part-time Medical Director, Emergency Operational Coordinator, Nursing Consultant (Quality & Infection Control), Data/ Analytical Lead, and a Secretary as well as the general and administrative costs for the support of the office(computer hardware/software, office supplies and general office operations). To date all position requests have been submitted, posted, and the Branch is ready to start the interview process.

Healthcare Facility Oversight

8. How many healthcare facilities (inpatient and outpatient), long-term care facilities, and community service programs is the department required to inspect?

There are over 4,000 licensed and/or federally certified health care facilities, including acute care hospitals, behavioral health facilities, nursing homes, assisted living facilities, Federally Qualified Health Centers, renal dialysis facilities, home care agencies, and ambulatory surgery centers. Oversight is required to ascertain compliance with regulations, assess minimum quality and safety standards, and assess access to health care for all citizens.

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a. At what frequency are the inspections required for each facility and program type?

FACILITY TYPE	COUNT	Inspection Frequency	Required Inspection Frequency
AMBULATORY CARE FACILITIES (Stand alone, Hospital based and Satellite)	1058	Currently in response to complaints	N.J.A.C. 8:43A-2.2(m) - Biennial inspection
HOSPITALS (General Acute, Comprehensive Rehab, Psychiatric, Special/LTACH)	108	Currently in response to complaints	N.J.A.C. 8:43G-2.2(g) - Biennial inspection Using Accrediting Body for "deemed status"
HOME HEALTH AGENCIES	42	DOH has the authority to conduct Federal inspections on behalf of CMS which is - 9 months for those without deemed status.	N.J.A.C. 8:42-2.2(f) - Biennial inspection
HOSPICES & BRANCHES	81	DOH has the authority to conduct Federal inspections on behalf of CMS which is - 9 months for those without deemed status	N.J.A.C. 8:4A-2.4(k) - Biennial inspection
MATERNAL & CHILD HEALTH CONSORTIA	3	Biennial by regulation	N.J.A.C. 8:33C-4.1(c) - Biennial inspection
PEDIATRIC COMMUNITY TRANSITIONAL HOMES	3	Currently in response to complaints	N.J.A.C. 8:43D-2.1(c) - Biennial inspection
SURGICAL PRACTICES Registered	162	N/A	N/A
Total Acute Care Facilities	**1,457**		
Long Term Care Facilities			
ADULT DAY	155	Currently in response to complaints	N.J.A.C. 8:43F-2.1(a) - Biennial inspection

ALTERNATE FAMILY CARE	4	Currently in response to complaints	Biennial inspection
ASSISTED LIVING PROGRAMS	15	Currently in response to complaints	N.J.A.C. 8:36-2.2(p) - Biennial inspection
ASSISTED LIVING RESIDENCES	206	Currently in response to complaints	N.J.A.C. 8:36-2.2(o) - Biennial inspection
COMPREHENSIVE PERSONAL CARE HOMES	34	Currently in response to complaints	N.J.A.C. 8:36-2.2(o) - Biennial inspection
NURSING HOMES – CMS Certified	360	Federal CMS schedule of every 9 – 15 months	No State Schedule - Federal CMS schedule of every 9 – 15 months
HOSPITAL BASED LTC SUBACUTE	5	Federal CMS schedule of every 9-15	No State Schedule - Federal CMS schedule of every 9 – 15 months
PEDIATRIC DAY	17	Currently in response to complaints	N.J.A.C. 8:43J-2.4(a) - Biennial inspection
RESIDENTIAL HEALTH CARE	13	Currently in response to complaints	N.J.A.C. 8:43-2.1(a) - Biennial inspection
DEMENTIA CARE HOME	28		N.J.A.C. 8:37-2.1(i) - Biennial inspection

Total Long-Term Care Facilities	**837**		
Behavioral Health Facilities			
Substance Use Disorder	1,135	Every two years	Every two years
Mental Health Residential	172	Annual (alternate between desk review and onsite)	Annual (alternate between desk review and onsite)
Mental Health Ambulatory	1,175	Every three years	Every three years
Total Licensed Facilities	**4,776**		

9. How many staff members are employed by or contracted with the department to conduct inspections?

Health Facility Survey & Field Operations
52 Long Term Care (LTC) Surveyors
12 LTC Complaint Investigators
5 Medical Day/AL Surveyors
28 Acute Care Surveyors
97

Behavioral Health - Certificate of Need & Licensing
12 Mental Health Inspectors
11 Substance Use Disorder Inspectors
23

Contracted surveyors (CertiSurv)

The NJDOH initially contracted with CertiSurv to perform 100 Focused Infection Control Surveys at all CMS certified facilities, by July 31 in accordance with CMS deadlines. The contract has been expanded to complete 150 Focused Infection control surveys of non-CMS certified facilities and to complete 285 pending complaints.

a. Are there any funded vacancies in the Division of Health Facilities, Survey and Field Operations; and the Division of Certificate of Need and Licensing? If so, how many?

As of September 11, 2020, there are no funded vacancies in the FY 2020 appropriation. With the recommended increase of 10 positions in FY 2021, DOH will have 9 funded vacancies beginning October 1, 2020.

b. Does the department intend to fill all vacancies?

Yes

c. What are the barriers to filling the positions?

Barriers include difficulty finding qualified candidates and a longer than average hiring process. From 12/1/18 to 12/1/19: 15 new surveyors were hired; 11 retired/resigned/transferred. The NJDOH has a continuous job posting and interviews are held regularly to bring in more surveyors. Due to the prescribed federal training, the complexity of processes and surveyor certification requirements it takes around one year for a surveyor to be fully certified and ready to go into the filed by themselves or as part of a standard survey team.

COVID-19 Preparedness

10. What pandemic preparedness and response plans did the department put in place since 2018?

Since 2018 the Division of Emergency Preparedness has been updating/revising all preparedness and response plans for the Department including:

- Panflu Plan
- All Hazards Plan
- Strategic Stockpile Plan
- COVID-19 Community Intervention Implementation Plan Summary

CDS has SMEs that have provided planning/response efforts in all the documents. As recently as last October, CDS and ODR met to provide guidance/review their Mass Vaccination Plan.

11. What department personnel are responsible for emergency response?

The Public Health Infrastructure, Laboratories, and Emergency Preparedness (PHILEP) Division works all year round with the NJ Office of Emergency Management to plan and prepare for disaster response and resiliency efforts.

a. Following news of a COVID-19 outbreak in China, at what point where they consulted?

The Emergency Response Division was monitoring the outbreak in Wuhan, China in early January 2020 and held the first DOH Crisis Management Team (CMT) meeting on January 24, 2020. The CMT met daily through from January 24th until March 30th. The team reviewed and updated the Emergency Response Plan; monitored the developing pandemic and coordinated the screening procedures at EWR in conjunction with our state and federal partners.

12. Prior to the pandemic, what efforts had been made by the department to ensure the State had an adequate supply of personal protective equipment?

The State stockpile of supplies pre-pandemic focused on Hurricane sheltering needs including bottled water, diapers, clothing, and Meals Ready to Eat(MRE). Very minimal PPE supplies were in that cache. However, NJDOH maintained the Hall's Warehouse contract for Strategic National Stockpile deliveries in preparation for federal shipments of PPE.

a. Please describe the State's current supply of personal protective equipment and assess the security of the State's supply chain.

The State through the Office of Emergency Management (OEM) is currently procuring 5 categories of PPE (N95 Masks, Surgical Masks, Face Shields, Gowns, & Gloves) for Hospitals, LTCFs, 17 State Agencies, FQHCs and for testing. The State has been able to procure most of our needs through a variety of vendors. We are impacted by the nitrile glove global supply shortage but have been able to meet 3/4 of our stockpile goal. The below shows the inventory in state control and does not reflect PPE with the agencies or county OEMs.

IV. Inventory *(as of 09/09/20)*

Operational Inventory (Hall's)	Coveralls	Face Shields	Gloves	Surgical Gowns	N95 Masks	Surgical Masks
Total	225,874	7,972	3,235,500	1,042,586	4,225,650	679,100

Stockpile Inventory (Hall's)	Coveralls	Face Shields	Gloves	Surgical Gowns	N95 Masks	Surgical Masks
Total	0	1,200,000	0	1,000,000	500,000	0

Stockpile Inventory (AMS)	Coveralls	Face Shields	Gloves	Surgical Gowns	N95 Masks	Surgical Masks
Total	0	120,120	0	113,520	520,000	1,020,000

As of 09/09/20

b. What actions is the department taking now to ensure the State has adequate personal protective equipment in the event of a second wave of COVID-19 infections?

The State has taken a multi-layered approach starting with mandating that Hospitals and LTCFs have their own formula-based PPE stockpile. These mandates require hospitals to have 3 months of surge-level PPE and for LTCFs to have 1-2 months (depending on the number of facilities they

have in NJ). The second layer is at least one month of PPE stockpiled at County OEMs. This is backed up by the State having a 3-month emergency stockpile for PPE. Also, there is an emergency stockpile in place for testing and one in development for vaccinations.

c. Does the State have a formula to allocate personal protective equipment?

The stockpile targets are based on a formula; distribution is based on the requests made and in close consultation with OEM who maintains the stockpile.

d. How is the distribution prioritized?

Distributions from the State stockpile will be made after the requestor has exhausted their stockpile and is unable to obtain any from their own county OEM. All decisions will be made in close consultation with the State Emergency Operations Center and OEM who maintains the stockpile. The expectation is that all facilities will maintain their own operational and strategic stockpile inventories and will only access the state's stockpile in an emergency.

e. What entities are eligible to receive personal protective equipment from the State stockpile?

Hospitals, LTCFs, FQHCs, 17 identified State Agencies and County OEMs will all be eligible to receive PPE from the stockpile.

13. Following an adenovirus outbreak at the Wanaque Center, the Legislature and the department designed protocols to provide protection to residents in nursing homes. What steps did the department take ahead of the COVID-19 outbreak to protect these residents?

In response to outbreak of infection at the former Wanaque Nursing Home and at other long-term care facilities throughout the state in 2019, the N.J. Department of Health (DOH) issued policy recommendations for infection control from both infection control and facility survey perspectives to help prevent and control future contagious disease outbreaks. The report (https://nj.gov/health/healthfacilities/documents/Wanaque%20Policy%20Report_DOH_06062019.pdf), recommended policies to strengthen the State's and long term care facilities' (LTCs) capacity to respond to outbreaks. Some policies outlined in the report were enacted into statute. Under N.J.S.A.2H-12.87, all LTCs must have an outbreak response plan and for facilities that have ventilator dependent patients, the plan must be submitted to the DOH. The plan must satisfy certain criteria including but not limited to:

- a plan for the notification of residents and caregivers of a contagious disease outbreak;
- implementation of an infection control committee;
- a protocol for isolating and cohorting infected and at-risk patients in the event of an outbreak;
- information on the availability of laboratory testing;
- protocols for assessing whether facility visitors are ill and requirements that ill staff not present to the facility for work duties; and
- a process for implementing evidence-based outbreak response measures.

- On March 6, the Department of Health issued a memo reminding all long-term care facilities to uphold their infection prevention response plans. For facilities with ventilator beds, the NJDOH reminded them of the deadline to submit the plans to NJDOH. All facilities complied with the submission of an outbreak plan.

The first documented outbreak in an assisted living was reported on March 11, 2020. Since that date the NJDOH has issued more than 20 documents giving guidance, waivers for staffing and other emergency preparedness so long-term care facilities could respond to the pandemic. The Communicable Disease Service (CDS) was actively involved in responding to the adenovirus outbreak at Wanaque, including the involvements of the Infection Control Assessment and Response (ICAR), who joined a team working with the local health department and the facility. There was an ICAR revisit on 11/1/2018.

- Infection prevention and control efforts following that event included outreach and on-site ICAR assessments at all (4) pediatric LTCFs in NJ and an additional 15 ICAR assessments with LTCF throughout the state.
- CDS's ICAR/HAI team developed the "Infection Control Assessment and Response (ICAR) 2.0 Tool" to assess facility Infection Prevention and Control programs with an emphasis on outbreak response and multi-drug resistant organism prevention and containment. This tool was piloted with 3 ventilator skilled nursing facilities, spending over 120 hours on-site working with facility leadership and staff to strengthen IPC and provide education on Candida Auris, a deadly fungus spanning across the globe and impacting NJ healthcare facilities. The ICAR 2.0 Tool was revised and rolled out to LTCFs with residents at higher risk of acquisition of MDROs (e.g., sub-acute units, indwelling medical devices). A total of 7 LTCFs partnered with ICAR for an ICAR 2.0 assessment. Limited resources coupled with COVID-19 interrupted our 1:1 work with these LTCFs.
- NJDOH recorded a webinar that partnered CDS with Health Facilities Survey & Field Operations to highlight common gaps or opportunities for improvement in LTCF based on routine survey data, followed by NJ LTCF ICAR assessment gaps. This webinar highlights resources publicly available to strengthen IPC programs and mitigate identified gaps.
- The ICAR team continues to send routine communications or "e-mail blasts" to share important updates, information, or resources available to further support IPC in NJ healthcare facilities.
- Delivered multiple presentations through our Infection Control/Antimicrobial Resistance quarterly webinar series, and through partner organizations such as the local chapters of the Association for Professionals in Infection Control and Epidemiology (APIC) and the Health Care Association of New Jersey's Top Gun course.
- The ICAR team partnered with 29 LTCFs using the COVID-19 Infection Prevention and Control Assessment Tool (Tele-ICAR) for Long-Term Care and Assisted Living Facilities. The ICAR team provided 19 virtual consultations. Each COVID-19 tele-ICAR partner received a fluorescent marking gel mini kit (an IPC resource) which has supported the competency-based training of 99 staff.
- Develops resources to support infection prevention and control gaps while reviewing existing ICAR resources to maintain current recommendations. ICAR resources are available on the NJDOH Communicable Disease Service, Healthcare-associated Infections, at https://www.nj.gov/health/cd/topics/hai.shtml . Most recent resources include:

    - COVID-19 Infection Prevention and Control Assessment Tool (Tele-ICAR) for Long-Term Care and Assisted Living Facilities

- Caught Red-Handed (a hand-hygiene activity)
- Infection Control Auditing Guidance
- Hand Hygiene in Healthcare Settings

P.L.2019, c.243 was passed after the Wanaque outbreak in 2019. It provides infectious control guidance for LTCs and facilities "equipped with medical ventilator machines." CDS produced guidance/messaging related to COVID-19 beginning on 1/9/20, and specifically for LTCFs beginning on 3/4/20.

14. How often are nursing homes inspected for safety protocols?

NJDOH inspects nursing homes every 9-15 months for compliance with both State and Federal regulations. Annual surveys are conducted by a multidisciplinary team including nurse, a dietitian, a pharmacist, and a life safety code inspector. The survey occurs over multiple days and usually totals around 200 survey hours.

15. The State commissioned a report on more effective ways to prevent the spread of a communicable disease in nursing homes. What steps have been taken to protect residents in nursing homes in the event of a second wave of COVID-19 infections?

NJDOH has regularly worked with LTC facilities and local health departments HFSFOs to encourage good infection control practices. In addition, CDS helped draft the State issued Executive Orders/Directives related to LTCFs – including provisions related to surveillance testing of staff and residents. DOH continues to work with its partners (i.e., LHDs and facilities) related to infection control and surveillance issues. The DOH entered into agreements with three long term care system providers to secure 1,229 beds for COVID + patients that could not be re-admitted or newly admitted safely, in accordance with NJDOH protocols and guidance, across the state. The Department of Health commissioned the Mannatt report. The Manatt Report was delivered on June 2, 2020. The Department of Health reviewed and analyzed the recommendations and subsequently developed a project plan.

COVID-19 didn't create the problems identified in the Manatt report – it exacerbated the long standing, underlying systemic issues affecting nursing home care in New Jersey. According to the report, while COVID-19 has shone a light on the structural deficiencies in how LTC services are provided and funded, it also presents an opportunity for meaningful change.

The report presented eleven main categories of recommendations divided between those which could be addressed in the near term (36 sub recommendations) and those that would take greater time, interdepartmental collaboration or even legislative action to effectuate (50 sub recommendations)

To date, the Department has completed 24 of the 36 near term recommendations with another eleven in progress. Three of the intermediate sub-recommendations are in progress as well.

Examples:

- Deputy Commissioner of Public Health at NJDOH was hired 6/22/20
- Established the LTC Emergency Operations Committee as the centralized emergency command and resource for response efforts and communications

- Executive Directive for Re-opening LTC facilities provided guidance, as a condition of reopening, that every facility have the following: Adequate isolation rooms/capabilities and the ability to cohort both staff and patients; an adequate minimum supply of PPE and test kits; and sufficient staffing and a staffing contingency plan and appropriate staff training to carry out its responsibilities.
- Established the DOH/DHS workgroup to align and troubleshoot on LTC issues and coordinate on key ongoing priorities impacting both departments, such as data-driven monitoring, quality, and payment methodology.
- Required LTC facilities to publicly post (i.e., on websites) policies otherwise required to be compliant with state law, including outbreak response plans, and have designated staff available to answer questions on policies.
- Mandated that every facility have a senior level infection control preventionist who reports to the CEO and the Board of Directors. For facilities with over 100 beds, this position should be full-time, and the person should not have any other responsibilities.

DOH/CDS has developed numerous resources and made them available in the event of a second wave of COVID infections, incorporating lessons learned since the introduction of COVID-19 into these vulnerable settings like nursing homes. First and foremost, frequent and proactive testing is a key tool that is important to detect the introduction and spread of COVID-19, so other infection prevention measures can effectively and rapidly be implemented. DOH recommended and then required ongoing weekly staff testing and weekly testing of all residents for at least 14 days during an investigation. In addition, DOH developed cohorting guidance, outbreak recommendations (PPE, cleaning, screening etc.), a COVID outbreak checklist, resources for healthcare personnel (HCP) risk assessments, and guidance for HCPs returning to work and residents to be taken off transmission-based precautions and isolation.

Also, DOH instituted a phased reopening of facilities with executive Directive 20-026 (and closing if necessary), based on the Stage of Reopening for New Jersey, of services to protect residents and staff which includes visitation, communal activities, trips outside the facility, and dining, PPE stockpile, emergency communications, data reporting, and infection control among others. directive that balances the health and well-being of residents with having proper infection control and employee safety protections.

The Directive has 4 phases for facilities to reopen:

Phase 0: Any facility with an active outbreak of COVID-19;

Phase 1: Facilities that never had an outbreak or that concluded an outbreak, and 14 days have passed since New Jersey moved to Stage 1 (May 2, 2020) of the Road Back to Recovery and the facility has submitted all the attestations required in this directive.

Phase 2: Facilities that never had an outbreak or that concluded an outbreak and 14 days have passed since New Jersey moved to Stage 2 (June 15, 2020) of the Road Back to Recovery and the facility has submitted all the attestations required in this directive.

Phase 3: Facilities that never had an outbreak or that concluded an outbreak per and 14 days have passed since New Jersey moved to Stage 3 (DATE TBD) of the Road Back to Recovery, and the facility has submitted all the attestations required in this directive.

For facilities to reopen there are a series benchmarks they must meet and corresponding attestations they must submit.

Facilities must conclude an outbreak. An outbreak is considered concluded when a facility has 28 days – two incubation periods – with no new positive staff or residents.

They are required to continue re-testing staff. Staff testing must be conducted weekly.

They must be fully staffed and have a plan to bring on additional staff in case of an outbreak or an emergency

It is essential that they have enough PPE. 8 or more facilities in a system must have one month, facilities that are not part of a system or a system with less than 8 facilities must have 2 months in stockpile, and the stockpile is for emergencies only and not for daily use.

They must have an updated outbreak plan with lessons learned from the COVID-19 pandemic. The plan must also include a communications strategy that outlines regular communication with residents and families about cases and outbreaks in the facility or any other emergency. The plan must also include methods for communication including video conference in the event of visitation restrictions

The plan must be posted on their website for the public to review.

Facilities with more than 100 beds or hemodialysis must contract with an infection control service within two months and must hire a full-time employee in the infection control role within one year of the directive enactment.

Facilities with ventilator beds are required to hire an infection control employee in accordance with current statute.

Within two months of enactment of the directive (October 10, 2020), facilities will need to start submitting data to the National Healthcare Safety Network.

When a facility is in Phase 2 and has submitted all the attestations required in this directive, indoor visitation by appointment will be allowed only for residents who are either COVID (-) or have recovered from the disease. Once visitation can begin, there will be rigorous infection prevention and control protocols facilities must follow.

For residents residing in facilities that meet requirements for Phase 2, DOH is also allowing additional activities for more social interaction.

Limited communal dining will be allowed for individuals who are COVID negative, asymptomatic or recovered.

Residents who are COVID negative, asymptomatic or recovered will also be able to enjoy haircuts, small group activities and participate in limited outings.

Recognizing that some residents need additional support regardless of the situation at their facility or their COVID status, we are allowing an essential caregiver for all residents with proper precautions such as screening and the use of PPE.

16. Please describe the status of the State's health care workforce. Are facilities and providers reporting shortages? If so, in what settings and for what type of professionals?

Anecdotally, we are aware of shortages throughout all levels of the healthcare workforce. Facilities and providers do not formally report shortages to DOH, but to the federal government. DOH has required that facilities have plans in place to address shortages.

During the Pandemic's response, the State set up a portal for healthcare workers seeking employment. Information for 5,500 individuals was provided to facilities and the industry associations from the portal. In addition, the Division of Consumer Affairs waived many requirements in order to increase the number of healthcare workers in NJ.

Information Technology

On its website, the department describes efforts to enhance the use of technology and electronic delivery systems to improve the provision of health care services to patients; facilitate communications between the department and providers; streamline billing and the use of electronic health records; and facilitate data collection, processing, and analysis. The COVID-19 pandemic has demonstrated the need for upgrades to the State's data collection, processing and analysis capabilities.

Questions:

17. What is the status of the department's various projects and initiatives to enhance the use of health information technology? Does the department anticipate the need for additional appropriations to support these projects and initiatives in FY 2021, and if so, in what amounts? Is the department able to leverage any federal COVID-19 funds in such a manner that its information technology infrastructure and systems could be permanently enhanced as a side effect?

The department continues to utilize technology to further programmatic initiatives and needs to modernize systems and expand knowledge management and workforce automation. Examples include:

1. Automating the healthcare facility licensing process and ensuring external partners and staff can use the web-based software to initiate and renew licenses.
2. Internal workforce improvement initiatives utilizing workflow management tools to eliminate paper processes

3. Developing the statewide vital statistics platform (birth through death), and data analytics platforms.

The department also maintains CDRSS, the state system of record for over 120 communicable diseases including COVID-19, Childhood Lead, HIV and STDs, Hepatitis, and other infectious diseases. We also maintain the statewide immunization information system (NJIIS), which is being modified to accommodate COVID-19 vaccines for both adults and children.

From a technical perspective, there are several planned health information technology initiatives, leveraging the federal COVID-19 funds. These initiatives, while helping with the immediate needs during the COVID-19 pandemic response, will also measurably improve the sustainability of technical and operational capabilities for NJDOH.

1. Simplified reporting mechanism for labs that do not have robust systems with HL7 data exchange capabilities has been developed and is in use. The CSV to HL7 reporting method leverages the existing Rhapsody interface engine but is a new route.

2. Efforts to streamline and support additional demographic variables for electronic laboratory reporting (ELR) are currently in progress, as we work with our data exchange partners to evaluate their capacity for reporting race, ethnicity, SOGI variables, in addition to ensuring patient address and phone number are included. Additional staff will be hired to ensure complete and timely reporting, faster onboarding for ELR, and enhanced data quality review for labs reporting via web entry directly into CDRSS.

3. Efforts to implement electronic case reporting (eCR) are also under way, which will be for specific diseases (possibly immediately reportable diseases or others whereby additional clinical information is critical to ensure accurate diagnosis and public health response). These eCR notifications will be received directly from the hospital or medical facility in the initial case report with additional clinical data elements. Plans include leveraging the New Jersey Health Information Network (NJHIN) as a partner for eCR. To that end, data exchange supporting sending/receipt of CCD/C-CDA is under development. The ability for the Communicable Disease Reporting and Surveillance system to receive data from ADT messages (Admit, Discharge, Transfer) for hospitalized patient and/or long-term care facilities is also planned.

4. Moving data to secured, HIPAA-compliant cloud environments to improve performance, reporting capabilities, and access to data for authorized users.

5. Long Term Care provider engagement to establish interoperability and sustainable technical infrastructure are also proposed.

6. Upgrades to the Electronic Death Registry System (EDRS) to support access via multiple internet browsers are also in progress to ensure continued use by stakeholders.

7. Upgrades to CDRSS and NJIIS technical architecture/server capacity are in progress. Several improvements Interoperability between CDRSS and NJIIS related to vaccination histories is also planned.

While federal funds will likely sustain the health information technology initiatives within NJDOH for FY 2021, dedicated annual funding for the Communicable Disease Reporting and Surveillance System (CDRSS)

and New Jersey Immunization Information System (NJIIS) will support the ongoing sustainability of these efforts.

18. What initiatives has the department undertaken to expand infectious disease data collection and reporting capabilities during the COVID-19 pandemic? What steps have yet to be taken to optimize infectious disease outbreak identification, data collection, and reporting? Are the system upgrades that the department has implemented to date enough to manage another surge in COVID-19 cases in the State? If not, what resources are needed to optimize the department's capabilities?

DOH has expanded existing electronic surveillance systems to accommodate data management and analysis needs for COVID-19. Greater functionality has been added to the Communicable Disease Reporting and Surveillance System (CDRSS), the database used to receive all reportable disease data. DOH's Communicable Disease Service (CDS) has also worked to develop a COVID-19 custom classifier in EpiCenter, which is the state's syndromic surveillance system. This allows CDS epidemiologists to monitor acute care visits and admissions overall and specifically related to COVID-like illness.

In addition to improving existing systems, CDS worked with other divisions in the Department of Health to expand the number of data sources used to provide timely data on COVID-19. CDS established a mechanism with Vital Statistics to provide CDS with access to death certificate data that is used to update mortality status on known COVID-19 cases and to identify persons who died with COVID-19 listed as a contributing cause of death that were not previously reported to NJDOH. DOH is also working to incorporate data provided by hospital discharge/universal billing data. Once complete, this will improve data quality and provide more complete data on hospitalization rates and length of stay and disease severity (whether the person needed ICU care and/or mechanical ventilation).

In order to collect timely data on long-term care facilities and outbreaks, DOH developed electronic reporting systems for facilities to provide data daily. This data is used by CDS epidemiologists to work with local health departments and long-term care facilities on outbreak control. Owing to the large number of outbreaks (over 670 to date) in these settings, electronic reporting is essential. Additional staffing resources were needed to develop the system and is needed maintain this system.

From a technical perspective:

- The Department of Health has launched a COVID-19 Contact Tracing Program, including procurement, custom configuration, and implementation of a new software application (CommCare), which is being used statewide. CommCare and CDRSS are interoperable and near real-time bidirectional data exchange has been implemented between the two systems. The implementation of a new app COVID Alert NJ to supplement contact tracing efforts in NJ through anonymized exposure notification is currently in progress.
- We have developed alternate mechanisms for reporting of lab data to CDRSS (CSV file), have onboarded over 1,600 new users to CDRSS, and onboarded 35 new ELR (Electronic Lab Reporting) partners (reporting electronically via HL7 standard messaging protocol) since March 2020. We have also leveraged approved and existing person search engines to get address and phone number data for COVID-19 cases and contacts to facilitate contact tracing.

- NJDOH has also rolled out a new feature of CDRSS, the Outbreak Module (as of April 2020) and are working on requested enhancements and to the Outbreak Module. We are also implementing enhancements in CommCare to support early alert/detection of possible clusters and outbreaks. Workflows and data related to outbreaks/clusters between CDRSS and CommCare are being harmonized.
- Efforts are currently underway to ensure that we receive lab test data from all facilities currently using rapid antigen testing for COVID-19.
- System upgrades to CDRSS have shown significant improvements in ELR processing capacity, supporting the increased number of users/overall demand on the system. Additional upgrades are planned within the near future to further ensure enough capacity. Upgrades to NJIIS are currently in progress and include implementation of higher capacity server, Oracle upgrades, improved interface capacity, creation of an additional mechanism to report doses administered data (expanding on current HL7 reporting capacity) and streamlined onboarding of new provider sites and users. The near-term upgrades should ensure that CDRSS and NJIIS are prepared for a possible surge in COVID-19 cases. Longer term upgrades to migrate to a cloud environment and leveraging interoperability with the New Jersey Health Information Network (NJHIN) are also planned.

19. How does the department utilize electronic data collection and reporting systems to track supplies of personal protective equipment (PPE) and workforce shortages in health care facilities across the State?

The NJDOH has partnered with NJHA to create a portal that captures over 105 data elements to include PPE inventories and staffing shortages. When the supply chain was experiencing major shortages, staff members would evaluate PPE inventories and send items based on formulas and burn rates, as indicated in the formula/portal.

a. What systems is the department using to disseminate pandemic response guidance, directives, and other COVID-19-related information to health care facilities?

This information has been sent numerous ways, including through calls and other communication with stakeholder groups, through the Health Alert Network, posting on websites, and communications from various other departments/divisions.

Cancer Epidemiology Services has been in contact with all hospital registrars to inform them of the new cancer surveillance COVID-related data items. We have generated a training video with coding guidelines, have shared guidance through our monthly newsletter to registrars in the State of New Jersey and the New York City and Philadelphia metropolitan area (NJSCR e-Tips), and working with the State cancer registrar association, Oncology Registrars Association of New Jersey (ORANJ) to ensure that COVID-related data items are abstracted and coded properly. CES is working collaboratively with NCI and its database administrators to develop a process that would allow staff to monitor incoming records. CDS and Consumer, Environmental, and Occupational Health Services use LINCS to disseminate guidance and COVID-19-related materials to stakeholders.

20. What is the number of New Jersey hospitals that have signed up to participate in the New Jersey Health Information Network, which facilitates the electronic exchange of patient health information?

All 71 hospitals have signed up to participate in the NJHIN network.

a. What role has the New Jersey Health Information Network played in responding to the COVID-19 pandemic?

COVID-19 response has relied most heavily on other systems such as CDRSS, however NJDOH's Health Information Technology Division has multiple efforts planned to support response efforts moving forward. The following are brief descriptions of three federally funded projects:

1. Electronic Case Reporting: Capacity Development

This effort allows healthcare providers and hospitals to send case reports regarding a patient's infectious disease status to the state registry system via NJHIN. This will automate the process and improve the timeliness of critical information such as hospitalization, discharge diagnosis, mortality, etc. COVID-19 and four other identified priority communicable diseases reporting will be supported through the capacity development.

2. Transitions of Care Use Case Data Enhancements

Surveillance activities relating to the analysis requires additional data collection support so that capacity, resources and interventions can be informed to address information sharing and health equity. Infrastructure to create alert functionality will be developed to support COVID-19 surveillance and information sharing and can be leveraged and replicated for other disease conditions, environmental, and/or social factor data points. This will establish bi-directional alerts between the NJDOH and attributed healthcare providers, or between providers, with the NJHIN as the transmission source.

3. Interoperability Promotion: LTC Provider Engagement

Long term care (LTC) facilities are in various maturity stages in relation to being interoperability ready. Some facilities do not utilize electronic health records while others operate on current versions and are connected to the NJHIN. This initiative will engage LTC facilities to acquire or upgrade a 2015 ONC certified EHR that is ready for information sharing through API, HL7, and FHIR functionalities. The scope includes the costs of vendor software, training, and rollout support. The facilities will be assisted in onboarding to the NJHIN to promote interoperability, specifically use cases for sending and receiving ADT notifications and a specialized Transitions of Care (CCD). An expansion of capacity to include 30 long-term care facilities will increase use case participation. An increased volume of engaged providers contributes to long term sustainable interoperability and reporting value.

Fiscal Year 2021 Revised Budget Proposal
Questions for the Department of Health

COVID-19 Contact Tracing

In July 2020, the Department of Health entered a $23.5 million, three-month contract with Public Consulting Group for the provision of contact tracing services by 1,200 tracers. According to the department's July 24, 2020 press release, the contractor would support local health departments across the State. It is not clear how the contractor's efforts would be coordinated with those of an existing contact tracing partnership into which the department had entered with Rutgers School of Public Health. A June 10, 2020 Rutgers press release noted that the Community Contact Tracing Corps Program sought to hire, train, and deploy 1,000 graduate students as contact tracers. News reports indicate that Rutgers would be paid $16.3 million to operate the Community Contact Tracing Corps Program through September 15. In addition, the State spent $1.9 million on a uniform, statewide contact tracing platform.

Questions:

21. How much has the State expended thus far on contact tracing activities? How much does the State anticipate spending on contact tracing in FY 2021? How are contact tracing activities funded? How much will be charged to the Coronavirus Relief Fund or other federal funds? What amount of total contact tracing expenditures has paid for staffing and for information technology? Does the department have enough funding to engage in an appropriate level of COVID-19 contact tracing for FY 2021? If not, what does the department anticipate the shortfall to be?

NJDOH currently has approximately $201.8 million ($166.2M for contact tracing and $35.6M for data and disease surveillance IT improvements) reserved from federal funds received via the 'ELC Enhancing Detection' funding for the Enhanced Detection, Response, Surveillance, and Prevention of COVID-19 Supported through the Paycheck Protection Program and Health Care Enhancement Act of 2020 from CDC. Please see table below for additional detail.

We believe this to be enough funding to support an appropriate level of contact tracing.

Expenditure	Federal Funds Reserved	Vendor	Amount Contracted to date	Amount Expended to date
Staffing	$140.3M	RUSPH	$13.3M *($11.6M for contact tracer salaries, $1.7M for vendor cost)*	$0
		PCG	$23.5M *($22.1M for contact tracer salaries, $1.4M for vendor cost)*	$0
IT-Contact Tracing	$18.9M	Dimagi CommCare	$2.3M	$500K
		NJIT	$2M	$539K

		Dell	$1.33M	$0
		Kapstone/Amazon Web Services	$416K	$0
		Trumpia	$332K	$332K
		NearForm	$2M (projected)	$0
IT-Data/Disease Surveillance	$35.6M	NJIT	$22M (projected)	$0
Public Awareness Campaign	$7M	Kivvit	$2.9M	$2M
TOTAL	**$201.8M**		**$70.1M**	**$3.4M**

22. What is the relationship between Rutgers School of Public Health contact tracing activities and those of Public Consulting Group? Given that Rutgers was already developing a sizeable contact tracing workforce, for what reasons did the department decide to hire a contractor to provide such services as well?

RUSPH developed and administers virtual training via a Learning Management System for all contact tracers hired by the State. The plan was always for RUSPH to serve as an interim support solution, where RUSPH recruited and trained graduate students to serve as contact tracing staff for our local health departments as quickly as possible while the State completed the procurement process for a longer-term vendor solution. RUSPH is an institution of higher learning, not a staffing vendor, and though extremely helpful in a critical time is not equipped to support rapid recruitment, deployment, and management of a large-scale workforce outside of the student population in the event of a second wave. This plan was discussed with RUSPH and announced by the Governor on May 12, 2020 at the daily press briefing.

Going forward, RUSPH will continue to manage the training platform and modify the training modules as necessary to ensure the materials is always up to date with current guidelines, while transitioning all staffing activities to PCG. PCG will handle recruitment, onboarding, performance management, and other workforce management activities for the state contact tracing program. All contact tracers hired by RUSPH have been given the option to transition to PCG, if their academic schedule allows for full-time employment.

23. What role are the local health departments playing in the State's contact tracing program?

LHDs are required by statute to control communicable disease in their jurisdiction and have always played a critical role in contact tracing. As the primary conductors of contact tracing even before COVID-19, they are the backbone of the program. The State's role is to augment their regular contact tracing duties to meet the scale and volume of the need presented by COVID-19. LHDs effectively manage the augmented workforce including scheduling according to the needs of their county/jurisdiction and assigning case investigation and contact notification via the statewide contact tracing platform, CommCare. NJDOH is in

regular contact with LHDs via our Office of Local Public Health to monitor performance, review data dashboards, and troubleshoot issues where they arise.

24. Please describe the status of the State's contact tracing program. How many contact tracers have been hired? How many have been trained and are currently providing services? Has the CommCare technology platform been implemented and is it operational across all the local health departments? What are the demographics of the contact tracers? Are most of the newly hired individuals New Jersey residents? Do the contact tracers appropriately represent the communities most impacted by COVID-19?

As of July 6, 2020, CommCare was implemented and operational across all local health departments. As of September 5, 2020, the statewide contact tracing workforce includes 1,835 contact tracers. Approximately 770 of those were hired and trained by RUSPH. Of the demographic information we have, of those hired by RUSPH, more than half identified their race as Black, Asian, or other non-White races and 12% identified as Hispanic. Most of the individuals hired through RUSPH were students or alumni of New Jersey colleges/universities. Many of our contact tracers speak languages other than English. For those that don't, we have provided access to Language Line services to ensure all NJ residents can communicate effectively with our contact tracers.

25. How effective will graduate students be in communicating with COVID-19 positive individuals and the individuals with whom they interacted? Why has a major qualification to be a contact tracer been that they have an advanced degree? Are there metrics that indicate someone with an advance degree would make a more effective contact tracer?

The State's contact tracing position does not require an advanced degree. The draft job posting shared in the Request for Quotes in May requires only a high school diploma. This was a purposeful action to allow for a more inclusive workforce and broader opportunity for residents of New Jersey from all walks of life to have an opportunity to serve their communities in an important and meaningful way in the time of crisis, and seek virtual employment in a time when many people were without work. The interim job posting under RUSPH had higher education requirements given that RUSPH is a graduate school and was gearing recruitment toward graduate students and alumni. The assumption was that all the presumed candidates would meet these requirements given the target population. We acknowledge that good contact tracing is a skill that must be learned and refined over time, but we are not aware of metrics that indicate individuals with degrees, advanced or otherwise, make more effective contact tracers. We maintain that graduate students could be just as capable as any well-trained, coached, and practiced individual at contact tracing. In addition, as we see cases increase among high school students and college-aged young adults, having contact tracers from the same age demographic may be beneficial in eliciting information during a phone interview.

Health Care Subsidy Fund Payments

The Executive has requested $51.7 million in General Fund appropriations to support the Health Care Subsidy Fund (HCSF) in FY 2021. In the 12-month FY 2020, the HCSF did not receive any support from the State General Fund, notwithstanding the $44.5 million in available resources in the account. The $44.5 million is currently placed in budget reserve, perhaps in anticipation of a lapse into the State General Fund at the end of the 15-month FY 2020. In general, the HCSF is primarily funded by dedicated revenue, but draws on the General Fund appropriation as a final source of funding when other revenues are insufficient to pay the fund's expenses. The fund supports, among other programs, the State's Charity Care program, NJ FamilyCare, the State's Federally Qualified Health Centers, and the New Jersey Quality Improvement Program (formerly the Delivery System Reform Incentive Payment (DSRIP) program).

Questions:

26. Will the $44.5 million that is currently placed in budget reserve in the Health Care Subsidy Fund Payments account be used to support the Health Care Subsidy Fund or is it intended to lapse into the General Fund at the end of September? Why is it necessary to appropriate $51.7 million to the Health Care Subsidy Fund in FY 2021 when the fund did not receive any General Fund support in the 12-month FY 2020? Are more expenses projected to be charged to the Health Care Subsidy Fund or are Health Care Subsidy Fund revenues projected to decrease or both? What would be the consequences of reducing or eliminating the recommended FY 2021 appropriation?

As noted by OLS, in general the HCSF is primarily funded by dedicated revenue but draws on the General Fund appropriation as a final source of funding when other revenues are insufficient to pay the fund's expenses. The $44m currently in reserve is the General Fund support (appropriation plus transfer amounts) for fiscal year 2020. Although it has temporarily carried forward, the funding will be utilized in the 13th period of fiscal 2020 to close out the fund.

In line with historic practice, the General Fund appropriation for the Health Care Subsidy Fund is not expended until the 13th period of the fiscal year. The $51m appropriated is needed to close out the fund in fiscal 2021, and likewise will not be expended until the 13th period of fiscal 2021.

Hospital Funding

Relative to the 12-month FY 2020, the Administration proposes reducing the FY 2021 appropriation to each of the Charity Care and the Graduate Medical Education programs, which support acute care hospitals, by 7.5 percent. The combined appropriation would be reduced by $38.3 million, with $19.2 million representing State funds and $19.2 million federal funds. The Charity Care appropriation of combined State and federal resources would fall by $20.2 million from $269.0 million in the 12-month FY 2020 to $248.8 million in FY 2021. The Graduate Medical Education appropriation of combined State and federal resources, in turn, would drop by $18.2 million from $242.0 million in the 12-month FY 2020 to $223.9 million in FY 2021.

As of FY 2021, the Hospital Delivery System Reform Incentive Program (DSRIP) will be transitioning to its successor program, the Quality Improvement Program-New Jersey (QIP-NJ). At $211.0 million, the recommended QIP-NJ's FY 2021 appropriation from all sources would be $44.4 million higher than the traditional FY 2020 appropriation for the DSRIP program of $166.0 million. As the State funds appropriation to the program is recommended to remain at $62.6 million, the federal funds appropriation would increase by $44.4 million because of an enhanced matching rate from the federal government.

Questions:

27. What is the rationale behind the recommended 7.5 percent cut to combined State and federal funds appropriations in FY 2021 to the Charity Care and Graduate Medical Education programs? What method did the department use to determine the size of the proposed reduction? What would be the impact of the proposed reduction on acute care hospitals and the training of an enough physicians? How does the department anticipate that hospitals will compensate for reduced Charity Care and Graduate Medical Education funding in FY 2021? Are hospitals receiving any additional federal funds support, either through the Coronavirus Relief Fund or any other federal COVID-19 response program, that would backfill or potentially even exceed the magnitude of the proposed cut?

All budget reductions proposed in the FY21 budget were given careful consideration due to the historic fiscal crisis. The proposed one year cut to the 43 hospitals with GME programs will likely not have a long-term impact on the total number of physicians who choose to practice medicine in the State.

Several federal funding awards have been made to support acute care hospitals' activities to respond to the Covid-19 pandemic. Publicly available funding numbers for New Jersey indicate that hospitals have received over $2.86 billion in CARES Act funding as of 9/20/2020, and $71.2 million dollars of these funds were specifically to reimburse hospitals to treat and test uninsured patients for Covid-19. As some funds are not yet reported, this number is expected to increase over the next year. The NJDOH compiles funding from publicly available source that are subject to change. The NJDOH cannot guarantee the estimates submitted in this document will remain unchanged in the future.

The federal government enacted three primary pieces of legislation that financially assist hospitals in responding to the Covid-19 pandemic. The Families First Coronavirus Response Act or FFCRA (P.L. 116-127) and the Paycheck Protection Program and Health Care Enhancement Act or PPPHCEA (P.L. 116-139) each appropriate $1 billion to reimburse providers for conducting COVID-19 testing for the uninsured and appropriated $75 billion in relief funds. The Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136) provides $100 billion in relief funds, including to hospitals and other health care providers on the front lines of the COVID-19 response.

HHS is distributing the $175 billion to hospitals and healthcare providers on the front lines of the coronavirus response through several different initiatives: phase I funding; phase 2 funding; Covid-19 High Impact Distribution I and II; Rural Distribution; Allocation for SNFs; Allocation for Tribal Hospitals, Clinics, and Urban Health Centers; and Allocation for Safety Net hospitals. Funding amounts from the CARES Act

Provider Relief Fund for each New Jersey facility can be found at https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/data/index.html.

Additionally, the federal government has established a fund to reimburse hospitals for the cost to test and treat the uninsured. Hospitals may submit bills for uninsured individuals to this fund and will receive reimbursement at the Medicare rate for service. The Medicare rate is generally higher than the reimbursement rate for Charity Care. More information and the amounts hospitals have received through the HRSA fund can be found at: https://coviduninsuredclaim.linkhealth.com and https://www.hrsa.gov/coviduninsuredclaim.

The Department of Treasury also had several programs to assist companies with federal grants and tax credits. It is likely that some hospitals took part in these programs as well. More information on these programs can be found at https://home.treasury.gov/policy-issues/cares/assistance-for-small-businesses.

Other hospitals are eligible for FEMA funding through Public Assistance Grants to support the costs they incurred to expand hospital capacity at the department's request. More information on the PA grants can be found at https://www.fema.gov/assistance/public/program-overview.

Certain details on all these federal funding sources can be accessed through the available websites. Other funding will be reported to the State through the quarterly and annual financial reporting of the hospitals.

28. Over the six months of the COVID-19 outbreak in New Jersey, have hospitals in the State either documented, or anecdotally reported, an increase or decrease in the amount of charity care they have provided to uninsured patients? If yes, by how much has the amount of charity care provided by New Jersey hospitals changed since March 2020?

Electronic claim activity for the 2020 2nd quarter audit declined approximately 50% in volume and 40% in value compared to 2019 2nd quarter audit, but the reason for the decline is not clear. Note hospitals can submit claims later in the year without penalty. Additional possible explanations for the decline could be a decline in charity care services and/or reduced hospital staff to process claims.

29. Does the department anticipate any FY 2022 changes to the Charity Care or Graduate Medical Education funding formulas in response to the COVID-19 pandemic? If so, please describe.

It is premature to determine funding levels for FY 2022. The cases of Covid-19 have declined significantly since its peak in April 2020. However, the future impact of Covid-19 on the State's finances is unknown. The department will continue to evaluate the impact of Covid-19 and the future financial concerns of hospitals.

30. Please detail, by hospital, the amount of special federal COVID-19 pandemic-related funds that has been distributed to New Jersey's hospitals. Does the department anticipate that additional federal funds will be made available to New Jersey hospitals?

Please see the data links provided in response to question #27 to download the most recent up-to-date information regarding federal funding related to the CARES Act and HRSA uninsured claims. Additional federal funding will be secured through additional uninsured claims submission. Other additional funding will be dependent upon Federal action.

31. What is the plan for implementation of the Quality Improvement Program - New Jersey (QIP-NJ)?

Due to the COVID-19 public health emergency, DOH delayed the start date of QIP-NJ and did not start on July 1, 2020 as originally planned. DOH is instead intending to start QIP-NJ on July 1, 2021. DOH and the Department of Human Services (DHS) are proposing to implement a payment for acute care hospitals for SFY2021 that will serve as a QIP-NJ "bridge" payment in the interim. As always, the methodology for the distribution funds is contingent upon approval from Centers for Medicare and Medicaid Services (CMS), which the State is still awaiting.

32. What is the department's intent behind recommending the addition of the following new language: "In order to permit flexibility in the handling of appropriations and ensure timely payments to hospitals, amounts may be transferred from the State, dedicated, and federal Quality Improvement Program-New Jersey (QIP-NJ) program accounts to the General Medical Services program classification in the Division of Medical Assistance and Health Services in the Department of Human Services, subject to the approval of the Director of the Division of Budget and Accounting."? Does this language give the department the authority to institute a Medicaid add-on?

The Medicaid "bridge" payment will be expended by the Division of Medical Assistance and Health Services. This language ensures the Division will have adequate budget authority to make payments on a timely basis.

Infectious Disease Control and Support for Local Health Departments

The Administration is recommending a 25 percent reduction, totaling $625,000, in funding for Public Health Infectious Disease Control from $2.5 million in FY 2020 to $1.9 million in FY 2021. The grant program was inaugurated in FY 2020 to provide grants to local health departments to address core public health initiatives, including developing and administering infectious disease and outbreak response through Statewide infection control initiatives.

Questions:

33. What rationale supports the recommended $625,000 reduction in the FY 2021 appropriation to the Public Health Infectious Disease Control Grant Program? Why is the Administration recommending a reduction in State funding for infectious disease control activities during a public health emergency? Will this reduction in General Fund appropriations be offset by an additional appropriation of federal funds to the program? How would the reduction in the State appropriation be allocated to county and local government grantees? What would be the effects of the reduction on county and local government health departments? How would this cut affect the State's public health response to the COVID-19 pandemic and the upcoming 2020-2021 influenza season? How was the $2.5 million FY 2020 appropriation used?

The department does not expect an impact from this reduction due to the more than $21.5M in federal funding awarded to LHDs specifically to assist with the COVID-19 response. Refer to question 34 below for further details. Nearly all of the FY 2020 Public Health Infectious Disease Control Grant Program allocation was utilized.

34. Have additional State or federal funds been allocated to the local health departments since March 2020 in response to the COVID-19 pandemic? Does the department intend to provide additional funds to local health departments? How much, if any, federal funds have been distributed to local health departments?

Yes, significant federal funding to aid the statewide COVID-19 response has been allocated for New Jersey's local health departments (LHDs). Five million dollars ($5M) from New Jersey's CDC Crisis Cooperative Agreement was awarded to the NJ Association of City & County Health Officials (NJACCHO) specifically to reimburse applicable LHD expenditures associated with the COVID-19 response utilizing a multi-faceted funding formula containing a base award plus adjustments for population, number of jurisdictional LTCs, and CV-19 case count. This funding is currently being distributed to all 99 LHDs.

Further, NJDOH will soon provide additional federal Epidemiology-Laboratory Capacity (ELC) Supplemental COVID-19 funding via health service grants directly to the New Jersey's 22 LINCS Agencies and 77 LHDs. In SFY21 alone, $7,150,000 will be awarded to LINCS Agencies to fund three full-time positions to support the regional COVID-19 response and the 77 LHDs will receive a combined $9,263,946 to support hiring a full-time Vulnerable Populations Coordinator within each health department. Additionally, the 22 LINCS Agencies will receive a total of $132,000 from CDC Public Health Emergency Preparedness (PHEP) funding to support isolation and quarantine activities.

35. Is the department's Infection Control Assessment and Response Team fully funded? If not, how much funding would be necessary to fully fund the team?

The Infection Control Assessment and Response Team will be fully supported through state and federal ELC funding.

Public Health Protection Services Deappropriation

Questions:

36. Some $2.0 million in FY 2020 "salary surplus" in the Public Health Protection Services program classification was deappropriated. Why was the salaries and wages account overfunded? Are there any funded vacancies that the department does not plan to fill? If so, how many?

The department realized more attrition than anticipated, allowing for surplus salary funding to be deappropriated. However, the department does not assume such savings will continue.

Public Health Laboratories

In response to the COVID-19 pandemic, the State's Public Health and Environmental Laboratories significantly scaled up the processing of COVID-19 tests and reporting of test results. In addition, the Department of Health has received $631 million in federal COVID-19 emergency funds for epidemiology and lab capacity for the prevention and control of emerging infectious diseases.

Questions:

37. How is the department using the $631 million it has received from the federal government in response to the COVID-19 pandemic for epidemiology and lab capacity for the prevention and control of emerging infectious diseases?

The Public Health and Environmental Laboratory (PHEL) was awarded $208M from the ELC Enhanced Detection Cooperative Agreement. PHEL's primary strategies are to: Increase flexible molecular and serological testing capacity throughout the State of New Jersey; Strengthen and enhance laboratory testing through evaluation and development of advanced molecular test methods; Partner with universities for the development of an internship and fellowship program; Enhance client outreach; Improve laboratory information management systems and improve grant management and procurement processes. Approximately $100 million of this funding will be awarded to clinical laboratories throughout the state via a competitive process to create private-public partnerships to achieve these goals.

a. What share of the $631 million is projected to be paid to private laboratories pr ocessing COVID-19 tests?

None of PHEL's funding will be paid to private laboratories for COVID-19 testing.

b. Does the federal funding allow for a reduction of State appropriations without a loss of lab capacity or services?

No. The federal funding is to support COVID testing only. Any reduction of state appropriations will impact other non-COVID programs.

38. What costs have the State's Public Health and Environmental Laboratories incurred in scaling up processing COVID-19 tests and reporting test results?

To date PHEL has spent $3.1M and we expect to distribute approximately $100 million to partnering clinical laboratories by Oct. 1.

a. Have the State's Public Health and Environmental Laboratories already scaled back these operations from the period of peak demand?

No, PHEL operations continue to ramp up in anticipation of a second wave in the Fall/Winter 2020/2021.

b. What were the laboratories' monthly expenditures during peak demand and what are they now?

To date, PHEL's highest monthly expenditures have been $1.4M. PHEL's current expenditures are $803K. PHEL anticipates monthly expenditures to increase as operations ramp up.

c. Have there been any additional hires and at what cost in FY 2020 and projected cost in FY 2021?

Yes, PHEL has onboarded six new permanent staff. PHEL continues to work aggressively to fill over 55 additional positions.

d. To what extent have the additional expenditures on testing and data reporting reduced wait times for test results in New Jersey?

PHEL's turn-around time (TAT) goal is 48 hours, current TAT is 24 hours. We expect to improve overall turn-around-times statewide once our grant program is completely executed and we have had the opportunity to greatly increase capacity for testing at PHEL. Without the additional expenditures, PHEL would have only been able to process 250 tests per day. PHEL is in the process of aggressively filling over 40 positions to increase testing capacity and reduce TATs.

39. What is the total cost per COVID-19 test processed at the State labs?

PHEL's current cost per test is under $30. This cost accounts for the test materials only. PHEL is still pricing out the administrative overhead cost for this test. At low scales this cost is negligent. At higher volumes this can be significant.

a. What does the State pay private laboratories to furnish specimen collection, testing, and results reporting services for the State?

Currently, the State does not pay private laboratories.

b. How quickly can private laboratories process COVID-19 tests and report result versus the State's Public Health and Environmental Laboratories?

This depends on the volume. PHEL's published TAT is 48 hours. As of today, 9/21/2020, PHEL TAT is 24 hours. However, this is subject to change. PHEL can maintain a TAT of 48 hours up to 1000 specimens per day. Volumes higher than 1000 per day will see a higher TAT.

c. How many COVID-19 tests have the State's Public Health and Environmental Laboratories processed this year and how many tests have private laboratories processed in New Jersey?

PHEL has processed 6,522 COVID-19 tests thus for 2020. PHEL does not track the number of tests performed by private labs.

40. Please describe the State's current COVID-19 testing capacity.

Most testing is performed in private laboratories. Currently, PHEL has the equipment to process 1,000 specimens per day. In October of 2020, PHEL will have equipment to process an additional 500 specimens per day for a total capacity of 1,500 specimens per day. However, due to staffing constraints, PHEL can only process 250 specimens per day. PHEL continues to interview and hire pre and post analytical and non-technical staff. Once all testing equipment and IT solutions funded by ELC are implemented, we expect to have the capacity to perform approximately 5,000 tests per day.

a. On average, how many tests are being performed per week?

State Public Lab: 228 per week
Commercial Labs:

1. Quest – average 32,200 per week
2. Bioreference - average 17,200 per week
3. Accurate - average 18,800 per week
4. Labcorp - average 33,300 per week

b. What is the current wait before individuals who were tested receive their test results?

PHEL reports results to clinicians in 24-48 hours. (Specimen must be received within 72 hours of specimen collection.)

c. What is the current supply of testing equipment?

PHEL has ordered, received and/or has committed delivery for all equipment purchased. However, worldwide shortages of equipment and supplies exist that make delivery of needed supplies/equipment unpredictable.

d. Does the State have extra testing equipment in stock in case testing capacity might have to be increased?

Yes, and DOH is working to further build the infrastructure needed to respond to the possibility of increased testing demands.

e. What is the distribution of the different types of tests being used (by specimen collection method, manufacturer, etc.)?

PHEL has the capability to perform both molecular diagnostic testing for COVID-19 acute infection as well as serology for detection of prior infection. We can currently perform three molecular tests (CDC, Abbott and Panther) and plan to operationalize two additional molecular testing methods (Cepheid and TaqPath) soon to ensure that we are adequately diversified to weather unexpected supply chain issues. We are taking a similar strategy regarding antibody testing- the PHEL has three different tests available.

41. Please provide information on the costs to the department for the State's Public Health and Environmental Laboratories to develop and validate its own coronavirus specimen collection kits, the number of specimen collection kits delivered to date, and any available projections of the number of kits the State will produce.

PHEL is only using FDA EUA approve specimen collection kits and, therefore, there were very minimal costs associated with validation. 136,293 swabs and 161,429 tubes with viral transfer media or saline solution have been produced. PHEL has since received significant numbers of swabs and tubes from the federal government – given that supply it is unclear if/when we will have to make additional collection kits in the laboratory.

Early Childhood Intervention Program

The Governor recommends lowering the FY 2021 appropriation to the Early Childhood Intervention Program by $9.2 million from the $115.4 million adjusted appropriation in the 12-month FY 2020 to $106.2 million in FY 2021. The Early Childhood Intervention Program, also known as Early Intervention Program, provides early intervention services to infants and toddlers under age three who have developmental disabilities.

Questions:

42. What factors account for the recommended $9.2 million decline in the FY 2021 appropriation to the Early Childhood Intervention Program? Are rates to providers being cut? Is eligibility being restricted? Is funding proposed to be shifted to other sources? Does the department anticipate changing the family cost participation schedule to partially offset the recommended funding reduction? What would be the effects of the reduction on program participants, meaning infants and toddlers under age three who have developmental disabilities?

Several factors impacted NJEIS during this period:

- Due to the COVID-19 pandemic, the period of March 2020-June 2020 saw a reduction in service expenditures due to the statewide shut down which provided a temporary cost savings of projected child/family expenses for yearend SFY 20.
- The advance payment recoupment which we were able to carry forward in SFY20.
- The one-time Medicaid sweep of past Medicaid claims.
- The additional $2.2M in Medicaid enhancement match funding in SFY21 as a one-time additional federal Medicaid funding in which EIP claims can be charged to and offset state claims expenses.

All these factors created additional funding which we were able to carry forward in SFY21.

a. Are rates to providers being cut?

No, as mentioned the reduction will not represent a reduction on provider rates.

b. Is eligibility being restricted?

No

c. Is funding proposed to be shifted to other sources?

No

d. Does the department anticipate changing the family cost participation schedule to partially offset the recommended funding reduction?

No

e. What would be the effects of the reduction on program participants, meaning infants and toddlers under age three who have developmental disabilities?
No reductions to future services or numbers of participants will be affected in SFY21.

<u>Childhood Lead Outreach</u>

In February, the FY 2021 Governor's Budget proposed a new $1.5 million appropriation for Childhood Lead Outreach "to mainly fund community health workers and pediatricians' lead prevention work." The proposed appropriation has been withdrawn in the revised budget plan.

Questions:

43. **Is funding for Childhood Lead Outreach to be shifted to other sources? Will other programs within the department or elsewhere conduct childhood lead outreach activities?**

The additional funding proposed for Childhood Lead Outreach was to cover hiring and training of community health workers (CHWs) to conduct lead outreach activities. Since this funding proposal was withdrawn from the revised budget, the Department will continue to promote childhood lead outreach activities through other programs, including:

Childhood Lead Grantees: Local health departments, regional childhood lead coalitions and community partners are funded to perform a variety of childhood lead-related activities. Outreach to families is one of these activities. The regional childhood lead coalitions main priority is to provide education and training to childhood lead and healthy home partners in New Jersey, and that work will continue in the next fiscal year.

CHW: Beginning last year, the Coordinator for the Childhood Lead Program began training existing CHWs to perform childhood lead outreach and education during home visits. The training was well-received and will continue in the next fiscal year.

School Nurses: Prior to COVID-19, the Childhood Lead Program designed and implemented a childhood lead educational webinar for school nurses. The webinar will be distributed again during the new fiscal year.

Other State Agencies: The Department partners with other state agencies to develop and promote childhood lead outreach activities, such as working with NJDEP to develop educational resources for communities, working with DCA to align childhood lead initiatives and working with DHS to promote childhood lead outreach among Medicaid providers.

Maternal, Child and Chronic Health Services

The appropriation to Maternal, Child and Chronic Health Services is recommended to be reduced by $789,000 from $36.9 million in FY 2020 to $36.2 million in FY 2021.

Questions:

44. How will services be affected by this recommended funding decrease? Has the department observed a change in demand for services funded out of the Maternal, Child and Chronic Health Services budget line since the onset of the COVID-19 pandemic?

The departmental services within the State Maternal, Child and Chronic Health Services block grant have utilized enhanced federal funding to continue needed services throughout New Jersey. The 2% reduction

is minimal, and the only service that would not be funded during FY 2021 is the NJ Council on Physical Fitness at $50,000. The demand for services has on the average been consistent, with some services changing to telemedicine.

State Psychiatric Hospitals

The patients and staff at the State's four psychiatric hospitals were among the vulnerable populations hard-hit by the surge in COVID-19 infections in March and April 2020.

Questions:

45. What policy changes and initiatives has the department implemented in response to the surge in COVID-19 infections in the State's psychiatric hospitals this spring? What was the cost of these policy changes and initiatives in FY 2020, what will be their cost in FY 2021, and how are the expenses funded? Which of these changes and initiatives are anticipated to be permanent? What lessons has the department learned from the outbreak of COVID-19 infections in its psychiatric hospitals?

- Visitation was halted at all facilities as of March 12, 2020. (Outdoor and Video Visiting is now occurring).
- Video Court implemented for Civil Commitment Court.
- Remote Therapy and meetings with patients are now conducted via telephone and electronic conferencing solutions.
- Instituted Respiratory Protection Program.
- Implemented and completed baseline testing of all staff and patients. Ongoing weekly testing of high-risk populations like geriatrics and the staff supporting them continues.
- Implemented Microsoft Teams use for therapy.
- Implemented Infection Prevention Audits of PPE usage, cleaning and hand hygiene procedures.
- Created Persons Under Investigation (PUI) and COVID-19 Units.
- Implemented temperature and symptom checking of all employees and visitors entering the hospitals.
- Ensured that appropriate PPE is provided to all staff and is required to be worn on grounds of the hospitals.
- Encouraged patients to wear masks.
- Conducting temperature, vital signs, and symptom checks on all patients twice a day.
- Eliminated communal dining and lines for medications.
- Temporarily discontinued group activities but are restarting now based upon space and social distancing guidelines.
- Implemented enhanced cleaning and disinfection protocols.
- Temporarily discontinued barber/beauty shop services (Barbershop services have resumed).
- Provide frequent scheduled and just in time updates and education to patients and staff
- Conduct workplace contact tracing with COVID-19 positive staff and workplace contacts

- Creation of one-month operational inventories of PPE at each hospital and a stockpile supply of PPE of an additional three (3) months.
- Use of telework and alternate staffing schedules to minimize transmission on the grounds, but still provide services

a. What was the cost of these policy changes and initiatives in FY 2020, what will be their cost in FY 2021, and how are the expenses funded?

FY 2020 Total Cost		
Non-Salary	$7,067,642.75	Includes PPE, Tablets for virtual visits, Tele-Health Infrastructure, Cleaning Supplies, etc.
Salary	Est. $24,000,000	March 28th- -June 30, 2020 Note: This amount is $9,000,000.00 Special Pay Rate and Regular Pay and $15,000,000.00 Special Rate Overtime Pay

FY 2021 Projected Total Cost		
Non-Salary	$8,000,000	Includes PPE, Tablets for virtual visits, Tele-Health Infrastructure, Cleaning Supplies, etc. These expenses will be funded by a combination of hospital budgets and State/Federal funding.
Salary	$-$9,000,000	Note: In the event of a second surge, the hospitals may need to implement the special pay rate, which would result in additional salary cost.

b. Which of these changes and initiatives are anticipated to be permanent?

- It is anticipated that the Division of Behavioral Health Services will continue to utilize Tele-health, Tele-work, and Tele-court on a more permanent basis moving forward, beyond the pandemic.
- Single bedrooms will be used on high risk units (i.e. Admission units and Geriatric units).

c. What lessons has the department learned from the outbreak of COVID-19 infections in its psychiatric hospitals?

- Ensuring adequate staffing is critical to maintaining daily operations.
- Providing support and incentives (such as special project pay) to staff to continue working helps maintain an adequate workforce
- Need to create career paths and train more certified infection control specialists.
- Education and frequent communication are important in getting staff and patient cooperation in maintaining a safe environment – wearing appropriate PPE, maintaining social distancing and frequently washing hands .
- Communicate frequently and with outside stakeholders- Transparency is important to maintain trust.
- Improve Telehealth capabilities and have adequate technology resources and staffing to support these initiatives.
- Maintain a stockpile of PPE and cleaning supplies
- Will need to conduct simultaneous Influenza and COVID-19 vaccinations.

46. Please provide information on the State's infectious disease control and mitigation plan to respond to a possible future surge in COVID-19 infections among the patients and staff of the State's psychiatric hospitals. Has the department identified the amount of personal protective equipment, COVID-19 tests and sanitizing supplies needed to respond to a future outbreak of COVID-19 in the State psychiatric hospitals, and have the hospitals secured the necessary supplies? If not, what are the barriers to obtaining these critical supplies? What is the actual or anticipated cost of securing these supplies? Will the department utilize State or federal funding to secure the requisite personal protective equipment, testing, and sanitizing supplies, or some combination of the two?

The psychiatric hospitals have taken proactive measures to prepare for a possible future surge in COVID-19 infections by assessing and identifying resources needed in the management of the virus and by improving identification, testing and management of confirmed positive and suspected individuals, as well as improving utilization of personal protective equipment (PPE).

The Division of Behavioral health Services has begun amassing a six-month stockpile of personal protective equipment, sanitizing supplies and testing supplies on behalf of the state psychiatric hospital system. Each psychiatric hospital maintains operational inventory of a one (1) month supply of personal protective equipment, sanitizing supplies and testing supplies on site.

The anticipated cost for these supplies is approximately $8 million and will be funded by a combination of hospital budgets and State/Federal funding.

Fiscal Year 2021 Revised Budget Proposal
Questions for the Department of Health

Division of Behavioral Health Services

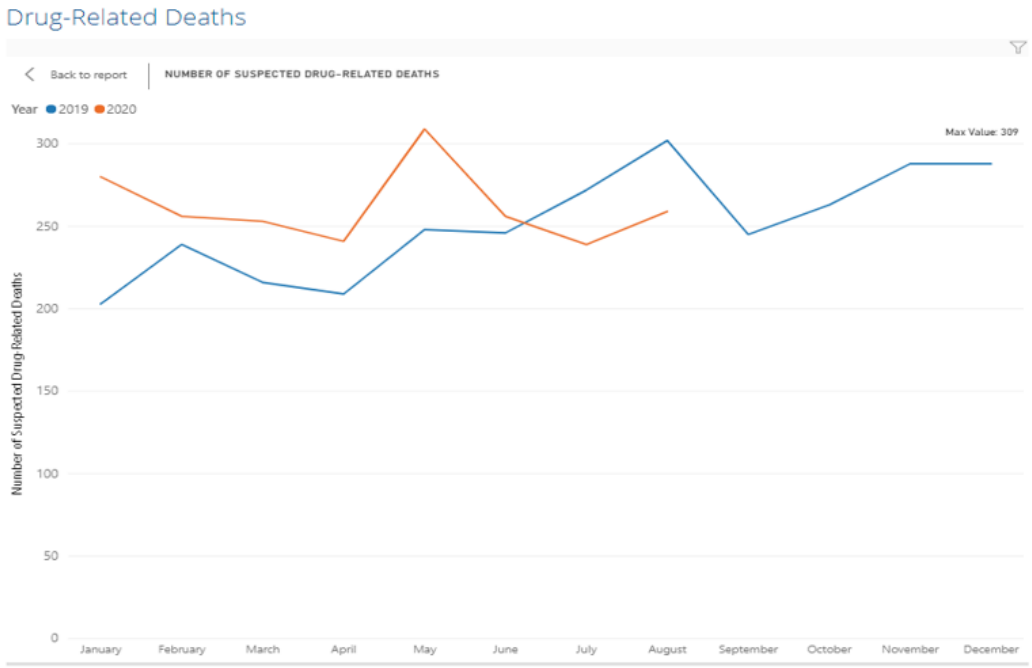
Questions:

47. Please provide monthly statistics on the number of overdose deaths since January 2020 and comment on the reason(s) for any change.

Please see table and chart below for monthly suspected drug-related deaths since January 2020, provided by the Office of Chief Medical Examiner. Overall, while we've seen some downward trends in 2020 data, the state has seen an 8.17 percent increase in suspected drug-related deaths from January to August 2020 (2093), when compared to the same time period of last year (1935). May 2020 was the highest number of suspected drug-related deaths seen in any month (309 deaths), not just for 2020 but for 2019, and 2018.

Please note these are all suspected and not confirmed numbers. As such, it is premature to explain definitively the specific causes behind these trends. These numbers oscillate over time and it is important to understand them over a continuum.

Because these numbers are suspected and not confirmed, it is also too early to tell the impact of COVID-19 on the overdose epidemic. COVID-19, however, has heightened our concerns about a surge in overdose deaths. The pandemic has brought about a constellation of triggers related to increased use and overdoses, including grief, job loss, economic instability, housing instability, vicarious trauma, social isolation, and increased anxiety related to general uncertainty.



Month	2019	2020
January	203	280
February	239	256
March	216	253
April	209	241
May	248	309
June	246	256
July	272	239
August	302	259
September	245	
October	263	
November	288	
December	288	

48. How has the provision of mental health and substance use disorder treatment services been affected by the COVID-19 pandemic? Has the department observed a decrease in the number of individuals receiving treatment?

The question is not part of DOH's purview as the Division of Mental Health and Addiction Services has transitioned back to the DHS.

49. How have telehealth and telemedicine affected access to mental health and substance use disorder care during the COVID-19 pandemic? Are there changes that have been made to the provision or payment of telehealth and telemedicine services that have been particularly effective in increasing access to services that the State should consider adopting permanently?

The question is not part of DOH's purview as the Division of Mental Health and Addiction Services has transitioned back to the DHS

Medical Marijuana

Questions:

50. **How has the Medical Marijuana Program been adjusted to provide continued services to patients during the COVID-19 pandemic while also ensuring the safety of patients and Alternative Treatment Center employees? Have Alternative Treatment Centers effectively implemented social distancing strategies? Have any Alternative Treatment Centers had to limit their hours or close indefinitely? What is the status of home-delivery of medical marijuana?**

The Department has implemented several regulatory waivers and issued guidance to help the industry better serve patients, and to keep patients safe during the pandemic. These waivers include allowing ATCs to conduct telephonic consultations with patients, volume-based discounts to incentivize patients to make larger purchases and reduce trips to the ATCs, curbside dispensing that allows patients to pick up their medical cannabis while minimizing contact, and most recently, we authorized home delivery by ATCs.

Additionally, the Department issued guidance that improved employee onboarding by allowing ATCs to submit third party background check results while new employees waited to get fingerprinted at a state-contracted facility.

Throughout the pandemic the Department has increased options for patients to safely purchase cannabis and continued to expand the industry. Even with pandemic restrictions in place, the Division has opened two new dispensaries – one in Vineland and one in Elizabeth – during the last several months.

51. Please describe New Jersey's supply of medical marijuana. Is there enough supply to meet the needs of patients?

Over the last 6 months, supply has held steady between 7,500 lbs. in the market and upwards of 9,000 lbs. There are some ATCs that have struggled to keep pace with demand and in-demand strains sell out quickly, but overall supply has been adequate. However, enrollment is accelerating – the Department added 7,500 new patients in July – and supply crunches could increase if production does not continue to expand and new ATCs are not brought into the market soon.

52. What is the status of the July 1, 2019 Request for Applications for new Alternative Treatment Centers?

There is a court-ordered stay in place on the RFA. The cases are ripe for decision. Oral arguments are to be scheduled by the court. Despite setting tentative dates in May 2020 for scheduling those arguments, the court has not yet scheduled arguments. The Department made a motion to dissolve the stay in early Summer 2020 but was denied. The Department cannot proceed until the cases are decided and/or the stays are lifted.

53. Are Alternative Treatment Centers experiencing workforce issues? If so, please describe.

There were workforce issues early in the pandemic – which is why the Department released guidance allowing ATCs to utilize third party background checks to more quickly on-board new employees.

54. What is the status of the formation of the Cannabis Regulatory Commission?

The Department is prepared to assist in a seamless transfer of responsibility for the Division of Medicinal Marijuana to the Cannabis Regulatory Commission once the Commission has been appointed.

General Questions

55. Please describe any changes in utilization trends of public health services provided by the department. (e.g. cancer screenings, STD screenings and treatment, vaccinations, maternity services, early childhood intervention services etc.)

- Cancer Epidemiology Services has heard anecdotally through their cancer affiliates that patients are delaying or foregoing cancer screening and treatment procedures due to COVID-19.
- CDS's Vaccine Preventable Disease Program did have a dramatic drop in vaccines ordered through the Vaccines for Children Program during the initial months of the pandemic (as did the nation) but has seen a steady increase in orders over recent months. During April of this year, vaccine ordering year over year (2019-2020) was down 67% compared to July when ordering was down only 17%. The Program has been working with multiple stakeholders and the provider community to emphasize the importance of routine immunizations, particularly during a pandemic.

- Early Intervention Services
    - Overall, about a 40% service use reduction. Our average monthly service utilization is at 57% of normal. Mostly due to fewer visits per family rather than a decrease in children in the program.
- Case Management Units (CMUs): have been operational throughout and have seen an increase in demand due to COVID19.
- Specialized Pediatric Services (SPSP)

    - Starting in mid-March 2020, all 17 SPSP agencies transitioned to a telehealth platform in order to ensure continuity of care for all established patient and meet the needs of all new patients. Only patients with urgent needs were seen in person on a case-by-case basis.
    - During mid-June 2020, all 8 CECs, 5 Craniofacial centers and 3 Tertiary Centers began to actively transition to a combination of in-person and telemedicine visits. As of September 1, 2002, 25-50% of all visits across the SPSP are completed with telehealth.
    - NJ SNAP-Ed has transitioned direct education to a virtual education format. We have seen a reduction in attendance and are actively working on effort to increase participation.
    - The number of participants served by WIC was impacted during the months of March, April, May, and June because of changes in local WIC agencies' operations. In March, all 16 local WIC agencies limited the number of participants they served in person and began moving towards remote operations. Because of this transition, the WIC average monthly caseload declined during those months. (See Table below).

Month	Average Participation
January	133275
February	132393
March	128329
April	125201
May	126252
June	129796
July	133238

56. Please identify any Department of Health program, service or activity suspended or discontinued upon the issuance of the COVID-19 public health emergency declaration; the status of the program, service or activity; and status for FY 2021. What number of persons, households, business entities or government entities were, are, or will be affected?

Consumer Environmental and Occupational Health Service (CEOHS):

- The declaration of the public health emergency reduced inspections services across all CEOHS Program areas. This reduction was directly related to the required shutdown of businesses that the Department regulates.
- In our Public Health and Food Protection Program, inspections and oversight were reduced to emergency or urgent complaints received in our wholesale food and dairy programs. Reduction of services was also seen in the seafood/shellfish industry which experienced a significant slowdown due the constraints on indoor and outdoor dining facilities. A reduction in the number of license youth camps (~400) was also experienced due to the uncertainty of camps opening for the summer season.
- In our Environmental Assessment Program, there was a reduction in the number of childcare centers needing an environmental review. However, the centers that provided services to essential workers remained active and required review.
- With the gradual opening of businesses, all essential services have been returned to normal activities. Inspections in all program areas are being routinely performed. The Public Employees Occupational Safety and Health program (PEOSH) did not encounter a need for reduced services. The program received a high volume of COVID-19 related complaints regarding workplace conditions. The staff received/responded to 91 COVID-19 complaints and is investigating over 25 fatalities.

Special Child Health and Early Intervention Services (SCHEIS)

- Early Intervention
    - Part C services were closed for a period of 2 weeks 3/17/20-3/31/20. This included 16 grantees and 52 Early Intervention Program Agencies (with over 6,000 practitioners) and Evaluation teams. As of our December 1st Headcount, EIS serves 15,132 children per month.
    - Due to the COVID-19 pandemic, the period of March 20-June 20 saw a reduction in service expenditures due to the statewide shut down which provided a temporary cost savings of projected child/family expenses of approximately $20M. However, as of 9/1/20, NJEIS resumed in-person services and already started providing obligated make-up services and therefore, NJEIS services will begin to normalize for the remainder of SFY21.

- Newborn Screening and Genetic Service Grantee
    - During the height of the pandemic one grantee noted that some lab and radiologic studies were suspended/delayed for some patient's due to patient's inability to go to labs for testing and radiology centers for imaging. For patients with cystic fibrosis (CF) the risk was too high. However, as state-wide shelter-in-place restrictions have been lifted this is not the case anymore. All lab and radiologic studies are now on track and being performed.

- Specialized Pediatric Services Program (SPSP)

- All 17 SPSP agencies transitioned to a telehealth platform during mid-March 2020. Agencies began to offer in-person visits starting mid-June 2020. Please note however that during March 2020-June 2020 "full team meetings" for the Craniofacial Centers were "suspended" due to restrictions on in-person visits and limitations of telehealth programs that could not accommodate for more than 3 or 4 providers at once. Instead of 1 team meeting with 6-8 providers, Craniofacial Centers frequently had to complete follow up assessments with several meetings of smaller groups of providers (3-4).

Supplemental Nutrition Assistance Program Education (SNAP-ED)

SNAP-Ed has not suspended or discontinued any activities.

Women Infants and Children (WIC)

- Due to the public health emergency, the WIC State Agency received several Waivers from the USDA in order to operate safely. Specifically, the following activities were either allowed to be modified or suspended based on these Waivers:
- Compliance buys and routine monitoring of WIC's 940+ retail stores located throughout New Jersey. Per USDA regulations 7 CFR 246.12(j)(2), the NJ State WIC Office is required to conduct compliance buys and routine monitoring of at least 5% of their WIC authorized retail stores. Due to COVID-19 and the public health emergency, that requirement was waived for the Federal Fiscal Year 20. This waiver is in effect until the public health emergency declaration is lifted in New Jersey.
- Pre-authorization visit per federal regulation 7 CFR 246.12(g)(5) of all newly applying retail stores to be WIC authorized was waived. As part of the authorization process of new WIC stores, State WIC staff conduct a pre-authorization visit to those stores. This visit was waived, and state staff are now authorizing without this visit.
- Local WIC agency audit/on-sites were modified based on a Waiver received from regulation 7 CFR 246.19(b)(3). The State WIC office is required to conduct onsite monitoring reviews of at least 20% of their agency. New Jersey conducts onsite review of 50% of their agencies, about 8 out of 16 agencies get monitored every year. During this public health emergency, onsite observation was suspended, and all monitoring occurred remotely.

All the above activities will be suspended once the Waivers expire. All Waivers received will be expiring September 30, 2020.

Senior Farmers Market Nutrition Program/Farmers Market Nutrition Program (S/FMNP)

- Waivers and flexibilities were exercised for both programs in order to adjust to the COVID-19 situation. The following flexibilities were implemented:
- SFMNP participants were able to be certified remotely and vouchers could be mailed or picked up by appointment.
- SFMNP and FMNP agency monitoring was done remotely.
- New Farmers and Farmers' Markets training was waived until September 30th.

- SFMNP proxy can be a proxy for more than one participant.
- Participants from both programs do not have to sign the vouchers in front of a cashier.

HIV

The impact of the mandatory statewide lockdown on March 9 severely impacted rapid testing activities in all phases of the HIV & STD prevention program. In particular, the lockdown resulted in a reduction in the number of high-risk clients who presented for rapid testing during February and was followed by the voluntary closure of most community-based testing sites. Virtually all sites other than hospitals voluntarily ceased testing during the months of March and April 2020 and only a handful began to re-open during the month of May. In May, collaborative efforts between NJ DOH DHSTS and the Rutgers – RWJMS Rapid Testing program resulted in a series of well-attended Zoom meetings designed to provide clear messaging and shared common approaches to allow sites to begin safely re-open screening operations. Efforts to assess, develop, evaluate and manage new testing strategies were broadly discussed among stakeholders and led to implementation of additional strategies employing modified approaches to manage potential rapid test operator risk.

Since the beginning of COVID, DHSTS staff have met with HIV and STD testing and treatment grantees frequently to assess barriers to their regular operations due to COVID. DHSTS staff have worked closely with grantees to develop alternative operational procedures to allow them to operate as fully as possible while maintaining staff and client safety. DHSTS has also worked with HIV/STD grantees to repurpose existing grant funds to be used for COVID response/adaptation needs (PPE, retrofitting testing sites with plexiglass partitions, increasing mobile testing operations, etc.). DHSTS continues to work closely with HIV/STD grantees on an ongoing basis to ensure that disruptions in services are minimized and all client needs are met.

Testing Activity:

Regardless of the rapid test or the rapid test algorithm employed, between January and June 2020 rapid HIV testing diminished ~ 65% compared to 2019. Starting in September, rapid screening has ramped up significantly.

Tuberculosis Program

Direct services for TB prevention and control are provided by local health jurisdictions in New Jersey. To date, no local TB programs/clinics have completely shut down. However, clinic schedules have been curtailed throughout the state to avoid or mitigate crowded waiting rooms. The COVID-19 pandemic and subsequent response has resulted in a >50% decrease in TB workload throughout NJ.

Through July 31, 2019:

- Clinic visits decreased by 52% across all funded programs reporting to the state.
- Statewide TB surveillance has noted a 53% decrease in reported cases through the first seven months of 2020 as compared to 2019.
- The PHEL TB Laboratory reported a 55.6% decrease in TB specimens submitted monthly.

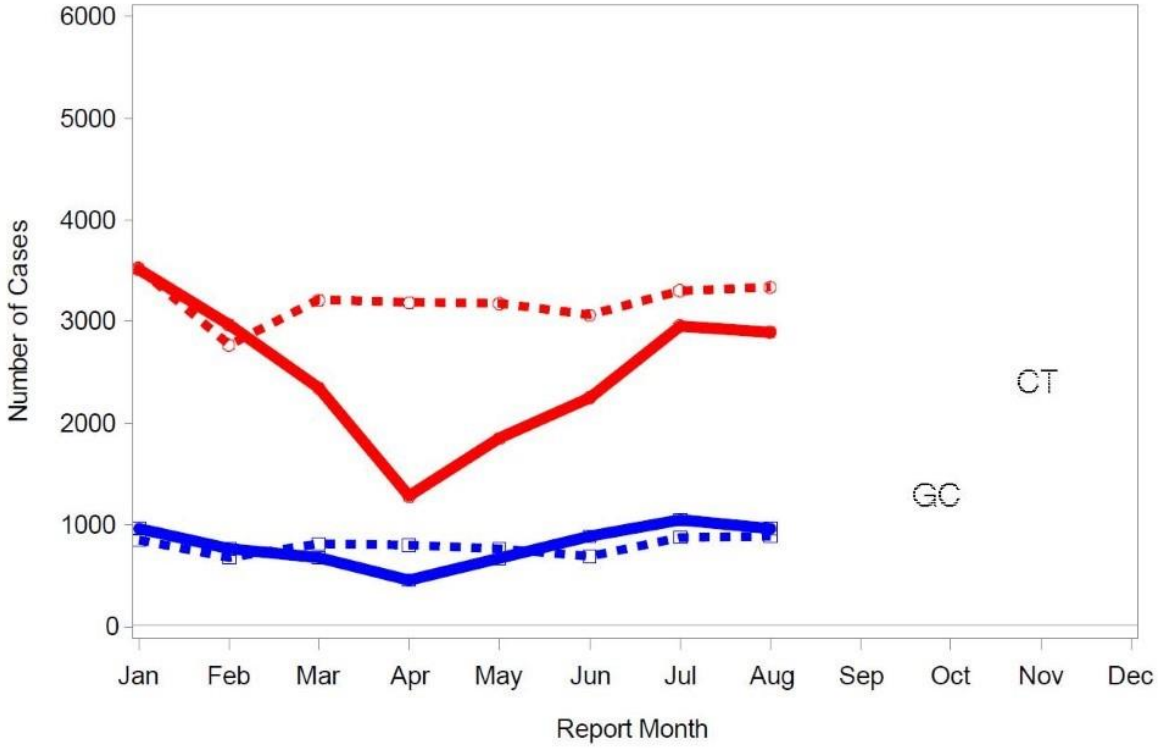
STD

For STD Screenings, we saw a dramatic drop in March/April that has been rebounding since May (see Figure 1 below). Many clinics decided to empirically treat based on exposure/symptoms of STDs vs. testing. As of July, reported cases of Chlamydia, the STD that was most impacted given the asymptomatic nature, are still below 2019 numbers, but have rebounded from the number of cases reported in April.

Figure 1: Reported Chlamydia (CT) and Gonorrhea (GC) Trends in 2019 and 2020

Dashed line: 2019 Solid line: 2020

CT and GC are reported through the last completed month due to data entry lags



57. With reference to the spending plan for the Coronavirus Relief Fund, set forth in the "Detailed Table of CRF Allocations" on pages 12-14 of the Governor's FY 2021 Revised Budget Proposal, please describe each program allocated to the Department of Health, the process by which funding will be allocated to any intended recipients, the amounts already award and disbursed, respectively, and the timetable for award and disbursement of the balance. Please also indicate the amounts allocated to the department and expended through June 30, 2020; amounts

allocated for the period July 1-September 30, 2020; and amounts to be allocated for the period beginning October 1, 2020-June 30, 2021.

The Department of Health is shown as potentially receiving allocations (in thousands) from the Coronavirus Relief Fund to support testing and safe isolation at $175,000, long-term care facility oversight at $10,000, testing capacity at $125,000, Department FEMA Matches of $15,000, FEMA Match for 12 counties at $20,000 and support for Emergency Rates at $23,000. To date, this department has received $2M in funding to support long-term care facility oversight, which was encumbered in early July, and $13.4M in FEMA Match, of which $12.3M was expended through June 30, 2020. The remaining balances of funding received are allocated for subsequent periods. Any future funding to recipients would follow standard departmental grant or procurement procedures.

58. How much federal COVID-19 relief funding has the department received since March 2020? Of those new funds, how much has been expended? Please provide a breakdown of the departmental accounts that have received the federal funding and the amount each account received.

The Department has received $690M in Covid-19 relief funding since March 2020 and as of September 10, 2020 the department has expended $43.1M.

Name of Funding	Funding Agency	Amount	Account Number
PUBLIC HEALTH CRISIS RESPONSE	CDC	19,224,891	4230-542
PUBLIC HEALTH CRISIS RESPONSE -LAB	CDC	2,000,000	4280-089
HOSPITAL REP & RES (HPP)	CDC	3,608,196	4230-548
RYAN WHITE HIV/AIDS PROGRAM PART B	HRSA	689,340	4245-185
RYAN WHITE HIV/AIDS PROGRAM PART D	HRSA	160,453	4220-572
COVID HOPWA-1 CARES		243,041	4245-187
COVID HOPWA-C CARES		144,507	4245-188
COV ELC CARES	CDC	15,400,178	4230-546, 4210-127 and 4280-088
COV ELC ENHANCED DETECTION	CDC	613,790,442	4210-126, 4230-547, 4220-573,4245-186,4280-090 & 4285-562
COVID IMMUNIZATION & VACCINES	CDC	500,000	4230-551
COVID IMMUNIZATION & VACCINES	CDC	3,596,616	4285-563

COVID-19 ELC PROJECT 1ST LINE	CDC	1,895,237	4230-550
HPP SUPP-EBOLA HOSP PREP & RES	CDC	250,000	4230-517
COVID FACILITY INSPECTION	CRF	2,000,000	4260-108
CMS CARES Act	CMS-DHHS	1,905,191	4260-109
DOH-DR4488PA COVID FEMA DOH	FEMA	3,000,000	4210-129
DOH-COVID CRF FEMA MATCH	CRF	1,000,000	4210-128
DR4488PA COVID FEMA PSYCH HOSP	FEMA	7,875,000	4294-260
COVID CRF FEMA MATCH PSYCH HOS	CRF	2,625,000	4294-261
COVID CRF FEMA MATCH PSYCH HOS-Hazard Pay	CRF	9,428,319	4294-262
SME-COVID CRF FEMA MATCH	CRF	375,000	4297-049
SME-DR4488PA COVID FEMA DOH	FEMA	1,125,000	4297-050
	Totals:	**690,836,411**	

59. Please identify any new Department of Health program, service and activity funded by non-recurring federal coronavirus pandemic assistance.

Epidemiology, Environmental and Occupational Health

- The COVID Contact Tracing Program has been implemented, including procurement and custom configuration of a new software application for COVID contact tracing (CommCare). This system is now being used statewide for case investigation and contact tracing for COVID-19 only. The Department is also in the process of implementing an exposure notification app (COVID Alert NJ). Procurement, customization and review and approval of the necessary legal documents are currently underway.
- The Communicable Disease Service is using non-recurring federal coronavirus pandemic assistance to greatly enhance the capacity to quickly detect COVID-19 cases in congregate and community settings and to quickly implement timely control measures to stop further transmission. Electronic systems have been developed that collect surveillance and outbreak data from long-term care facilities to better understand the impact of COVID-19 on this vulnerable population, and to provide timely information for stakeholders and the public. A new electronic platform (CommCare) was brought on to both improve the completeness of COVID-19 investigations and contact tracing, and to allow for more accountability in ensuring timely follow-up. Staff are bring brought on to assist with epidemiological response and outbreak management, improved data management and analysis, school health coordination, and improved infection prevention, education, and control in healthcare and long-term care settings.
- Regarding staffing, funds will support close to 100 new staff that will work on everything from infection control, to surveillance, to improving data flows.

- Within the immunization program, funds are being utilized to enhance the infrastructure of the NJIIS (the state's immunization registry), support/enhance provider flu and pandemic vaccination infrastructure (specifically to our at risk populations through FQHCs), social media campaigns to encourage flu vaccination uptake, and increase program resources and staffing to meet the needs of the upcoming COVID vaccination campaign.

Family Health Services

- Funding will address vulnerable populations through community health workers focused on outreach, education, contact tracing, and the establishment of alternative testing sites.
- Funding to support data collection for CDC-requested data on 2- and 6-month outcomes of infants born to mothers with COVID-19 during pregnancy.
- Ryan White Part D:
  - The HRSA COVID funds provides Ryan White HIV/AIDS Program recipients the flexibility to meet the evolving COVID-19 needs in their respective communities, including but not limited to, extending operational hours, increasing staffing hours, purchasing additional equipment, enhancing workforce training and capacity development, and providing critical services to people with HIV during this pandemic, such as home-delivered meals, emergency housing, and transportation.

- Supplemental Nutrition Assistance Program Education (SNAP-ED)
  - SNAP-Ed has not received any additional federal funding. All funding is based on the federal allocation.

60. Please identify and quantify all shifts of costs of existing Department of Health programs, services and activities to non-recurring federal coronavirus pandemic assistance.

Usage of non-recurring federal assistance is specifically tied to new programs and services to avoid supplanting resources. Some existing programs will be augmented to provide expanded services with the federal coronavirus pandemic assistance. Eligible, quantifiable COVID-related overtime will be submitted to FEMA for reimbursement consideration, and emergency rates for staff at the state psychiatric hospitals has been supported with the Coronavirus Relief Fund.

61. Please identify each FY 2021 Department of Health spending reduction from the 12-month FY 2020 level that is non-recurring, i.e., will require an appropriation of State funds in FY 2022 to continue at its FY 2021 annual level.

It is the Department's understanding that any reductions proposed to the FY2021 funding level would recur without the submission of restorative growth requests in subsequent years. It is projected that any reductions offset by federal resources could continue to be supported at static levels if federal funding persists. The Department has received no notification of reductions to federally supported programs or resources.

62. How is the department adjusting its operations, training, and programming to eliminate racial disparities and biases in its service delivery?

The Department is continuing to expand its focus on the elimination of racial disparities and biases throughout our operations, programs, and service delivery. The FY21 budget includes $250,000 for implicit bias reduction training aiming to improve the delivery of care in all healthcare facilities. Currently, the Department's Supplemental Nutrition Assistance Program Education (SNAP-ED) supports several training programs for staff aimed at eliminating racial disparities and biases. The Women Infants and Children (WIC) program conducts a mandatory, annual civil rights training to all state WIC employees and local agency staff. This content of this training spans across topics such as civil rights coverage and legal authorities, areas of compliance, complaints of discrimination, racial and ethnic data collection and disability discrimination and compliance. The Department's Healthy Women, Healthy Families Program provides community health workers and doulas with resources via virtual quarterly meetings. The CAHP staff hosted the 2nd Virtual Youth Town Hall on the topic of Equity, Social Justice and Racism, and the Division of Family Health Services shifted its entire Improving Pregnancy Outcomes Program from a global outreach program to a data-driven approach focusing on areas with the highest black infant and maternal mortality rates/disparities. In addition, implementation plans are being prepared for the roll-out of National Standards for Culturally and Linguistically Appropriate Services (CLAS) trainings from the Office of Multicultural Health.

63. **What processes does the department utilize to monitor internal fraud and abuse? How often does the department audit its credit card transactions? How many transactions were identified as fraudulent in each of the last five fiscal years? How much money did the transactions equate to? How much money did the department recoup from fraudulent transactions in each of the last five fiscal years?**

- DOH conducts annual Internal Control Assessment including detailed Fraud Risk Assessments. Each DOH Assessable Unit considers the identification of risks related to fraudulent activity and evaluate their likelihood and impact on operations. DOH divisions/offices uses the results of the Risk Assessments to identify the key controls that are specifically designed to address the risk of fraud in the significant areas. The Audit Office is knowledgeable of the divisions'/offices' fraud risk exposure and aware of the step's divisions/offices are taking to monitor and mitigate those risks.

- The Audit Office has the responsibility to coordinate the annual state single audit and other external audits, monitor the results of the audits. The audit office is also responsible for cooperating with conducting the corrective actions for the internal control weakness identified during the audits.

- DOH ensures that all employees are aware of the State/Departmental policies concerning fraud, waste and abuse. Anti-Fraud Policy and appropriate trainings are provided to employees via DOH e-learning system.

- DOH promotes the tools for effective reporting of suspicious or inappropriate activities. Divisions/offices have hotlines/the staff responsible for the receipt, retention, and

treatment of employee complaints across a variety of issues, including fraud and misconduct.

DOH has a documented policy of how fraud allegations will be investigated and resolved.

a. How often does the department audit its credit card transactions?

- DOH restricts the use of credit cards, verified all charges made to credit cards to ensure they were department business related, limited the number of credit cards and users.
- DOH examines credit card statements and corresponding receipts each month, independently, to determine whether charges are appropriate and related to department business.

b. **How many transactions were identified as fraudulent in each of the last five fiscal years?**

None

c. How much money did the transactions equate to?

None

d. How much money did the department recoup from fraudulent transactions in each of the last five fiscal years?

None