Discussion Points

Health Services

Lead Testing

1. P.L.2017, c.7 (N.J.S.A.26:2-131 et al.) requires the Department of Health (DOH) to ensure that all department regulations regarding elevated blood lead levels and the appropriate responses thereto are consistent with the most recent recommendations of the federal Centers for Disease Control and Prevention (CDC). In practice, this law compels the State to take responsive action where a lead screening test shows an elevated blood lead level of five micrograms per deciliter or more. This is lower than the previous standard, which required action at 10 micrograms per deciliter or more. Additionally, the law requires the department to, on at least a biennial basis, review and revise the rules and regulations to ensure that they comport with the CDC's latest guidance on this issue.

State law and regulations (N.J.S.A.26:2-137.1 through N.J.S.A.26:2-137.7 and N.J.A.C.8:51A) require a physician, a registered professional nurse, or a health care facility, unless exempt, to perform a two-part lead screening test on each patient who is between six months and six years of age. If the child's test indicates an elevated blood lead level then the local board of health will be required to provide environmental intervention at the child's primary residence, and at any planned relocation address, and to ensure that a public health nurse provides case management services to the child and the family. Case management involves the coordination, oversight, and provision of services necessary to identify the lead source, eliminate the child's exposure to lead, and reduce the child's blood lead level below a level of concern.

Evaluation Data in the Governor's FY 2020 Budget show an increase in the number of children with a diagnosis of elevated blood lead levels from 1,029 in FY 2017 to 3,906 in FY 2018, and an estimated 5,090 in FY 2019 and an estimated 5,599 in FY 2020. The department has attributed the increase to the changed standards for elevated blood lead level identification. In response to FY 2018 and FY 2019 OLS Discussion Points, the department reported that it allocated $4.1 million to lead prevention activities in FY 2017, $14.0 million in FY 2018, and recommended $14.0 million for this purpose in FY 2019.

- ***Questions:***

  a. What is the department's FY 2019 and recommended FY 2020 appropriation for lead prevention activities? In what line item(s) are these appropriations located?

SFY2019:	$14,907,750	
State:	$12,180,000	Maternal Child and Chronic Health Block (MCCHBG)
State:	$600,000	Child Lead Poisoning Administration
Federal:	$846,000	Maternal and Child Health Services Block Grant (MCHBG)
Federal:	$600,750	CDC Cooperative Agreement/Childhood Lead Poisoning
Federal:	$410,000	Lead Abatement
Federal:	$25,000	Adult Blood Lead Survey (award not received)
Federal:	$86,000	Lead Training and Cert Enforcement
Other:	$160,000	Lead Abatement Certification Revenue

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SFY2020:	$14,752,000	
State:	$12,180,000	Maternal Child and Chronic Health Block (MCCHBG)
State:	$600,000	Child Lead Poisoning Administration
Federal:	$846,000	Maternal and Child Health Services Block Grant (MCHBG
Federal:	$445,000	CDC Cooperative Agreement/Childhood Lead Poisoning
Federal:	$410,000	Lead Abatement
Federal:	$25,000	Adult Blood Lead Survey (award not received)
Federal:	$86,000	Lead Training and Cert Enforcement
Other:	$160,000	Lead Abatement Certification Revenue

b. What is each local board of health's FY 2019 and recommended FY 2020 appropriation for lead prevention activities?

The Department administers funding to 24 local health department grantees who provide childhood lead screening, case management and environmental investigations for nearly all municipalities in New Jersey (exception is Cape May County who funds their own activities).

FY 2019 for case management and environmental investigations

- Atlantic County $283,000
- Bergen County $307,000
- Bloomfield $250,000
- Burlington County $311,312
- Camden County $434,000
- Cumberland County $516,000
- East Orange $513,000
- Elizabeth $158,000
- Gloucester County $153,000
- Hudson Regional Health Commission $380,000
- Irvington $568,000
- Jersey City $834,000
- Middlesex County $802,000
- Monmouth County $352,000
- Montclair $129,500
- Newark $1,954,000
- Ocean County $202,000
- City of Passaic $817,000
- Paterson $849,000
- Plainfield $825,000
- Salem County $207,000
- Somerset County $256,000

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- Trenton $825,000
- Warren County $199,000

FY 2020 for case management and environmental investigations

Subsequent funding for FY 20 is contingent upon the availability of funds, timely and accurate submission of reports, satisfactory progress toward completion of SFY 2019 objectives, an approved annual work plan and a well-defined sustainability plan per the RFA.

- Atlantic County
- Bergen County
- Bloomfield
- Burlington County
- Camden County
- Cumberland County
- East Orange
- Elizabeth
- Gloucester County
- Hudson Regional Health Commission
- Irvington
- Jersey City
- Middlesex County
- Monmouth County
- Montclair
- Newark
- Ocean County
- City of Passaic
- Paterson
- Plainfield
- Salem County
- Somerset County
- Trenton
- Warren County

c. Given the expected continued increase in the number of children with a diagnosis of elevated blood lead levels, are the amounts appropriated to lead prevention activities in FY 2019 and the recommended FY 2020 appropriation sufficient for local boards of health to provide the required intervention services in a timely manner? Is a backlog developing of children with a diagnosis of elevated blood lead levels who are waiting for the provision of required intervention services?

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Yes, the funding amounts as proposed are sufficient for the services local health departments (LHDs) provide when responding to children with elevated blood lead levels (EBLL), which are outlined in N.J.A.C. 8:51 and include nursing case management and environmental investigations. The Department's Childhood Lead program (CLP) closely monitors the 24 local health department grantees in the childhood lead activities they are authorized by NJAC 8:51 to perform, including childhood lead screening of insured and uninsured children, nursing case management, and environmental inspections. If there was an increase in children with EBLLs where nursing case management and environmental inspections were not implemented by a LHD due to lack of funding, the department would allow grantees to modify their spending plans to meet this need (e.g., shift funding from screening outreach to nursing case management).

Medicinal Marijuana Program

2. Subsequent to a review conducted under Executive Order No. 6 of 2018, the department expanded the medicinal marijuana program in: allowing alternative treatment centers to obtain different endorsements for the cultivation, production, and dispensing of medicinal marijuana; allowing alternative treatment centers to open satellite dispensary locations and, with department approval, cultivate medicinal marijuana at more than one location; eliminating the physician registration requirement; adding additional debilitating medical conditions that will qualify patients for medicinal marijuana, including chronic pain, migraine, anxiety, Tourette's syndrome, and opioid use disorders; streamlining the process for approving additional debilitating medical conditions under the program; reducing the general registration fee for patients and primary caregivers from $200 to $100 and allowing senior citizens and military veterans to pay the $20 registration fee currently authorized for recipients of certain benefits programs; allowing patients to have up to two primary caregivers; creating a new "access portal" for patients, primary caregivers, and physicians; and engaging in outreach efforts to encourage increased participation in the program by physicians.

The department additionally indicated in the report that it would review ways to potentially establish a system of home delivery of medicinal marijuana, determine whether external laboratories could be used to supplement the department's laboratory testing system, promulgate standardized dosage guidelines and administration protocols, review the alternative treatment center permitting and criminal history record background check requirements to improve efficiency, and work with the Department of the Treasury to exempt medicinal marijuana from the State sales and use tax.

In December 2018, the department selected six businesses to apply for new alternative treatment center permits. In a March 14, 2019 press release, the Governor's Office announced that 42,528 patients, 1,736 caregivers and 925 doctors now participated in the expanded medicinal marijuana program. These totals reflected increases of 25,500 patients, nearly 1,000 caregivers, and 412 doctors since the current Administration took office.

The Governor's FY 2020 Budget proposes supporting the administrative expenditures of the medicinal marijuana program with an $857,000 State appropriation, which is unchanged from the FY 2019 Appropriations Act, and an estimated $1.5 million in dedicated program fee collections. The Administration also anticipates $20 million in sales and use tax revenues from the expanded medicinal marijuana program that would be available for general State purposes.

Discussion Points

- ***Questions:***

  a. **What is the anticipated growth in the number of patients in FY 2020? How many additional patients does the department anticipate will qualify for medicinal marijuana based on chronic pain related to musculoskeletal disorders, chronic pain of visceral origin, migraine, anxiety, Tourette's syndrome, and opioid use disorders?**

  The Department estimates that with no changes to the program, enrollment could see an increase of 35,000-50,000 patients with total enrollment reaching 85,000-105,000 by the end of FY 2020. Currently, two thirds of the patients in the program have one of the expanded conditions. The Department expects the proportion of patients with the new conditions to increase gradually (i.e. from 2/3rds of total registration to 3/4ths or more of total registration in FY2020).

  b. **Please provide by practice specialties the total number of physicians authorizing patients for medicinal marijuana and the number of physicians who are newly authorizing patients under the 2018 program expansion.**

  Since the program expansion was announced in March 2018, 400 new physicians have signed up to authorize patients for medicinal marijuana.

  Here is a breakdown by specialty of all physicians:

Physician Specialty	Number of Physicians
ALLERGY & IMMUNOLOGY	3
ANESTHESIA	97
CARDIOVASCULAR DISEASE (CARDIOLOGY)	6
DERMATOLOGY	2
EMERGENCY MEDICINE	37
ENDOCRINOLOGY AND METABOLISM	1
FAMILY PRACTICE	139
GASTROENTEROLOGY	22
GENERAL PRACTICE	18
GERIATRIC MEDICINE	11
GYNECOLOGIC ONCOLOGY	7
GYNECOLOGY	7
HEMATOLOGY	5
INFECTIOUS DISEASES	8
INTERNAL MEDICINE	179
NEPHROLOGY	4
NEUROLOGICAL SURGERY	2
NEUROLOGY	63
OBSTETRICS AND GYNECOLOGY	14
ONCOLOGY, MEDICAL	60
OPHTHALMOLOGY	6
ORTHOPEDIC SURGERY	6

Discussion Points

OTORHINOLARYNGOLOGY (EAR, NOSE & THROAT)	1
PATHOLOGY	1
PEDIATRICS	17
PHYSICAL MEDICINE AND REHABILITATION	72
PLASTIC SURGERY	7
PREVENTATIVE MEDICINE	5
PSYCHIATRY	82
PULMONARY DISEASE	5
RADIATION ONCOLOGY	16
RADIOLOGY, DIAGNOSTIC	5
RHEUMATOLOGY	4
SPORTS MEDICINE	4
SURGERY, COLON AND RECTAL	3
SURGERY, GENERAL	8
SURGERY, THORACIC	1
SURGERY, UROLOGY	9
SURGERY, VASCULAR	1
Total:	938

c. **Does the department anticipate issuing any new requests for applications or new alternative treatment center permits in FY 2020? If so, does it anticipate issuing plenary permits, discrete endorsements, or both? If issuing discrete endorsements, please describe the types of endorsement the department anticipates requesting.**

As outlined in the Department's Biennial Report, we project the need for between 25 and 50 cultivation sites plus up to 90 dispensaries to meet growing patient demand. An RFA would be noticed in the New Jersey Register, and would include specific numbers at the time of release.

The Biennial Report can be found here:
https://www.nj.gov/health/medicalmarijuana/documents/BIENNIAL%20REPORT%20-%20Final.pdf

d. **Have the existing alternative treatment centers been able to produce medicinal marijuana in quantities, strains, and formulations that meet current patient demand under the expanded program? In FY 2018 and FY 2019, did the department issue any waivers or otherwise authorize alternative treatment centers to expand medicinal marijuana production and inventory levels in anticipation of expanded patient demand? In FY 2018 and FY 2019, have any alternative treatment centers requested approval to expand production capacity?**

Globally, demand has kept pace with supply – however there have been shortages of particular strains and products at each Alternative Treatment Center (ATC), and some across-the-board shortages at individual ATCs. Please see the Department's Biennial Report for data on overall

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supply. The Department has approved several expansions in capacity and is currently reviewing several other proposals. Supply must be expanded via three avenues: 1) allowing expansion at current facilities; 2) opening 6 new ATCs as part of the July 2018 RFA; and 3) issuing a call for applications for additional facilities.

e. Does the department anticipate any need to hire additional staff in FY 2020 to perform administrative, oversight, and regulatory tasks under the expanded medicinal marijuana program? What additional staff does the department anticipate needing, and what is the expected annualized cost of the additional staff?

Yes, the Department is hiring a Regulatory Officer, an Administrative Analyst Trainee, an Executive Assistant, and two Investigator Trainees in FY2019. In FY2020, the Department anticipates the need for additional Investigators to assist with background investigations and monitoring of ATCs. At a minimum, the Department needs 3 additional field monitors which would be an annualized cost of roughly $250,000.

f. Does the department currently have a system in place that is capable of tracking medicinal marijuana from initial cultivation through final dispensation to patients? If so, what are the costs to the department of maintaining the system, and is there any cost-sharing or participation fee for alternative treatment centers?

The Department is in the process of studying the requirements for an enterprise seed to sale tracking system. Currently, the Department requires all ATCs to maintain inventory management systems (IMS) and Department staff have access to those systems. Those systems do provide seed to sale tracking capability. An enterprise seed to sale tracking system would hook up with the ATC's IMSs and provide aggregated data for every aspect of the supply chain.

g. How will the program expansion affect anticipated FY 2020 medicinal marijuana program fee collections? Please provide by fee category anticipated FY 2020 fee collections as the department expects them to accrue under the expanded program.

The Department expects fee collections to continue to increase. Projected FY2020 fee collections:

	Number	Projected Revenue
Total Registrations (renewal and new)	42500	
Full price registrations ($100)	17000	$1,700,000.00
Discounted registrations ($20)	25500	$510,000.00
ATC Permits ($20,000)	12	$240,000.00
Total Revenue		$2,450,000.00

h. What are the anticipated costs or savings to the State of utilizing external laboratories to test medicinal marijuana?

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The Department is not projecting any savings to the State in moving to external laboratories in quality control testing. Any staff currently deployed on medicinal marijuana testing would be re-assigned and tasked with oversight and quality control of external labs.

i. **What is the status of the department's review of potentially establishing a home delivery system? What would be the anticipated costs to the department to authorize, administer, monitor, and regulate a home delivery system?**

The Department is still studying the regulatory requirements of establishing home delivery for qualified patients in New Jersey.

j. **What are the anticipated costs of establishing a new access portal? Does the department anticipate issuing a request for proposals for a private entity to create the portal? What are the anticipated ongoing costs of operating and maintaining the portal?**

The Office of Health Information Technology within the Department is undertaking the redesign of the patient/physician portal. The cost is roughly $750,000 per fiscal year (FY19 and FY20), with a total project cost of $1.5 million.

Adult Use Cannabis

3. Legislation currently moving through the Legislature, Senate Bill No. 2703, would authorize the sale of adult use cannabis. Per other legislation currently moving through the Legislature, Assembly Bill No. 10 and Senate Bill No. 10, certain alternative treatment centers would be authorized to concurrently hold adult use licensure and engage in conduct related to the growing, processing, and retail sale of adult use cannabis using the same facilities and customer counters as are used for medicinal cannabis patients. Adult use cannabis customers would be allowed to purchase and possess on their person up to one ounce of cannabis at one time, but would be allowed to possess in their homes a total of up to 10 ounces of cannabis at one time, and would not be restricted in the number of adult use cannabis purchases made in any given time frame, provided the consumer does not exceed the possession limits. Adult use cannabis would be subject to an excise tax of $42 per ounce, in addition to sales and use taxes. The adult use cannabis system would involve the use of a "cannabis tax stamp" to be purchased and attached to the product during cultivation and processing.

Medicinal cannabis patients would continue to be subject to 30-day quantity limits, which would increase from the current limit of two ounces to three ounces as of July 1, 2019, but may be dispensed the total authorized amount at one time. Although medicinal cannabis is currently subject to the State sales tax, this tax would be phased out over the next five years, and medicinal cannabis would not be subject to any excise tax.

Assembly Bill No. 10 and Senate Bill No. 10 would additionally: transfer administration of the medicinal cannabis program from the DOH to the Cannabis Regulatory Commission being established pursuant to Senate Bill No. 2703; authorize the use of institutional caregivers; allow out-of-State patients and caregivers to be dispensed medicinal cannabis in New Jersey; expand the list of practitioners who could authorize patients for medicinal cannabis and the treatment capacities in which they could do so; revise the permitting system to create discrete cultivator, manufacturer, and

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dispensary permits, as well as establishing new permit types; revise the structural and organizational requirements for permitted entities; and require all permitted entities to execute a labor peace agreement and enter into a collective bargaining agreement.

- ***Questions:***

a. **If applicable, what are the department's plans to prepare for a seamless transfer of the medicinal cannabis program to the Cannabis Regulatory Commission?**

In the event of a transfer, the Department is committed to working with the Governor's Office and other agencies to ensure a seamless transfer of the Medicinal Marijuana Program.

b. **If applicable, what are the anticipated costs of transferring administration of the medicinal cannabis program to the Cannabis Regulatory Commission? What is the anticipated timeframe for completing the transition? Will the transition result in the transfer of DOH staff to the new commission?**

The Department is committed to working with the Governor's Office and other agencies in the event of a transfer to ensure a seamless transfer of the Medicinal Marijuana Program.

c. **How would the department manage transitioning alternative treatment centers to the envisioned organizational framework, or maintaining existing alternative treatment centers on the current framework and requiring new alternative treatment centers to conform to the envisioned statutory framework?**

As mentioned previously, the Department is committed to working with the Governor's Office and other agencies to ensure a seamless transfer of the Medicinal Marijuana Program in the event of a transfer. Regarding ATCs, the most critical measure in a transition would be ensuring they had enough supply of medicinal marijuana for patients first and foremost. None of the existing ATCs have the current capacity to supply their patient population and an adult use customer base.

d. **How would the department manage implementing a parallel system of adult use cannabis and medicinal cannabis utilizing the same facilities for cultivation, processing, and sales and dispensing; and at what administrative costs? Are the current alternative treatment centers equipped to anticipate medicinal and adult-use demand and create separate production streams to serve both populations? What would be the costs of implementing a system capable of monitoring and tracking the separate production streams to ensure a sufficient inventory of medicinal cannabis is available to medicinal cannabis patients while ensuring adult-use cannabis is properly tracked for tax purposes?**

It is premature to answer this question. If legislation is passed and signed, the Department will be prepared to work within state government to ensure patients are protected, and that the industry is efficiently regulated.

e. **Does the department plan to issue any directives, protocols, or other requirements for alternative treatment centers to preserve the confidentiality of patient health information**

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for medicinal cannabis patients when the centers would simultaneously be serving adult-use consumers?

Patient information is confidential and must be protected as a matter of law.

f. **Does it appear the current alternative treatment centers have sufficient cultivation and processing capacity and sufficient inventory of cannabis to serve both the adult-use and medicinal markets?**

None of the currently permitted ATCs have the capacity to supply patients and an adult use customer base. As outlined in the Department's Biennial Report, we project that New Jersey needs between 500,000 and 1,000,000 square feet of cultivation capacity for medicinal marijuana alone. Using a similar model, the Department's estimates indicate that adult use could require over 2 million feet of capacity initially. In calendar year 2018, the total licensed capacity in
New Jersey was only 105,000 square feet, indicating that the current ATCs in their current facilities could not supply both the medical and adult use markets.

g. **What would be the anticipated administrative costs of verifying and tracking out-of-State medicinal cannabis patients and caregivers who are accessing medicinal cannabis in New Jersey? What would be the anticipated administrative costs of registering, overseeing, and enforcing departmental regulations regarding facilities that have authorized the use of institutional caregivers?**

The Department has factored several potential costs into the development of the patient/physician portal. Any additional requirements that are enacted via legislation will result in additional staff time, consultant costs and an expanded redesign process.

h. **What would be the administrative costs of tracking patient authorizations by the expanded list of practitioners who would be authorized to approve patients for medicinal cannabis, in order to prevent fraud and abuse?**

The Department has factored several potential costs into the new patient/physician portal. Any additional requirements that are enacted via legislation will result in additional staff time and salary costs for contractors during the redesign process.

i. **To what extent does the department anticipate the requirement for permitted entities to execute a labor peace agreement and enter into a collective bargaining agreement would enhance or limit the ability of interested parties to obtain and maintain a permit, or to recruit qualified staff and professionals?**

The Department does not have any data on this potential requirement.

Maternal, Child and Chronic Health Services

Discussion Points

4. A variety of grant programs in the Division of Family Health Services are funded under the Maternal, Child and Chronic Health Services (MCCH) budget line. The Governor's FY 2020 Budget maintains the MCCH Grants-in-Aid appropriation at $36.95 million. Additionally, annual appropriations language funds DOH administrative expenditures for the MCCH program out of the program's Grants-in-Aid appropriation (about $1.7 million per year).

- ***Questions:***
  a. **Please break down the MCCH funding by program and provide the amount each grantee received in FY 2019 and the amount each grantee is intended to receive in FY 2020.**

  The FY 2019 allocation is indicated in the chart below. FY 2020 allocations are pending final grant review and approval process.

Description	Grantee		FY2019
Hemophilia			
	HANJ	451,805	
	Rutgers/RWJMS	281,276	
	Newark Beth Israel Medical Center	175,840	
	CHOP	143,670	
	St. Michael's Medical Center/Prime	192,409	
Sub-Total			**1,245,000**
Special Child Health Services-Case Management			
	Children's Specialized Hospital (Atlantic County)	17,141	
	Bergen County Department of Human Services	16,928	
	Burlington County Department of Health	44,352	
	Camden County Division of Health	68,004	
	Cape May County Department of Health	5,032	
	Cumberland County Department of Health	13,006	
	Essex County Office of Alcohol and Drug Abuse	88,490	
	Gloucester County Department of Health	31,127	
	Jersey City Medical Center (Hudson County)	5,549	
	Hunterdon Medical Center (Hunterdon County)	5,808	
	Mercer County Special Services School District	16,491	
	Middlesex County Department of Health	12,146	
	Visiting Nurses Assoc of Central Jersey (Monmouth County)	43,975	
	Atlantic Health Systems Hospital Corporation (Morris County)	38,862	
	Ocean County Department of Health	15,670	
	Catholic Family and Community Serv ices (Passaic County)	13,759	
	Salem County Department of Health	7,158	
	Somerset Crippled Children's Treatment Ctr (Somerset County)	14,635	
	Sussex County Department of Health	11,000	
	Children's Specialized Hospital (Union County)	25,700	

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Program		Grantee	Amount	Amount	Total
		Warren County Department of Health	14,029		
		Statewide Parent Advocacy Network (SPAN)	92,684		
		NJ Chapter, American Academy of Pediatrics (NJAAP)	20,000		
		Fee for service - TBD	47,810		
	Sub-Total				**669,356**
SCHS- Ped Tertiary					
		Cooper Cleft		67,952	
		Monmouth Cleft		21,502	
		St. Barnabas Cleft		82,702	
		St. Joseph’s Cleft		39,302	
		St. Peter’s Cleft		18,602	
		Cooper Tertiary		252,302	
		Newark Beth Israel Tertiary		309,902	
		Rutgers RWJ Tertiary		277,315	
	Sub-Total				**1,069,579**
SCHS- Child Evaluation					
		Atlantic Health System (Morristown Memorial CEC)	31,000		
		Children’s Hospital of Philadelphia CEC	91,000		
		Children’s Specialized Hospital CEC	133,760		
		Cooper Hospital CEC	78,000		
		HMH-Jersey Shore CEC	37,000		
		Jersey City CEC	90,019		
		JFK Rehabilitation CEC	78,000		
		Rutgers RBHS CEC	103,000		
		St. Joseph’s Medical Center CEC	84,000		
	Sub-Total				**725,779**
Renal					
		Trans Atlantic Renal Council	480,570		
		TBD	27,060		
	Sub-Total				**507,630**
Cystic Fibrosis					
		NJ Organization of Cystic Fibrosis	368,148		
		TBD	1,852		
	Sub-Total				**370,000**
Birth Defects					
		Rutgers, The State University RBHS	2,070		
		St. Peter's University Hospital	32,930		
	Sub-Total				**35,000**
Newborn Screening					

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	Children's Hospital of Philadelphia	20,550	
	The Cooper Health System	64,000	
	Hackensack University Medical	37,939	
	Newark Beth Israel Medical Center	12,000	
	Rutgers, The State University RBHS	8,451	
	Rutgers, The State University RBHS	16,150	
	Rutgers, The State University RBHS	67,700	
	St. Joseph's Regional Medical Center	35,117	
	St. Peter's University Hospital	30,175	
Sub-Total			**292,082**
Maternal Child Health-Ped Tertiary			
	Cooper Cleft	11,964	
	Monmouth Cleft	7,962	
	St. Barnabas Cleft	9,962	
	St. Joseph's Cleft	752	
	St. Peter's Cleft	10,962	
Sub-Total			**41,602**
MCH-Case Management			
	Children's Specialized Hospital (Atlantic County)	34,459	
	Bergen County Department of Human Services	53,950	
	Burlington County Department of Health	57,685	
	Camden County Division of Health	158,207	
	Cape May County Department of Health	4,485	
	Cumberland County Department of Health	40,600	
	Essex County Office of Alcohol and Drug Abuse	85,000	
	Gloucester County Department of Health	109,600	
	Jersey City Medical Center (Hudson County)	37,300	
	Hunterdon Medical Center (Hunterdon County)	5,323	
	Mercer County Special Services School District	67,600	
	Middlesex County Department of Health	103,459	
	Visiting Nurses Assoc of Central Jersey (Monmouth County)	106,100	
	Atlantic Health Systems Hospital Corporation (Morris County)	34,300	
	Ocean County Department of Health	43,000	
	Catholic Family and Community Serv ices (Passaic County)	109,533	
	Salem County Department of Health	4,195	
	Somerset Crippled Children's Treatment Ctr (Somerset County)	26,676	
	Sussex County Department of Health	21,100	
	Children's Specialized Hospital (Union County)	14,532	
	Warren County Department of Health	23,300	

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	Statewide Parent Advocacy Network (SPAN)	35,415	
	NJ Chapter, American Academy of Pediatrics (NJAAP)	50,000	
Sub-Total			**1,225,819**
MCH-Child Evaluation			
	Atlantic Health System (Morristown Memorial CEC)	44,000	
	Children's Hospital of Philadelphia CEC	87,000	
	Children's Specialized Hospital CEC	151,700	
	Cooper Hospital CEC	79,500	
	HMH-Jersey Shore CEC	156,180	
	Jersey City CEC	127,190	
	JFK Rehabilitation CEC	2,000	
	Rutgers RBHS CEC	151,000	
	St. Joseph's Medical Center CEC	44,300	
Sub-Total			**842,870**
MCH-Lead Poisoning			
	Bergen County	307,000	
	Bloomfield	250,000	
	Burlington County	311,312	
	Camden County	434,000	
	Cumberland County	516,000	
	East Orange	513,000	
	Gloucester County	153,000	
	Hudson Regional Health Commission	380,000	
	Irvington	568,000	
	Jersey City	834,000	
	Middlesex County	802,000	
	Monmouth County	352,000	
	Newark	1,954,000	
	City of Passaic	817,000	
	Paterson	849,000	
	Plainfield	825,000	
	Somerset County	256,000	
	Trenton	825,000	
	Warren County	199,000	
Sub-Total			**11,145,312**
Healthy Woman Healthy Family			
	Central Jersey Family Health Consortium	679,821	
	Project Self-Sufficiency	156,496	
	The Children's Home Society of New Jersey	208,685	

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Program		Grantee	Amount	Total
		The Partnership for Maternal & Child Health of Northern NJ	1,008,334	
		Greater Newark Healthcare Coalition	598,731	
		Southern New Jersey Perinatal Cooperative	773,323	
	Sub-Total			**3,425,390**
MCH-Health Corp School				
		HealthCorps	225,000	
	Sub-Total			**225,000**
MCH-Fetal Alcohol				
		Central Jersey Family Health Consortium	99,552	
		The Partnership for Maternal & Child Health of Northern NJ	149,323	
		Southern New Jersey Perinatal Cooperative	93,562	
		Family Health Initiatives	74,677	
	Sub-Total			**417,114**
MCH-Oral Health				
		Southern Jersey Family Medical	100,000	
		Zufall Health Center Inc.	114,000	
	Sub-Total			**214,000**
Lead Poison				
		Atlantic County	283,000	
		Burlington County	1,068	
		Elizabeth	158,000	
		Montclair	129,500	
		Ocean County	202,000	
		Salem County	207,000	
	Sub-Total			**980,568**
Cleft Palate				
		Cooper Cleft	177,645	
		Monmouth Cleft	77,580	
		St. Barnabas Cleft	92,780	
		St. Joseph’s Cleft	197,210	
		St. Peter’s Cleft	141,680	
	Sub-Total			**686,895**
Tourette's Syndrome				
		New Jersey Center for Tourette Syndrome	400,000	
	Sub-Total			**400,000**
Cancer Screening Detection & Education				
		AHS Hosp. Corp.-Morristown Medical	220,352	
		Barnabas Health CMC (Ocean)	209,308	
		Bergen County Health Dept	400,250	

Discussion Points

	Cape May County Health Dept	102,021	
	Cooper Hospital System (Camden)	333,205	
	Hoboken Family Planning (Hudson & Union)	871,145	
	Hunterdon Regional Cancer Center	99,371	
	Inspira Medical Center (Cumberland)	106,661	
	Inspira Medical Center (Gloucester)	93,062	
	Middlesex County Health Dept	411,834	
	NORWESCAP (Warren)	99,950	
	Rutgers NJ Medical School (Essex 1)	322,441	
	Shore Memorial Hospital (Atlantic)	224,390	
	St Joseph's Hospital (Passaic)	482,040	
	St. Michael's (Essex 2)	338,034	
	Sussex County Dept. of Env & PH	101,123	
	Virtua Health, Inc. (Burlington)	187,352	
	VNA of Central Jersey (Monmouth)	328,221	
	Zufall Health Center (Somerset)	208,425	
	Trenton Health Team (Mercer)	138,090	
	Shiloh Community Development	114,441	
Sub-Total			**5,391,716**
SIDS Assistance			
	RWJ Medical School SIDS	221,000	
Sub-Total			**221,000**
Huntington's Disease			
	Rowan University	308,450	
Sub-Total			**308,450**
Post Partum Screening			
	Mercer Co.	40,000	
	Center for Family Services	245,500	
	Rutgers, The State University RBHS	210,000	
	Partnership MCHNNJ (Gateway)	524,000	
	So. NJ Perinatal Coop (Cam)	353,500	
	Central Jersey Family Health Consortium	471,300	
	TBD	55,700	
Sub-Total			**1,900,000**
NJ Council on Physical Fitness			
	Family Health Initiatives	50,000	
Sub-Total			**50,000**
Tuberculosis Services (EPI)			
	Bergen Co.	272,472	
	Camden Co Court House	107,603	

Discussion Points

	Grantee	Amount	Total
	Hudson Co.	302,780	
	Middlesex Co.	219,121	
	Somerset Co.	72,086	
	Paterson City	208,700	
	Rutgers, The State University RBHS	682,720	
	The Cooper Health System	284,518	
Sub-Total			**2,150,000**
Immunization Services			
	Camden Co Court House	25,675	
	Monmouth Co.	9,800	
	City of Jersey City	19,203	
	Elizabeth City	9,472	
	Paterson City	22,495	
	Henry J. Austin Health Center	3,565	
	North Jersey AIDS Alliance, Inc	34,790	
	Newark City	153,875	
	New Jersey Chapter American Academy of Pediatrics, Inc.	56,600	
	The Partnership for Maternal & Child Health of Northern NJ	150,000	
	Visiting Nurse Association of Northern New Jersey	36,613	
Sub-Total			**522,088**
Administrative Funding			
	FHS Admin	1,695,000	
Sub-Total			**1,695,000**
Sub-Sub-Total			**36,757,250**
Audit Fee		190,750	
TOTAL			**36,948,000**

b. Please indicate whether there were any significant changes to MCCH funding awarded to grantees in FY 2019 as compared with the intended amounts indicated in the department's responses to an FY 2019 OLS Discussion Point. Does the department anticipate any significant changes in the amount to be awarded to a grantee from FY 2019 to FY 2020? If so, please indicate the nature and reasons for the changes.

The Department is committed to maximizing all available funds to meet the Administration's goals and objectives. FY 2020 allocations are pending final grant review and approval process.

Doula Care

Discussion Points

5. According to a July 7, 2018 press release, the department allocated $450,000 to a doula pilot program in municipalities with high black infant mortality rates. Some $280,000 would go to the Statewide Parent Advocacy Network (SPAN) to implement a doula pilot program in Newark and $120,000 would go to Children's Futures for a similar program in Trenton. An independent evaluator would be paid $50,000 to evaluate the effectiveness of the doula pilot program.

According to the Governor's Budget Message, the Governor's FY 2020 Budget includes $1 million in Medicaid funding for doulas who are trained professionals who provide physical, emotional, and educational support, but not medical care, to mothers before, during, and after childbirth. Research has demonstrated that support from a doula is associated with lower caesarian section rates, fewer obstetric interventions, fewer complications, decreased use of pain medication, shorter labor hours, and higher scores on the APGAR test (which indicates how well the baby is doing outside the womb).

Questions:

a. Please indicate the budget line that includes the $450,000 the department provided in FY 2019 to support the doula pilot program. Did the funding come out of the Maternal, Child and Chronic Health Services budget line?

Funding for the doula pilot program was supported from the Maternal, Child and Chronic Health Services budget line represented on D-151 & D-152.

b. Has the department received the report by the independent evaluator on the effectiveness of the doula pilot program? If so, please share the report. If not, by what date does the department expect to receive the report,

Given the limited sample size, nature of the pilot, and pregnancy duration, there is not yet enough data to measure the effectiveness of the pilot. Dr. Chris Bruzios, formerly of the Bloustein Survey Research Center at Rutgers is assisting the department with data collection and evaluation efforts currently.

c. Please indicate any changes in the maternal or infant mortality rates in New Jersey, including any changes in racial disparities in such rates, that are attributable to the doula pilot program.

Implementation of the doula pilot program and its services is a brand-new initiative undertaken by the department in FY 2019. It is too early in the funding and reporting process to quantify attributable results and sample size too small to detect a change within a one-year timespan.

d. Does the department anticipate expanding the doula pilot program or establishing additional doula programs in FY 2020?

Given the limited sample size, nature of the pilot, and pregnancy duration, there is not yet enough data to measure the effectiveness of the pilot.

e. Please explain how the Department of Health's doula program will interact with the $1 million Medicaid doula initiative the Governor announced in the Governor's Budget Message. Are the programs coordinated?

Discussion Points

The Department is working collaboratively with Medicaid to ensure that doulas within the pilot program as well as other community doulas are aware of the opportunities afforded by the Medicaid allocation.

New Jersey Report Card of Hospital Maternity Care

6. P.L.2018, c.82 requires the department to gather and compile information necessary to develop a New Jersey Report Card of Hospital Maternity Care. The department is to make the report card available on its website to inform the public about the quality of maternity care provided in each licensed general hospital.

- ***Question:*** **What is the status of the New Jersey Report Card of Hospital Maternity Care? Does the department anticipate that the report card's implementation, administration, and maintenance will necessitate additional staff or result in additional administrative or other costs to the department?**

The New Jersey Report Card of Hospital Maternity Care is under development and the Department of Health anticipates issuance on the DOH website in the summer of 2019.

- DOH staff have been working closely with national technical experts to validate DOH analytic processes for purposes of issuing the Report Card, which has required a considerable investment of staff resources.
- Significant headway includes the completion of data preparation and the generation of some preliminary statistics, such as Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rates hospital. In addition, statewide morbidity statistics are finalized.
- Because the statute requires reporting of certain measures by hospital and because mothers delivering in different facilities vary by social, demographic, and health status, DOH is working hard to adjust for such variations among hospitals prior to reporting most of the required measures to make hospital comparisons fairer. This effort is achieved through statistical modeling and is expected to be finalized by summer 2019.
- A user-friendly, interactive dashboard is being developed that will be used to post the report card statistics and figures along with definitions, methods, and other reference materials.

Administration and maintenance

- To meet the prescribed timeline for enactment, DOH redirected staff to work on this project on a temporary basis. Allocation of staff to this statutory mandate is being accomplished by holding back other equally important jobs and assignments, such as the opioid dashboard.
- The project requires extensive data linking, validation, and analysis as well as staff work to build findings into the dashboard.
- To bring effect to legislative intent, need dedicated staff to continue this work.
- Project continuation requires two mid to senior level research staff with excellent quantitative and clinical expertise.

Discussion Points

Tobacco Prevention and Cessation Programs

7. According to department statistics, in New Jersey, 13.8 percent (1,260,840) of adults (aged 18+ years) are cigarette smokers. New Jersey ranks sixth lowest among all states for the prevalence of cigarette smoking among adults. Among youth aged 12 to 18 years, 8.2 percent smoke in New Jersey. According to the department's website, "a major goal of the DOH is to decrease deaths, sickness and disability among New Jersey residents who use tobacco or are exposed to environmental tobacco smoke. The department's Comprehensive Tobacco Control Program and its partners implement comprehensive programs to prevent the initiation of tobacco use among young people, to help tobacco users quit, to eliminate nonsmokers' exposure to secondhand smoke, and to reduce tobacco-related disparities. These programs include free quitting services, school- and community-based prevention programs and education regarding the New Jersey Smoke-Free Air Act."[1]

As of November 1, 2017, the legal age for purchasing tobacco products in New Jersey increased from 19 to 21. In addition, P.L.2017, c.242 requires that, commencing in FY 2019, one percent of annual cigarette tax collections be directed to the department to fund and implement evidence-based tobacco control programs that align with the federal Centers for Disease Control and Prevention Best Practices for Comprehensive Tobacco Control Programs and that include the goals of preventing youth initiation of tobacco usage, reducing exposure to secondhand smoke, and promoting tobacco cessation.

The Governor's FY 2020 Budget anticipates $5.9 million in FY 2020 Anti-Smoking Cigarette Tax Dedication revenue in accordance with P.L.2017, c.242 but does not detail which specific programs are intended to receive funding out of the anticipated $5.9 million. Although an unchanged proposed $500,000 appropriation for Smoking Cessation and Prevention in FY 2020 is the only line in the department's budget that is explicitly dedicated to anti-smoking programs, the department indicated in response to an FY 2019 OLS Discussion Point that it intended to spend $17.3 million on several tobacco prevention and cessation programs in FY 2019.

- ***Questions:***
  a. **How much did the State spend on tobacco prevention and cessation programs in FY 2018, and how much does the State anticipate spending thereon in FY 2019 and FY 2020?**

The State spending on tobacco prevention and cessation programs in FY 2018 and projections for FY 2019 and FY 2020 are as follows: **Actual and Projected Tobacco Prevention and Cessation Programs**
($ in thousands)

Department	**FY18**	**Proj.FY19**	**Proj. FY20**
Health	3,423	11,531	10,764
Education, Interdepartmental, and Treasury*	2,101	2,312	2,543
Human Services**	4,080	7,312	7,828
Total	**9,604**	**21,155**	**21,135**

[1] http://www.nj.gov/health/chs/hnj2020/health/tobacco/index.shtml

Discussion Points

*Information is for calendar year.
**Medicaid data is by service date.

b. Please detail any significant changes from FY 2019 in the funding amounts recommended to be provided in FY 2020 to tobacco prevention and cessation programs and where the funding can be located in the Governor's FY 2020 Budget. Please provide a separate listing of any significant changes to the programs that will be funded through the Anti-Smoking Cigarette Tax Dedication in FY 2020 as compared with FY 2019.

The dedication to anti-smoking initiatives is reduced in FY20 as a result of the projected decrease in gross cigarette and tobacco revenues. Since the dedication represents 1% of gross revenues, as the gross revenues decline, so will the dedication to the anti-smoking initiatives. The dedicated funding is located on page C-11 of the FY20 budget on the line "Anti-Smoking Cigarette Tax Dedication."

The Department has implemented the strategic plan for FY 2019 utilizing the Anti-Smoking Cigarette Tax Dedication funding and will continue to implement the program activities to meet goals and objectives for FY 2020, without significant changes.

Department of Health

- The Maternal Child and Chronic Health Services account funds an annual grant to combat tobacco-related addiction services. (D-151, State funds)

- Smoking Cessation and Prevention. (D-151, State funds)

- New Jersey Quitline provides phone counseling services and Nicotine Replacement Therapy. (C-19, federal funds)

- The Tobacco Age of Sale (TASE) conducts inspections assessing retailers' compliance with the age of sale requirements for tobacco and nicotine. It also conducts advertising/labelling inspections. (C-19, federal funds)

- The Chronic Disease Prevention and Health Promotion Program reduces secondhand smoke exposure (outdoor ordinances), promotes the use of the New Jersey Quitline, and provides public education and research on emerging tobacco products. (C-18, federal funds)

- The Preventive Health Services Block Grant funds the tobacco cessation program for pregnant women and new parents. (C-19, federal funds)

- The Youth Anti-Smoking Program is designed to reduce youth smoking and enforce compliance with state tobacco age of sale laws. (C-12, State fund)

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Anti-Smoking Cigarette Tax Dedication
Governor Murphy's proposed SFY 2020 budget, includes $5.932 million for "Anti-Smoking Cigarette Tax Dedication, as presented on page C-11.

c. What effect has the increased tobacco purchase age had on smoking prevalence rates and the rates at which vapor products are used in FY 2018 and FY 2019?

The Department began measuring e-cigarette use in 2014. In 2014 the overall e-cigarette prevalence among high school students was 12.1% and dropped to 9.6% in 2016. The cigarette prevalence among high school students was 8.2 % in 2014 and dropped to 4.7% in 2016. Continued monitoring of this trend is required and it is too early to draw the conclusion that the change in age of sale will impact youth prevalence of smoking and e cigarette use.

Syringe Access Programs

8. There are currently seven syringe access programs operating in the State which operated as part of larger harm reduction programs: Visiting Nurse Association of Central Jersey in Asbury Park; South Jersey AIDS Alliance in Atlantic City; Camden Area Health Education Center, which is a mobile site; Hyacinth AIDS Foundation in Jersey City; North Jersey Community Research Initiative in Newark; Hyacinth AIDS Foundation in Paterson, which is a mobile site; and Hyacinth AIDS Foundation in Trenton. These syringe access programs were initially authorized through a demonstration program as part of the "Bloodborne Disease Harm Reduction Act," P.L.2006, c.99 (N.J.S.A.26:5C-25 et seq.). P.L.2016, c.36 made these programs permanent and authorized any municipality in the State to operate a syringe access program. In response to an FY 2019 OLS Discussion Point, the department indicated that it was reviewing an additional application for a syringe access program from Hyacinth AIDS Foundation.

The Syringe Access Program received a supplemental $2.1 million State appropriation in FY 2018, of which $1.7 million was expended. In FY 2019, the program received $2.5 million as part of the $100 million Expanded Addiction Initiatives appropriation. The funds were used to increase the number of Access to Reproductive Care and HIV Services (ARCH) nurses at the site of each needle exchange program. No specific funding for syringe access programs is proposed in the Governor's FY 2020 Budget, although the $100 million appropriation to Expanded Addiction Initiatives is recommended to be renewed.

In response to FY 2019 OLS Discussion Points, the department indicated that the ARCH Nurse Program; which supports nurses operating at syringe access program sites to provide prevention, recognition, and referral services for injection drug users; is a highly-effective program to prevent overdose deaths and the spread of bloodborne pathogens, such as HIV and hepatitis C, as well as sexually transmitted diseases.

Harm reduction programs are eligible to receive federal Centers for Disease Control and Prevention funding. Beginning with the Health Omnibus Programs Extension of 1988, all federal funding included a stipulation that the funding could not be used for needle exchange programs.[2]

[2] This ban was briefly lifted by a provision in the federal Consolidated Appropriations Act of 2010 which permitted federal funding to be used for needle exchange programs. The five New Jersey programs received a total, one-time appropriation of $600,000 from federal CDC funding in the 2010 federal fiscal year. The one-time appropriation permitted the programs to purchase needles. However, language included in the Consolidated

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However, the Consolidated Appropriations Acts of 2016, 2017, and 2018 included new language in Division H, Sec. 520 which still prohibits the purchase of syringes, but gives states and local communities, under limited circumstances, the opportunity to use federal funds to support the distribution and exchange of syringes, and to administer the needle exchange program. This language was not included in the Consolidated Appropriations Act of 2019.

- ***Questions:***

a. **Please list the syringe access programs currently operating in this State. What was the decision regarding the Hyacinth AIDS Foundation application referenced in the department's response to a FY 2019 OLS Discussion Point?**

There are currently seven Syringe Access Programs (SAP) in New Jersey operating in the following municipalities: Atlantic City, Newark, Camden, Jersey City, Paterson, Trenton, and Asbury Park. The program sites for each SAP are as follows:

- South Jersey AIDS Alliance, Atlantic City
- North Jersey Community Research Initiative, Newark
- Camden Area Health Education Center, Camden
- Hyacinth AIDS Foundation, Jersey City
- Hyacinth AIDS Foundation, Paterson
- Hyacinth AIDS Foundation, Trenton
- Visiting Nurse Association of Central Jersey, Asbury Park

Hyacinth AIDS Foundation's application to operate SAP in Paterson was approved in May 2018 and it is now one of the seven SAP service providers in New Jersey.

b. **Has the department received any additional applications to operate syringe access programs since responding to last year's OLS Discussion Points? If so, what is the status of the applications?**

No. The department did not receive any additional applications to operate SAP.

c. **Does the department anticipate an allocation to the Syringe Access Program out of the $100 million recommended FY 2020 appropriation for Expanded Addiction Initiatives? If so, in what amount? If the program is not intended to receive an allocation out of the recommended FY 2020 appropriation for Expanded Addiction Initiatives, will the Syringe Access Program receive funding from another source?**

The department anticipates $1.9 million under the FY 2020 appropriation for Expanded Addiction Initiatives to sustain current SAP programs.

d. **What is the current status of the ARCH Nurse Program? Are there any plans to expand the program to include additional nurses and support staff at syringe access program sites, or to**

Appropriations Act of 2011 reinstated the prohibition on federal money being spent on syringes and needle exchange programs and was included in each such act until the Consolidated Appropriations Act of 2016.

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otherwise modify the program? What funding changes would be associated with any such expansion or modification?

The Access to Reproductive Care and HIV Services (ARCH) nurse program continues to be highly effective in utilizing a licensed registered nurse at each of the seven syringe access programs in the state as well as at local health departments and community-based organizations in Bergen, Burlington, Cape May, Cumberland, Gloucester, Monmouth, and Ocean counties. ARCH nurses are integral in providing prevention services that focus on identifying HIV, Hepatitis C, STDs, pregnancy, distribution of Naloxone, linkage to care and/or prenatal services. The ARCH program funding would continue as part of the FY2020 Expanded Addiction Initiatives budget. The expansion of the ARCH program would coincide with the SAP expansion to five more counties in order to provide a nurse at those locations. It's anticipated that an additional $500,000 ($100,000 x 5 ARCH programs) would come from opioid expanded addiction funding.

e. For each fiscal year from FY 2014 through FY 2020 proposed, please detail the amount of federal grant funding that was used or is recommended to be used to support the Syringe Access Program, as well as the specific federal grant from which the funding was drawn.

Year	Federal Funding Source	Funding Amount	Program Activities
FY 2020	CDC Component A	$210,000	Harm Reduction Sessions only
FY 2019	CDC Component A	$210,000	Harm Reduction Sessions only
FY 2018	CDC Component A	$210,000	Harm Reduction Sessions only
FY 2017	CDC Component A	$210,000	Harm Reduction Sessions only
FY 2016	CDC Category A	$150,000	Harm Reduction Sessions only
FY 2015	CDC Category A	$150,000	Harm Reduction Sessions only
FY 2014	CDC Category A	$150,000	Harm Reduction Sessions only

Each SAP site received $30,000 ($30,000x7 sites= $210,000) from federal funding (level funding) to provide harm reduction sessions to SAP participants. Before 2017, there were only five SAP sites, hence the funding amount is $150,000 ($30,000x 5 sites= $150,000) for FY 2014,2015 and 2016.

f. Please list the funding, by source and by recipient program, that the department provided to harm reduction programs in FY 2019 to support the purchase of syringes.

For FY 2019, State funds under the $100 million Expanded Addiction Initiatives were utilized to provide syringes to all SAP sites and each SAP site received $32,140. The following is the list of agencies with the appropriated funds for syringes:

- $32, 140- South Jersey AIDS Alliance, Atlantic City
- $32, 140- North Jersey Community Research Initiative, Newark
- $32, 140- Camden Area Health Education Center, Camden
- $32, 140- Hyacinth AIDS Foundation, Jersey City-
- $32, 140- Hyacinth AIDS Foundation, Paterson
- $32, 140- Hyacinth AIDS Foundation, Trenton

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- $32, 140- Visiting Nurse Association of Central Jersey, Asbury Park

g. Please list the funding, by source and by recipient program, that the department intends to provide to the harm reduction programs in FY 2020 to support the purchase of syringes.

Based on utilization in FY 2019, it is anticipated that each SAP agency will receive $32,140 for the purchase of syringes in FY 2020 as well. The following agencies are anticipated to receive funds for syringes under the $100 million Expanded Addiction Initiatives:

- South Jersey AIDS Alliance, Atlantic City
- North Jersey Community Research Initiative, Newark
- Camden Area Health Education Center, Camden
- Hyacinth AIDS Foundation, Jersey City
- Hyacinth AIDS Foundation, Paterson
- Hyacinth AIDS Foundation, Trenton
- Visiting Nurse Association of Central Jersey, Asbury Park

With the proposed expansion of SAP to five additional locations, the total funding allocation for syringes only would amount to $224,980. The additional five sites are not yet identified but the counties with the highest incidence of overdose death rates (Ocean, Union, Bergen, Burlington and Middlesex counties) will be prioritized for SAP expansion.

Residential Treatment for Pregnant Women and New Mothers

9. In FY 2018, Residential Treatment for Pregnant Women and New Mothers received a $5.0 million supplemental appropriation. The full amount was expended. In January 2019, the program received $1.2 million out of the $100 million FY 2019 "Expanded Addiction Initiatives" appropriation. The $100 million appropriation is to be used to develop, support, and expand programs and services that are determined to be most effective in directly addressing the statewide public health crisis associated with substance use disorders, including opioid use disorder. The Governor recommends renewing in FY 2020 the $100 million appropriation for "Expanded Addiction Initiatives" but the allocation of the funding is unspecified.

- ***Questions:***

a. Is the $1.2 million FY 2019 allocation to Residential Treatment for Pregnant Women and New Mothers intended to be the full program appropriation in FY 2019? If not, please provide the program's total anticipated FY 2019 spending and detail the sources of the funds to be used to cover program expenses.

b. If Residential Treatment for Pregnant Women and New Mothers is to be funded at less than $5.0 million in FY 2019, please explain the impacts of the reduction in funding over FY 2018 on program participants. Is any reduction in funding indicative of the program not meeting its stated objectives in an effective manner?

c. Does the department anticipate an allocation to the program out of the $100 million recommended FY 2020 appropriation for Expanded Addiction Initiatives? If so, in what amount? If the program is not intended to receive an allocation out of the recommended FY

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2020 appropriation for Expanded Addiction Initiatives, will the program receive funding from another source?

d. Please detail the number of pregnant women and new mothers who received services under the program in FY 2018 and are estimated to receive services in FY 2019 and, if applicable, FY 2020.

The Residential Treatment for Pregnant Women and New Mothers program is administered by the Department of Human Services (DHS), Division of Mental Health and Addiction Services (DMHAS). This program went back to DHS with the Reorganization Plan to transfer certain function of DMHAS back to DHS.

Early Intervention Program

10. The Early Childhood Intervention Program (ECIP), also known as Early Intervention Program, provides early intervention services to infants and toddlers under age three who have developmental disabilities. Contracted agencies act as service providers and arrange for early intervention practitioners to address the needs of eligible children and their families. The services are free-of-charge for families whose income does not exceed 300 percent of the federal poverty levels. Families that do not qualify for free services may still participate in the program but are subject to a cost-sharing schedule. According to Evaluation Data in the FY 2020 Governor's Budget, the number of children receiving services through ECIP is anticipated to increase by 1,384 children, from 28,793 children in FY 2018 to 30,177 children in FY 2019, and is estimated to increase by another 1,384 children, to 31,561 children in FY 2020.

In FY 2020, total recommended funding for ECIP equals $200.4 million, allocated as follows: $115.4 million in State funds, $69.2 million in federal funds through the Infants and Toddlers with Disabilities Program, Part C of the Individuals with Disabilities Education Act; $11.8 million in family contributions for children who are medically eligible, but whose families' incomes are above 300 percent of federal poverty levels; and $4.0 million in dedicated funding from the Autism Medical Research and Treatment Fund. The Administration also proposes the continuation of contingency language that would allow for supplemental appropriations of unspecified amounts to the program in the course of the fiscal year and without additional legislative approval.

According to the department's website,[3] the ECIP is not currently enrolling new providers but will open enrollment opportunities for new providers when it identifies capacity needs, including service availability in a given area, availability of specialized services, and discipline-specific services.

Furthermore, in January 2017, the State Interagency Coordinating Council (SICC), Service Delivery Committee made recommendations for competency standards for EIP providers.[4] The committee recommended that the State should use these competency standards as a basis for a competitive Request for Application (RFA) process for identifying future EIP provider agencies. According to the department's response to an FY 2019 OLS Discussion Point, the department anticipated issuing a competitive RFA in 2018.

Additionally, according to the department's response to an FY 2019 OLS Discussion Point, a new contract for an information technology, billing, and collection services system for the ECIP program, the Early Intervention Management System (EIMS), had been awarded to Public Consulting Group, and efforts were ongoing to optimize functions related to user training, enrollment, backfilling

[3] http://www.nj.gov/health/fhs/eis/for-providers/become-provider/index.shtml

[4] http://nj.gov/health/fhs/eis/documents/provider_competency_standards.pdf

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data, and billing and payment for services. Additionally, $10 million had been provided to EIP providers to assist with agency cash flow pending full functioning of the EMIS. Some other program administration functions are performed directly by the department.

- ***Questions:***
  a. **What is the status of the implementation of the new EIMS? Has it been necessary to provide EIP providers with additional funds pending the system's full functioning?**

     The new Early Intervention Management System (EIMS) has been implemented and is operational. The Department of Health and PCG teams continue to work on improving system functionality, resolving any outstanding claims migration issues and on implementing operational improvements.

     While implementing the new EIMS, it was necessary to provide EIP providers with advanced payments to safeguard against potential cash-flow issues and to ensure there would be no disruption of services for children and families. These payments were individualized to agencies based on an established formula and totaled approximately $44.1 million dollars to-date.

  b. **What is the department's timeline to solicit RFAs for future EIP provider agencies? Has the department issued any RFAs?**

     The Department of Health intends to establish a timeline in FY 2020 to solicit RFAs for future EIP provider agencies. The Department has not issued any related RFAs in FY 2019.

  c. **In FY 2018 and, if available, FY 2019, what were the actual copayments from families whose children participated in the ECIP program but whose family incomes were above 300 percent of federal poverty levels? For how many children did families make copayments? Has the department changed any rates charged for family contributions in FY 2019? Does the department plan any changes thereto in FY 2020? If yes, please provide specifics as to any increases or decreases.**

     Actual copayment collections for Early Intervention Services in FY 2018 were approximately $5,590,000 and as of March 19, 2019, collections for FY 2019 totaled approximately $3,850,000.

     Since it's possible for multiple children to receive services in a single household, Family Cost Participation is tracked by participating families. In FY 2018 a total of 4,187 families participated in FCP. For FY 2019 the number of families is not currently available.

     The Department of Health did not change rates charged for family contributions in FY 2019 and the department has not proposed changes to the co-payment or System of Payments for FY2020.

Discussion Points

Statewide Trauma Registry

11. The Governor's FY 2020 Budget does not recommend a new appropriation to establish a Statewide registry of hospitalizations for traumatic injury. As in FY 2018 and FY 2019, however, the proposed budget includes a language provision authorizing the use of unexpended balances in the Statewide Trauma Registry account for the establishment of the registry. Some $690,000 remained available in the account, as of March 22, 2019.

P.L.2013, c.223 required the establishment of the registry. The law was intended to establish a Statewide "trauma system that defines the roles of all health care facilities in the State, taking into account their resources and capabilities, allowing for the provision of care to injured patients in the State along the continuum of care." The Department of Health is the lead agency for this initiative and was directed to "appoint a State Trauma Medical Director to oversee the planning, development, ongoing maintenance, and enhancement of the formal State trauma system."

In response to the FY 2019 OLS Discussion Points, the department stated that the State currently employed a State Trauma Medical Director, that the department was currently collecting data from all trauma hospitals in phase I of the Statewide Trauma Registry implementation, and that Rowan University was conducting analyses of non-trauma hospital discharge data. The department noted further that it would cost approximately $300,000 per year to manage the registry and software.

- ***Questions:***

a. What is the current status of implementing the Statewide trauma registry? If it is not yet operational, what factors account for the delay, and when is the registry expected to become operational? Is Rowan University fulfilling its obligations as a contractor for the registry?

Development of the Statewide trauma registry is still in progress. It is not yet fully operational. Multiple factors caused delay including but not limited to the following: (1) DOH experienced delays in appointing a State Trauma Medical Director and other dedicated staff; and (2) Trauma Centers took longer than anticipated to submit their data.

Rowan is scheduled to submit final deliverables and transition the completed Trauma Registry to DOH to manage by June 30, 2019. DOH is in the process of revising the MOA with Rowan to ensure a defined level of completion is met by expiry. The Department will then need to evaluate next steps to move forward with completing the next phase of the registry's development.

b. Has work begun on designing a formal system of trauma care in the State, and what is the expected timeline for project completion?

The State Trauma System Advisory Committee (STSAC) submitted a report to the Department and it is under review. The STSAC report will be released shortly. Once Rowan University completes its work on the Trauma Registry, DOH will analyze the compiled data along with the recommendations of the STSAC report to design a formal system of trauma care in the State.

Discussion Points

Infectious Disease Control and Response

12. In 2018, there were a number of infectious disease outbreaks reported in New Jersey health care facilities, and one outbreak in particular, at the Wanaque Center for Nursing and Rehabilitation, resulted in a number of pediatric fatalities. The department reportedly dispatched infection control officials and experts to inspect and conduct trainings in at least five facilities and ordered Wanaque to hire a certified infection control practitioner and a physician specializing in infectious disease.

The Governor's FY 2020 Budget includes a new $2.5 million appropriation for Public Health Infectious Disease Control, which would be distributed through grants to local health offices to address core public health services, including developing and administering disease and outbreak response through Statewide infection control initiatives.

- ***Questions:***

  a. What facility-specific and Statewide measures has the department initiated or implemented in FY 2019 to address facility-based infections? What additional measures does the department anticipate implementing in FY 2019 and FY 2020?

  NJDOH's Communicable Disease Service (CDS) routinely works with local health and health care partners on investigations of reportable communicable diseases and outbreaks. During July 1, 2018 to March 15, 2019, CDS has received reports on 464 outbreaks of various diseases (e.g., respiratory virus, enteric viruses, ectoparasites) occurring in a range of settings (e.g., camps, correctional facilities, acute and long-term care facilities, restaurants, schools). CDS provides technical support/guidance as needed, in addition to obtaining consultations from CDC as needed.

  CDS successfully competed for one-time Ebola-related CDC funding in 2015, which was used to develop a core Infection Control and Response (ICAR) team which includes one full-time infection preventionist, two part-time infection preventionists, and one full-time epidemiologist. The ICAR team is a non-regulatory entity, and its primary responsibilities have been to partner with and support individual healthcare institutions throughout NJ, while building collaborative relationships with outside partners (e.g., the New Jersey Hospital Association and CMS Healthcare Quality Strategies, Inc.). Health care facilities voluntarily request consultations from the ICAR team which performs on-site assessments with a focus on the prevention of healthcare-associated infection (HAI) investigations and prevention of infection control breaches in healthcare facilities through adherence to best practices and state and federal requirements.

  Since 2015, these assessments have been provided to healthcare facilities across the continuum of care in NJ, and these services are continually requested by facilities throughout the state. During July 1, 2018 to March 15, 2019, the NJ ICAR team conducted 25 on-site assessments (6 acute care, 15 long-term care, 4 outpatient).

  Additionally, the ICAR team has already completed several training webinars on various infection prevention topics, such as blood glucose monitoring and medication preparation. The team is continuing efforts on developing sustainable education resources to reach facilities throughout NJ and is also planning to develop training webinars with NJDOH's

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Division of Health Facility Survey & Field Operations, in which the most common infection control breaches found during surveys and on ICAR assessments will be presented along with resources to mitigate identified gaps.

Further, the ICAR team has provided expertise in infection prevention and control during (HAI), including bloodborne pathogen (hepatitis B, hepatitis C, HIV) transmission identified in dialysis centers and through drug diversion investigations, which are directly related to the current opioid epidemic. Additionally, this team has also built the capacity and expertise to effectively respond to emerging pathogens in healthcare settings, such as Candida auris, multidrug resistant Acinetobacter baumannii; while also responding to events of public health importance. Some of the most recent investigations like the ones during FY19 at Wanaque and University Hospital have drawn on ICAR expertise for response activities.

CDS will be able to maintain routine HAI and reportable communicable disease investigation activities during FY20. CDS will likely be able to maintain current ICAR activities at least through the first part of FY20. Current and possibly enhanced/expanded ICAR activities will be implemented during the second part of FY20 (and possibly beyond), pending state funding availability.

Finally, during FY20, CDS plans on updating its "NJDOH Guidelines for the Control of Respiratory Virus Outbreaks in Long-Term Care and Other Institutional Settings."

b. **Does the department anticipate the need to hire or dedicate additional staff to administer and enforce State and local disease and outbreak responses and other infection control initiatives? If so, what is the anticipated cost of the additional staff?**

In 2015, CDS successfully competed for federal grant funding that was being offered through a competitive application, CDC's Supplement to Epidemiology Laboratory and Capacity for Infectious Diseases Grant (i.e., one-time Ebola-related CDC funding that was to focus on building infection control and prevention capacity in the state). CDS was granted approximately $2.5 million to be spent during FFYs 2015-2018, with a one-year extension until March 30, 2019. CDS was able to identify federal carryforward funds from different grants to continue funding until July 31, 2019. If funding sources cease, the ICAR team will be disbanded.

Given the demand and the level of time associated with effective consultation and response activities, the ICAR program should continue and grow, supporting ten FTEs, at a cost of $951,841 annually. This would allow for six infection control specialists and four epidemiologists, with a breakdown of $842,191 for salaries and $109,650 in non-salary support costs.

c. **What specific disease and outbreak response measures and infection control initiatives are to be funded with the $2.5 million appropriation for Public Health Infectious Disease Control?**

The $2.5 million appropriation would be used to build and/or strengthen communicable disease surveillance and outbreak response in local health departments (LHDs), as LHDs have

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the statutory and regulatory authority to monitor communicable diseases and respond to outbreaks. LHDs receiving grant awards would be funded to dedicate staff (e.g., public health nurse) to closely monitor and quickly respond to reports of communicable diseases and outbreaks; establish formal agreements (e.g., mutual aid agreement) with neighboring LHDs to serve as back-up in monitoring and responding to communicable disease; execute data-sharing agreements to rapidly exchange communicable disease data in response to multi-jurisdictional health threats; and perform outreach to healthcare providers and healthcare facilities to ensure timely reporting and appropriate response measures.

Health Administration

Strategic Plan Facilitation Services

13. On January 26, 2018, the Division of Management and Administration in the DOH issued a request for quotation (RFQ) for qualified firms to assist in the development and initial implementation of a strategic plan for the DOH for the years 2018 to 2021.

- ***Questions:***
  - **a. How many quotes were submitted in response to the RFQ? How many responses have been disqualified as not meeting the RFQ's criteria? Have the qualified bidders demonstrated deep knowledge of the operations of the DOH and New Jersey's public health challenges and policies?**

    Quotations were due for submission on 2/21/18. DOH received four (4) quotes. On 5/21/18 the RFQ was cancelled. There was never a review of the materials submitted and the bids were sealed, so none were disqualified.

  - **b. What is the department's anticipated timeline for awarding the contract to a vendor and drafting a strategic plan?**

    The timeline for awarding the contract to a firm (consultant) will be made when a new RFQ is issued.

  - **c. What is the overall anticipated cost of developing the strategic plan, what were the costs incurred in FY 2019, and what are the anticipated costs in FY 2020?**

    No costs were incurred in FY 2019 as DOH cancelled the bids for the project. The anticipated costs in FY 2020 will depend on the bid submission and DOH will value base the project as it is a wide-ranging complex study.

  - **d. What are the specific goals of developing a strategic plan? What specific changes are anticipated with regard to the department's functions, goals, and overall mission?**

    Coupled with an organizational assessment and strategic planning process, the DOH will be better equipped to determine its role, priority, organizational capacity and improve

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performance. Through this process, the DOH will review its vision, mission, guiding principles, values and workforce as well as refine strategic health priorities, using measurable and realistic goals and objectives.

Minimum Wage Increase

14. P.L.2019, c.32 established several multiyear schedules for gradually raising the State minimum wage from currently $8.85 per hour to not less than $15.00 per hour. The increase may affect department staff, third parties that provide services to or on behalf of the department, and programs with means-tested eligibility criteria.

In FY 2020, the general State minimum wage will rise as follows: 1) on July 1, 2019 to $10 per hour; and 2) on January 1, 2020, to not less than $11 per hour. The general minimum wage schedule will increase to at least $12 per hour on January 1, 2021; $13 per hour on January 1, 2022; $14 per hour on January 1, 2023; and $15 per hour on January 1, 2024.

- ***Questions:***

a. **Please quantify the fiscal impact to the department in FY 2020 of the increases in the minimum wage of department employees from $8.85 to $10 per hour on July 1, 2019 and from $10 to $11 per hour on January 1, 2020, and the number of employees who will be impacted by each increase. Relative to current compensation levels, please provide the same information assuming an hourly minimum wage of $12, $13, $14, and $15.**

The minimum wage increase will have a fiscal impact to the Department for FY 2020 of approximately $350,000 and will impact 247 employees.

b. **Please quantify the fiscal impact to the department in FY 2020 of the increases in the minimum wage of employees of third parties that provide services either to the department, including temporary employment services, or on behalf of the department according to contractual agreements. Relative to current compensation levels, please provide the same information assuming an hourly minimum wage of $12, $13, $14, and $15.**

The minimum wage's fiscal impact for DOH's third party providers is minimal for FY 2020.

c. **Please quantify the fiscal impact to the department in FY 2020 of the increases in the minimum wage of enrollees in programs run by the department that have means-tested eligibility criteria. Relative to current compensation levels, please provide the same information assuming an hourly minimum wage of $12, $13, $14, and $15. Please list the programs with income-based eligibility criteria that will be affected by P.L.2019, c.32 and for each such program specify the law's projected effects on enrollment, the benefits provided to enrollees, and the projected cost savings to the department.**

The impact is limited to the special supplemental program for Women, Infants, and Children (WIC), and will be minimal in FY 2020.

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Health Information Technology

15. The department describes on its Internet website[5] 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. In testimony before the Senate Budget and Appropriations Committee and the Assembly Budget Committee in 2018, the Commissioner of Health indicated the department would dedicate $13 million to developing electronic health records to support connectivity among different types of providers, as well as workforce development and training.

In January 2019, the Administration transferred $5.4 million out of the $100 million FY 2019 Expanded Addiction Initiatives appropriation to the Department of Health for the Health Information Technology interoperability upgrade. No readily identifiable funding for the Health Information Technology interoperability upgrade is proposed in the Governor's FY 2020 Budget, although the $100 million appropriation to Expanded Addiction Initiatives in the Department of Human Services is recommended to be renewed.

- ***Questions:***

  a. **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, and if so, in what amounts?**

  The New Jersey Health Information Network (NJHIN) has made significant progress this year in terms of getting the majority of hospitals to sign the data sharing agreement either directly, or through a local Health Information Exchange. DOH has made health data interoperability a strategic objective and has promoted joining the NJHIN by reaching out to hospitals and moving incentive levers through Delivery System Reform Incentive Payment (DSRIP) and Charity Care programs. NJHIN also provides a mechanism for patient identity across the state by utilizing a Master Person Identifier (MPI). DOH is currently is in development of an "integrated licensing system" or Single License for the provision of primary care, mental health care and/or substance use disorder treatment services.

  b. **Does the department anticipate an allocation to the Health Information Technology interoperability upgrade out of the $100 million recommended FY 2020 appropriation for Expanded Addiction Initiatives? If so, in what amount? If the project is not intended to receive an allocation out of the recommended FY 2020 appropriation for Expanded Addiction Initiatives, will the Health Information Technology interoperability upgrade receive funding from another source?**

  Funding is not set for FY 2020 at this point, but DOH is working with inter-agency process to secure additional funds for the sustainability of the program. DOH is also currently exploring other opportunities to include federal funding.

[5] https://www.nj.gov/health/njhit/

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c. Please specify the budget line(s) in which the $13 million, or the updated total, to develop electronic health records is budgeted. Is the $13 million, or the updated total, a one-year allocation or does the department intend to provide that sum in several installments over several years?

DOH received $5.4 million from the Expanded Addiction Initiatives to fun Substance Abuse Disorder (SUD) Inoperability as well as $1M for iPHD. The majority of the funding will be used in year one, with the remainder of the funding used in year two.

d. Has the increased use of health information technology resulted in any changes in department staffing; including hiring additional personnel to develop and maintain electronic systems, reallocating personnel whose job functions have been automated through the use of health information technology, and any positions that have been created or eliminated in response to the increased use of health information technology?

Beginning in 2014, the department undertook a modernization effort to eliminate the manual paper processes and workflows for tracking procurements throughout the lifecycle across all procurement related agencies including DOH, State OIT, OMB and Treasury. The system is Reqtrack and is built on the MS SharePoint and SQL Server platforms. Since the success of Reqtrack, the department has built this platform into a configuration based, no programming/code needed, flexible automation and workflow system. Backoffice functions that are now automated in 2019 include: MOA, MOU, Scientific, Office Supplies, Travel Requests, Travel Reimbursement, Employee on boarding, employee off boarding, HR new hires, bill comments, rules/regulations update tracking. Reqtrack is used as an example, but these same behaviors and outcomes apply to all of the workflow automation initiatives mentioned. Two consultants were brought on board and they developed new workflows, maintained existing workflows, upgraded the infrastructure as needed. While we have not reduced staff, as staff has been reduced in these operational work areas, we have been able to maintain and even improve efficiencies.

e. Has the department contracted with third-party entities to develop and maintain any electronic delivery systems used by the department, and if so, what is the status of those contracts? Have there been any delays or other delivery issues?

The New Jersey Innovation Institute (NJII) is the State Designated Entity for Healthcare interoperability and is contracted through a MOU to manage NJHIN. Technology capabilities for MPI, ADT notifications and connectivity to Immunization registry have been delivered. After all agreements have been signed, DOH is working with NJII to keep the HIN on time.

f. What cost savings and increases has the department realized in FY 2017 through FY 2019 from the use of health information technology?

A fundamental approach to development of NJHIN has been to utilize systems that have a proven success record such as the solutions provided from the Michigan Health Information Network. Other savings have been achieved by strategically utilizing interoperability investments made through ARRA and the Meaningful Use programs to leverage existing

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infrastructure and established trust agreements. This has allowed New Jersey to stand up a statewide Health Information network at a significantly reduced cost compared to other states.

g. What efforts are being made to ensure health information technology systems that are being used or developed by the department are interoperable with information technology systems utilized by other State departments and agencies, including, for example, the prescription drug monitoring system administered by the Division of Consumer Affairs in the Department of Law and Public Safety and professional licensure and certification databases maintained by professional licensing and certification boards?

Efforts for interdepartmental collaboration are ongoing.

NJHIN has developed pilot Use Cases with the intent of utilizing data form NJ PMP and is in the early stages of working on a maternal health use case in collaboration with DCF and DHS. The addition of a dedicated Director of Opioid Response and Policy position within the Department, DOH is assisting the department to collaborate and define data use agreements and optimize provider access to key Opioid resources.

Integrated Population Health Data Project

16. In November 2018, the Department's Division of Management and Administration received $1 million for the integrated Population Health Data Project out of the $100 million FY 2019 "Expanded Addiction Initiatives" appropriation. The $100 million appropriation is to be used to develop, support, and expand programs and services that are determined to be most effective in directly addressing the statewide public health crisis associated with substance use disorders, including opioid use disorder. The Governor recommends renewing in FY 2020 the $100 million appropriation for "Expanded Addiction Initiatives" but the allocation of the funding is unspecified.

P.L.2015, c.193 requires the Rutgers Center for State Health Policy to establish an integrated Population Health Data Project. The project is to be capable of securely receiving, maintaining, and transmitting data collected by New Jersey administrative departments and agencies related to health and publicly supported programs that will facilitate approved, project-by-project analysis and research and the development of the most effective means for improving the health, safety, security, and well-being of New Jersey residents and the overall cost-efficiency of government programs.

The law provided no State appropriation to the integrated Population Health Data Project and did not require any information technology investments to be made by the State. The Director of the Rutgers Center for State Health Policy has testified when the bill was subject to legislative deliberations that the center could support project costs without a State appropriation. Initially, the project could be supported through grant funding from private foundations and federal agencies. After several years, the center expected that project fees for access to the data would fund most of its operational costs.

- ***Questions:***

a. What is the implementation status of the integrated Population Health Data Project?

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Rutgers Center for State Health Policy, under the oversight of the iPHD Governing Board, is working to implement the iPHD Project in 2019 and transfer the initial sets of publicly supported programs into the iPHD Project by late 2019.

b. Please specify the element(s) of the integrated Population Health Data Project that the $1 million FY 2019 appropriation to the project is supposed to support and how the element(s) relate(s) to the stated purpose of the Expanded Addiction Initiatives.

A portion of the $1 million FY 2019 appropriation will support several key positions needed to accelerate the implementation of the iPHD Project, including time for the Director, Executive Director, and Assistant Director of Data Management at Rutgers Center for State Health Policy to facilitate receipt of data from public agency sources approved by the Governing Board, and research staff to develop application materials and assure IRB compliance. Funding will also be used to support project management and web development resources. A portion of the $1 million FY 2019 appropriation will also support fees and costs related to the data core/computing environment at Rutgers Center for State Policy. Finally, a portion of the $1 million FY 2019 appropriation will be allocated to support 4 pilot research projects.

The iPHD Project adopted the following Research Priority, "Informing New Jersey's integrated approach to addressing the opioid epidemic". Research addressing this priority will inform New Jersey's efforts to combat the opioid misuse epidemic, recognizing that this is one of New Jersey's highest policy priorities, involving multiple state programs and agencies. Analysis of integrated data within the iPHD Project will contribute to addressing the opioid epidemic by illuminating patterns of opioid prescribing, examining other drivers of opioid misuse and overdoses, identifying potential policy solutions, and recommendations, and evaluating prevention and treatment program outcomes, including addressing disparities in care.

c. Please explain the motivation behind the $1 million appropriation to the integrated Population Health Data Project. What has changed since the Director of the Rutgers Center for State Health Policy stated during the legislative deliberations that led to the enactment of P.L.2015, c.193 that the center could support the project without a State appropriation?

The iPHD Project is a vital tool for research into the effectiveness of New Jersey's integrated approach to addressing the opioid epidemic. The Commissioner of Health has identified the implementation of the iPHD Project as a priority for 2019. The iPHD Governing Board approved research efforts to combat the current opioid epidemic as one of the iPHD Project's initial research priorities. To that end, a focus will be on research projects that use administrative data linked through the iPHD Project to inform policy and program development. Immediate funding is required to meet the accelerated timeline and implementation goals outlined by the Commissioner of Health and the iPHD Governing Board.

d. Is the FY 2019 appropriation to the integrated Population Health Data Project intended to be a one-time or a recurring appropriation? Does the department anticipate an allocation to the project out of the $100 million recommended FY 2020 appropriation for Expanded Addiction Initiatives? If so, in what amount? If the project is not intended to receive an

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allocation out of the recommended FY 2020 appropriation for Expanded Addiction Initiatives, will the project receive funding from another source?

The $1 million FY 2019 appropriation is intended to be a one-time appropriation; however, the Department is still assessing the needs of the iPHD Project. In addition to research fees collected through the iPHD Project, Rutgers Center for State Health Policy is also developing a funding strategy that includes philanthropic support.

Alternatives to Opioids Program for Hospital Emergency Departments

17. In December 2018, the department's Division of Management and Administration received $1 million out of the $100 million FY 2019 "Expanded Addiction Initiatives" appropriation for the Alternatives to Opioids program for hospital emergency departments. The program is to encourage physicians to seek and prescribe alternative pain management options to opioids for patients. The "Expanded Addiction Initiatives" appropriation is to be used to develop, support, and expand programs and services that are determined to be most effective in directly addressing the statewide public health crisis associated with substance use disorders, including opioid use disorder. The Governor recommends renewing in FY 2020 the $100 million appropriation for "Expanded Addiction Initiatives" but the allocation of the funding is unspecified.

- *Questions:*

a. Please describe the design, structure, and objectives of the Alternatives to Opioids program for hospital emergency departments.

The Opioid Reduction Options ("ORO") Program in the Emergency Department ("ED") ultimately seeks to prevent overdose deaths and to curb the devastating impact this epidemic has had upon the State of New Jersey ("the State") by taking a targeted approach focusing on reducing the number of opioid prescriptions written in EDs in the State. Although the opioid epidemic has a complex etiology, the prescribing of opioids within the healthcare setting is a salient contributing factor. The ORO Program seeks to reduce opioid prescriptions written in EDs and at discharge to 12% or lower in the State. The national average percentage of patients leaving EDs with a prescription for opioids is 17%.

To meet this end, ORO will aid hospitals to implement practices that assist aggressive advanced acute-pain management while decreasing an individual's reliance on opioids. The initiative includes training and education that will promote evidenced-based programs to assist hospitals in achieving this reduction in the administration and prescriptions of opioids. These programs will institute clinical protocols that call for alternative prescriptions, therapies, or procedures in an ED to address acute and/or chronic pain.
The State's hospitals/health systems are at various levels of utilization and measurement around opioid administration. As such, the project will implement a multi-tiered ORO Opioid Reduction Plan ("Opioid Reduction Plan"), which will take into consideration the hospitals' various levels by certifying hospitals with "tiers" that define levels of implementation, a reduction of opioid prescriptions given in the ED and at discharge, percent of patients achieving reduction in pain through alternatives, percent of patients with increased functionality, and overall patient satisfaction.

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b. Is the program operational? If not, please provide the target date for full implementation.

The agreement with New Jersey Hospital Association (NJHA) is to be executed by mid-April to implement the coordination, curriculum development, and evaluation of the program.

c. Please set forth any performance metrics for the programs, including any measurements to determine success and effectiveness.

Metrics are still under deliberation, but potential metrics include:

a. *Number of patients receiving opioid Rx / Total patients discharged from ED
b. *Number of patients assessed for an ORO protocol / Total patient discharged from ED
c. *Number of patients who received an ORO protocol / Total patient discharged from ED
d. *Number of warm-handoffs of discharged patients to outpatient care
e. *Number of ED staff trained in best practice protocols
f. *Number of downstream provider staff in the community trained in best practice protocols

d. Has the department hired or intends to hire any additional staff to implement the program?

No.

e. Is the FY 2019 appropriation to the Alternatives to Opioids program for hospital emergency departments intended to be a one-time or a recurring appropriation? Does the department anticipate an allocation to the program out of the $100 million recommended FY 2020 appropriation for Expanded Addiction Initiatives? If so, in what amount? If the program is not intended to receive an allocation out of the recommended FY 2020 appropriation for Expanded Addiction Initiatives, will the program receive funding from another source?

The appropriation is one-time funding and we are in the process of assessing whether additional funds are needed. Additional federal dollars (e.g., USHHS/Substance Abuse and Mental Health Services Administration [SAMHSA]) have been devoted to this program.

Eligibility Determinations

18. General Provision #89 of the FY 2019 Appropriations Act authorizes State agencies to obtain employment and income information from third-party commercial consumer reporting agencies for the purpose of obtaining real-time employment and income information to help determine program eligibility. The intent of the general provision is to achieve cost savings, improve timeliness, and minimize fraud.

- ***Question:*** **Please describe the extent to which the department uses the services of third-party commercial consumer reporting agencies for the purpose of obtaining real-time**

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employment and income information to help determine program eligibility. What cost savings does the department attribute to the use of commercial consumer reporting agencies in the eligibility determination process? If the department does not use such services, please provide the reason(s) for not doing so.

Eligibility for most programs are currently being determined and verified by each program. This method has been successful in ensuring clients receiving services are within the eligibility guidelines. Due to this, at this time, the Department of Health does not require the services of a third-party vendor but may utilize that option in the future.

Office of the Chief State Medical Examiner

19. P.L.2018, c.62 reformed the State's medical examiner system effective on September 1, 2018. The law maintained the system's prior organizational structure in that a State medical examiner office oversees several independently-operated county and intercounty medical examiner offices. The law, however, abolished the Office of the State Medical Examiner in the Department of Law and Public Safety and transferred all of its functions, powers, and duties to the new Office of the Chief State Medical Examiner in, but not of, the Department of Health.

The law also made numerous revisions to the responsibilities of State, county, and intercounty medical examiner offices; including modifications to standard operating protocols, an expansion of the categories of deaths that require a medicolegal investigation, the strengthening of the oversight function of the State office vis-à-vis the county and intercounty offices, the establishment of research and oversight boards within the State office, and the issuance of an annual report by the State office on the performance of the Statewide system.

In addition, a September 4, 2018 press release by the department noted the modernization of the State Toxicology Laboratory as one of five top areas of focus for the Office of the Chief State Medical Examiner.

- ***Questions:***

A. **Please explain to what extent the jurisdictional transfer of the Office of the State Medical Examiner and the provisions of P.L.2018, c.62 have affected the performance of the State's medical examiner system. Please provide specific examples and use any statistics that may be available to illustrate the impact of the changes.**

One of the principal reasons for transferring the Office of the Chief State Medical Examiner (OCSME) from the from the Office of the Attorney General to the Department of Health was to bring the office in line with national guidelines, which require the office to be independent of any law enforcement agency. Six months after the transition, the OCSME is still in a restructuring phase, identifying budgetary needs, creating and filling new positions required to support its expanded responsibilities, and revising salaries and job positions in an effort to attract and retain personnel. One of the top goals is to have

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the OCSME and the two regional Medical Examiner Offices (MEO's) accredited by the National Association of Medical Examiners (NAME) by June 2020.

B. Please detail any organizational and personnel changes that have been implemented or are planned to be implemented at the Office of the Chief State Medical Examiner since January 1, 2018. If applicable, how have these changes affected, or are anticipated to affect, the office's count of funded and filled positions as well as annual costs.

Several hires have been made at the State Office in Trenton and at both the Northern and Southern Regional offices.

a. At the Central Office, key positions including a Chief Financial Officer (CFO), Regulatory Officer, Attorney Assistant and Software Development Specialist (SDS) have been partially accounted for in the FY19 budget. The CFO and SDS have been hired, however, we are still waiting on placement of the Regulatory Officer (Attorney) and Attorney Assistant. These positions are necessary to provide strategic planning, budget development and control, and legal analysis and advisory skill sets to the Central Office. They are also critical to the ability of the Chief State Medical Examiner's Office to plan, design and implement effective and efficient oversight of all medical examiner offices in New Jersey, including the establishment of research and oversight boards as required by P.L.2018, c.62.

b. New hires have also been made at the regional offices, with backfill of investigators at the Northern and Southern offices. A business Manager has also been hired, providing additional support to procurement, fiscal operations and project management, coordination, and support and a histologist has been hired within the State Tox Lab. The office is also in the process of creating a second SDS position.

c. Future plans include the addition of 2 senior medicolegal death investigators at the OCSME whose responsibility would be to oversee the cases handled by the various offices across the state and manage a Quality Assurance/Quality Control system.

C. Please describe the plan for modernizing the State Toxicology Laboratory and provide an update on the plan's implementation and projected costs.

<u>Projects in progress and/or completed:</u>

- <u>Laboratory equipment purchased (approx. $1.7 million)</u>:
    - Two Quadrupole Time of Flight Liquid Chromatography–mass spectrometry (QTOF LC-MS) and 2 LC-MS/MS systems – only one LC-MS/MS system installed.
    - An exhaust vent system to be designed and built to accommodate four new LC-MS instruments above.

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- The design phase is complete, and the construction phase is pending selection of mechanical contractor.

- Large refrigerator to accommodate chemicals/ samples associated with opioid testing.

- One headspace Gas Chromatography/ Mass Spectrometer ($80,000)
- Lab Information Management System (LIMS)
    - Scope of work and user/system requirements through Lab Information Management System (LIMS) consulting company to be funded up to $60,000 with an estimated completion 1-3 months.
    - Selection, purchase and implementation of LIMS estimated at $200,000 requiring an additional 3-6 months completion.

Mental Health and Addiction Services

State Psychiatric Hospitals

20. Following reports of overcrowding, violent attacks, and staffing shortages at the four State psychiatric hospitals, the New Jersey Health Care Facilities Financing Authority commissioned a report in December 2017, to be produced by New Solutions Inc. at a cost not to exceed $740,500, which would review the entire State psychiatric hospital system.

New Solutions Inc. submitted the "Organizational Review & Assessment of State Psychiatric Hospitals – Executive Assessment"[6], which included several recommendations. The department then released the August 22, 2018 report entitled "Action Plan: Response to Executive Assessment of NJ State Psychiatric Hospitals."[7] In that document, the department contended that the findings of New Solutions presented the picture of a hospital system that had been under-resourced, understaffed, and otherwise afflicted with a culture that had not prioritized the system's role in achieving patient-centered clinical care delivery. The department concluded that the systems of care were in significant need of quality improvement as a result of shortcomings that reflected underinvestment in key areas of clinical quality, most notably, appropriate staffing levels. Therefore, the DOH informed that it had launched a turnaround effort to achieve rapid quality improvement in the clinical care delivered across all of the state psychiatric hospitals.

In response to an FY 2019 OLS Discussion Point, the department provided details concerning staff turnover rates, overtime payments, the number of patients on Conditional Extension Pending Placement (CEPP) status, the length of time each patient has been continuously on CEPP status, and the length of time each patient was on CEPP status prior to transitioning to a community placement for FY 2017, as well as the number of officially-reported incidents involving violence for calendar year 2017.

[6] https://nj.gov/health/integratedhealth/documents/NJHCFFA-ExecutiveAssessment.pdf
[7] https://nj.gov/health/integratedhealth/documents/DOHActionPlanforPsychiatricHospitals.pdf

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In FY 2018, the State expended $313.8 million on the operation of the four State psychiatric hospitals. The adjusted FY 2019 appropriations for the psychiatric hospitals combined are $305.1 million, while the Governor's FY 2020 Budget recommends a virtually unchanged $305.2 million for this purpose in FY 2020.

- ***Questions:***

a. What actions is the department taking based on the findings and declarations included in the report by New Solutions on the State psychiatric hospital system?

In response to the NS Report, in August 2018, the Department of Health ("Department") embarked on an 18-month action plan geared to strengthening the system-wide oversight of the State's four (4) psychiatric hospitals (Ancora, Ann Klein Forensic Center, Greystone Park, and Trenton) into a single psychiatric healthcare system. During this time Division of Mental Health and Addiction Services was administratively transferred back to the Department of Human Services; however, the State's four (4) psychiatric hospitals remained under the authority of the Department of Health.

As a result, the Department's Integrated Health Services Branch established the Division of Behavioral Health Services (BHS) to provide oversight of the State's psychiatric healthcare system. As part of this process BHS' Central Office was created, and the identification/appointment of key personnel were made.

Actions and Implementations:

- All facilities across the system continue to work towards the reduction of restraint usage.
- Implemented a Lean Management approach across the system to aid in the development of an integrated system of care by providing a structured and disciplined approach to creating alignment with what our patients want and need.
- Created Ancillary Response Teams (ART) to engage with patients prior to a violent episode and assisting de-escalation and offering staff training, role modeling and support.
- Continued training in 3 Steps to Safety, Trauma Informed Care, Motivational Interviewing, Therapeutic Options.
- Continued evaluation and abatement of ligature risks in the environment. All State hospitals made progress toward 100% compliance in ligature resistant updates in areas of; environmental improvements, hardware upgrades and complete room renovations.
- Initiated mock psychiatric code drills.
- Instituted Fidelity Supervision with Rutgers professors and other subject matter experts on Illness Management and Recovery, Special Instructions Services Unit, Trauma Addictions Mental Health and Recovery, Readiness Check-in and Tools for Moving On.
- Implemented use of a Dynamic Risk Assessment to predict violence.
- Trauma-Addictions Mental Health and Recovery Treatment (TAMAR) programs implemented to successfully re-integrate patients into the community.

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- Developed and Implemented a Behavioral Chain Analysis conducted by Psychologists following a restraint event.
- Implementing across the system, the use of clinical data to identify patients involved in violent behaviors to effectively manage their treatment.
- Implemented a system-wide Violence Prevention Committee.
- Introduced Substance Use Level of Care programs.

Please detail any metrics that already show improvements in the quality of care.

- Across the hospital system, there has been a 66% reduction in violent patient assaults resulting in moderate or major injury—or 21 fewer incidents—in the first quarter of this year (11) vs. the first quarter of last year (32).
- Overall system reduction of census is approximately 9.8% since the beginning of the administration. This reduction allows for additional active treatment to promote quality of care and an overall reduction in the length of stay throughout the system.
- Overall reduction in 1:1s across the system.
- Overall reduction in moderate and major assaults (Patient to Patient/Patient to Staff).
- Compliance in the implementation and utilization of varying risk assessment tools Statewide (Broset/Dynamic Appraisal of Situational Aggression) to assess aggressive/violent behavior which assists in reducing violence.
- Increase in the number of clinical reviews of patients involved in violent behaviors to effectively manage their treatment.
- 100% elimination of administrative seclusion at AKFC.

b. Given that the department declared that the systems of care at the psychiatric hospitals were in significant need of quality improvement because of underinvestment in key areas of clinical quality, most notably, appropriate staffing levels; what are the department's plans for enhancing staffing levels and when will the department begin to implement the plans?

The Department conducted a full assessment of each hospital's staffing plans in an effort to assess current staffing and to develop a standard for the number of clinical staff required at each facility. Due to the state/nationwide shortage of psychiatrists, the Department developed a salary adjustment program to aid in the recruitment and retention of psychiatrists across the State's psychiatric healthcare system. As a result, the Department was able to successfully increase the salary of the clinical psychiatrists by 10% across all three (3) tiers.

· Board Eligible - $191,899.84 to $219,686.49;
· Board Certified - $203,492.70 to $232,957.96; and
· Post Certified (3+ years) - $218,842.78 to $250,530.70.

As part of its recruitment program, the Department has formed an ongoing collaboration with Rutgers/Robert Wood Johnson Medical Center and contracted third-party locum tenens providers to promote recruitment of new psychiatrists. It is DOH's intent to hire 4 Chiefs of Psychiatry and 10 clinical psychiatrists in the 1st quarter of the fiscal year. Pending successful recruitment, an additional 15 clinical psychiatrist would be added by the end of FY20.

Discussion Points

The Department conducted an analysis on the current recruitment and retention issues found by the State's Psychiatric Hospitals as it relates to the Registered Nurse position. Based on the assessment, the Department is exploring recruitment options as it relates to the position with the goal of filling critical positions by the end of FY20.

Does the Governor's FY 2020 Budget provide additional funding for staffing level enhancements?

The current FY 2020 budget does not provide additional resources to support staffing level Increases in the state psychiatric hospitals.

C. For each of the four State psychiatric hospitals, please provide details concerning:

- **Staff turnover rates;**

Hospital	Turnover Rate
Ancora Psych	11.1%
Ann Klein Forensic Center	7.1%
Greystone Park	10.2%
Trenton Psych	9.7%

Overtime payments:

Division of Behavioral Health Services
Overtime Payments
3/20/2019

	Projected FY19
Greystone	$11,536,401
Trenton	$15,589,626
Ancora	$13,064,320
AKFC	$11,838,327
	$52,028,674

- **The number of patients on Conditional Extension Pending Placement (CEPP) status;**

  358

- **The length of time each patient has been continuously on CEPP status and the length of time each patient was on CEPP status prior to transitioning to a community placement for FY 2018;**

Discussion Points

End of Month CEPP Census Aug 2018 - Current by CEPP LOS

Month	Hospital											
	Ancora			Trenton			Greystone			Total		
	Days on CEPP Status		CEPP Census	Days on CEPP Status		CEPP Census	Days on CEPP Status		CEPP Census	Days on CEPP Status		CEPP Census
	Median	Mean		Median	Mean		Median	Mean		Median	Mean	
Aug 2018	187	375	142	279	416	59	316	483	128	252	424	329
Sep 2018	186	367	143	291	446	52	270	450	138	237	414	333
Oct 2018	186	377	133	258	396	56	252	443	139	224	408	328
Nov 2018	172	368	141	258	416	50	245	432	143	215	403	334
Dec 2018	165	361	143	223	361	60	245	436	137	203	391	340
Jan 2019	144	315	164	139	300	73	227	409	138	168	347	375
Feb 2019	134	316	156	132	299	73	203	389	137	158	340	366
Mar 2019	88	268	162	111	215	73	203	374	132	140	296	367
Current (4/2/19)	88	269	160	111	215	73	203	374	132	140	296	365

CEPP Discharges August 2018 - March 2019

Month of Discharge	Hospital											
	Ancora			Trenton			Greystone			Total		
	Days on CEPP Status		Number of Discharges	Days on CEPP Status		Number of Discharges	Days on CEPP Status		Number of Discharges	Days on CEPP Status		Number of Discharges
	Median	Mean		Median	Mean		Median	Mean		Median	Mean	
Aug 2018	62	126	45	109	179	14	161	342	27	78	202	86
Sep 2018	69	127	25	115	176	10	100	158	19	85	147	54
Oct 2018	81	113	47	144	239	8	83	156	20	94	138	75
Nov 2018	59	67	26	61	175	11	120	157	17	77	117	54
Dec 2018	69	72	25	120	108	4	93	136	17	78	99	46
Jan 2019	55	98	29	182	195	5	115	349	12	83	174	46
Feb 2019	69	88	37	37	57	10	229	337	11	86	130	58
Mar 2019	61	153	42	156	517	12	126	235	17	104	234	71
Total	69	110	278	115	220	74	110	230	140	86	161	492

- **Number of officially-reported incidents involving violence for calendar year 2018.**
  - Assaults resulting in Moderate and Major Injury totaled: 121; there is a 66% reduction in mod/major assaults in the 1st quarter of 2019 (11) compared to that in 2018 (32).
  - Patient to Patient assaults: 2018 – 79; there is a 61% reduction in P to P assaults in the 1st quarter of 2019 (9) compared to that in 2018 (23).
  - Patient to Staff assaults:2018 - 23; there is a 61% reduction in P to S assaults in the 1st quarter of 2019 (2) compared to that in 2018 (9).

State Psychiatric Hospitals

21. In February 2017, the department issued a Certificate of Need Call for 864 newly licensed hospital beds for the treatment of psychiatric disorders, including for persons with co-occurring mental health and substance use disorders. Pursuant to this call, the department issued Certificates of Need to 26 of the 30 applicants in November 2017, authorizing an additional 811 adult acute care psychiatric hospital beds. In February 2018, the department issued a subsequent call for 53 hospital beds to satisfy the remaining unmet need for beds. Any increase in private psychiatric hospital beds could potentially reduce the need for public psychiatric hospital beds in State or county facilities; however, in response to an FY 2018 OLS Discussion Point, the Department of Human Services indicated

Discussion Points

that "[w]ith rare exception, the voluntary bed complement does not serve the cohort of individuals who would otherwise be admitted to a public facility."

- ***Questions:***

a. Has the increase in private psychiatric treatment capacity led to a decline in the number of placements at public facilities?

There has not been an increase in capacity that would result in any decline in the number of placements at the public facilities.

b. Has the increase in private psychiatric treatment capacity reduced wait times for patients seeking treatment for psychiatric disorders?

There has not been an increase in capacity that would reduce the wait times for patients seeking treatment

c. Does the department anticipate issuing a Certificate of Need Call for additional adult acute care psychiatric beds in FY 2020?

The Department has no further plans to expand these beds under CN in FY 20.

d. Have efforts to expand the private psychiatric treatment capacity been hindered by a shortage in mental health care professionals? Are there plans in place to ensure the number of mental health care professionals is sufficient to meet patient demand?

There is a state and national shortage of mental health care professionals, the Department cannot speak towards efforts taken by the private psychiatric treatment facilities. However, as mentioned above, the State set forth a salary adjustment program as well as embarked on a recruitment and retention plan geared to meeting critical staffing needs.

Health Planning and Evaluation

Telemedicine

22. Telemedicine is the remote delivery of health care services and clinical information using telecommunications technology. This includes a wide array of clinical services using internet, wireless, satellite, and telephone media. Currently, more than 30 states and the District of Columbia require that private insurers cover telehealth services the same as in-person services. Many other insurers cover at least some telehealth service.[8]

New Jersey authorized the use of telemedicine pursuant to P.L.2017, c.117 (N.J.S.A.45:1-46 et al.). The law requires telehealth and telemedicine organizations to annually register with the department and to report certain encounter data; including the total number of encounters, the types of technology being utilized to provide services, the categories of medical condition for which services are sought, the region where the patient was located, the patient's age and sex, the patient's race and

[8] http://www.americantelemed.org/main/about/about-telemedicine/telemedicine-faqs

Discussion Points

ethnicity, any prescriptions issued, diagnostic codes, evaluation management codes, and the source of payment for the encounter.

- ***Questions:***

  a. How many telehealth and telemedicine organizations are currently registered with the department?

  None currently. A Notice of Proposal of New Rules is being finalized by the Department of Health. The Notice must be published in the New Jersey Register. Public comments will be received. The Department will review and respond to public comments, and then proceed with publishing a Notice of Adoption.

  b. What types of services are being provided via telehealth and telemedicine and how many patients are receiving telehealth and telemedicine services?

  Since services are deemed allowable under a provider's professional license and the professional board sets stipulations for the service, the Department does not track this information.

  c. What has been the increase in the number of patients receiving services in medically underserved areas that is attributable to the availability of telehealth and telemedicine services?

  The registry does not apply to all telemedicine provided in the state and additional funding would be required to get a larger registry than is currently operated.

  d. What has been the increase in the number of patients receiving services in connection with substance use disorder treatment that is attributable to the availability of telehealth and telemedicine services?

  Since services are deemed allowable under a provider's professional license and the professional board sets stipulations for the service, the Department does not track this information.

Charity Care

23. Acute care hospitals are required by State law to provide all necessary care to patients regardless of ability to pay, pursuant to P.L.1992, c.160 (N.J.S.A.26:2H-18.52 et al.). Charity Care is free or reduced charge care that is provided to uninsured patients who receive their inpatient and outpatient services at acute care hospitals throughout the State. To offset the costs to hospitals of uncompensated care delivered to low-income uninsured patients, the State provides subsidies through the New Jersey Hospital Care Payment Assistance Program (Charity Care Program). The source of funding for hospital care payment assistance is the Health Care Subsidy Fund (HCSF) administered under P.L.1997, c.263. The Governor's FY 2020 Budget includes expenditures of $262 million from the HCSF for Charity Care, which is the same as the revised FY 2019 appropriation.

Discussion Points

The current statutory Charity Care distribution formula, established pursuant to subsection b. of N.J.S.A.26:2H-18.59i, ranks hospitals according to the percentage of each hospital's gross patient revenue attributable to Charity Care patients, and pays hospitals with a higher rank a larger subsidy in proportion to their total documented Charity Care. Notably, the statutory formula directs that hospitals that provide the most Charity Care and serve the communities with the lowest median incomes receive 96 percent of the hospital's documented Charity Care. The formula also provides for a minimum reimbursement to each hospital of 43 percent of its documented Charity Care. The current statutory formula has never been implemented precisely as enacted, as appropriations language has overridden it in each Appropriations Act since the current formula was established in 2004.

The proposed formula for FY 2020 differs from the statutory formula, and results in Charity Care subsidies for certain hospitals that are less than the statutory minimum of 43 percent. The recommended FY 2020 formula is substantively identical to the FY 2019 formula, except that the years of the source data are updated.

Uncompensated care claims by New Jersey hospitals decreased significantly from about $1.0 billion annually from calendar year 2010 through calendar year 2013 to $451 million in calendar year 2016. New Jersey Charity Care appropriations mirrored this trend: in FY 2015, for example, Charity Care expenditures were $650 million while the revised FY 2019 appropriation stands at $262 million. The downward trend in the costs associated with individuals who do not have alternative forms of health insurance was due to two elements of the federal Affordable Care Act (ACA): the health insurance purchase mandate imposed on individuals in conjunction with federal premium tax credits and cost-sharing subsidies, and the State's decision to opt into the ACA's optional expansion of Medicaid coverage to individuals with household incomes up to 138 percent of the federal poverty level.

In calendar year 2017, the downward trend in uncompensated care claims by New Jersey hospitals reversed with claims totaling $482 million. Federal health insurance policy changes in 2017 may have contributed to the trend reversal. In October 2017, the federal government ceased to make cost-sharing reduction subsidy payments to health insurance carriers. These payments effectively lowered the cost of qualified insureds for health insurance policies purchased through the health insurance marketplace. In December 2017, the "Tax Cuts and Jobs Act," Pub.L.115-97, then repealed the individual mandate penalty under the ACA as of tax year 2019. Through tax year 2018, the ACA required taxpayers to pay a penalty on their tax returns if they did not have minimum essential health insurance coverage or qualified for an exemption.

In reaction to the federal changes, P.L.2018, c.31 restored the individual mandate in New Jersey beginning in tax year 2019. If the taxpayer does not obtain coverage, the bill imposes a State shared responsibility tax equal to a taxpayer's federal penalty under the ACA prior to the repeal of the federal mandate.

- ***Questions:***
  - **a. Please provide a table displaying the hospital-specific distribution that would result from the statutory Charity Care distribution formula, using the most recent available cost and documented charity care data available.**

Discussion Points

HOSPITAL NAME	Charity Care Subsidy Statutory Allocation
Hackensack University Medical Center	$7,368,707
Newark Beth Israel Medical Center	$8,240,367
Hackensack UMC - Palisades	$9,160,175
Hunterdon Medical Center	$968,368
St. Mary's General Hospital	$3,392,232
Holy Name Medical Center	$1,529,970
Clara Maass Medical Center	$2,735,957
University MC of Princeton - Plainsboro	$1,866,009
Cape Regional Medical Center	$419,425
Valley Hospital	$1,225,561
Cooper Hospital/University MC	$15,382,775
Morristown Medical Center	$3,894,300
CarePoint Health - Christ Hospital	$11,992,886
Chilton Medical Center	$208,704
St. Joseph's University Medical Center	$44,874,806
St. Francis Medical Center	$4,262,482
RWJ University Hospital - Rahway	$393,825
CarePoint Health - Bayonne Medical Center	$2,882,694
Trinitas Regional Medical Center	$28,451,222
Newton Medical Center	$313,288
Our Lady of Lourdes Medical Center	$3,110,821
Deborah Heart and Lung Center	$1,453,290
Riverview Medical Center	$1,189,430
Hackensack UMC - Pascack Valley	$169,628
Robert Wood Johnson University Hospital	$12,224,491
CarePoint Health - Hoboken University Medical Center	$10,826,381
Community Medical Center	$1,251,345
Capital Health Medical Center - Hopewell	$4,463,799
Englewood Hospital and Medical Center	$3,394,101
Shore Medical Center	$577,750
RWJ University Hospital - Somerset	$1,363,304
St. Clare's Hospital - Denville	$1,074,487
Overlook Medical Center	$2,158,766
Ocean Medical Center	$911,091
Hackensack UMC - Mountainside	$516,377
Virtua-Mem. Hospital of Burlington County	$1,504,136
New Bridge Medical Center (Bergen Regional)	$15,821,107
St. Luke's Warren Hospital	$431,364

Discussion Points

Lourdes Medical Center of Burlington Cty.	$1,390,817
Inspira Medical Center - Elmer	$241,905
St. Peter's University Hospital	$14,697,392
Jersey Shore University Medical Center	$3,991,702
Jersey City Medical Center	$11,142,603
Monmouth Medical Center	$4,784,597
St. Barnabas Medical Center	$2,393,432
Inspira Medical Center - Woodbury	$266,425
East Orange General Hospital	$4,432,788
Monmouth Medical Center - Southern	$2,320,594
Salem Medical Center	$109,869
Capital Health Regional Medical Center	$14,205,903
St. Michael's Medical Center	$6,872,099
JFK Medical Center	$4,655,652
RWJ University Hospital - Hamilton	$804,960
CentraState Medical Center	$1,848,778
Bayshore Community Hospital	$284,049
Southern Ocean Medical Center	$355,921
Hackettstown Regional Medical Center	$133,400
St. Joseph's Wayne Medical Center	$1,069,019
Hudson Regional Hospital (Meadowlands)	$128,641
University Hospital	$58,307,681
St. Clare's Hospital - Sussex *	$0
Virtua-West Jersey Health Sys. - Voorhees	$1,174,984
Virtua-West Jersey Health Sys. - Berlin *	$0
Virtua-West Jersey Health Sys. - Marlton	$566,784
Inspira Medical Center - Vineland	$2,676,317
Raritan Bay Medical Center - Perth Amboy	$3,183,666
Raritan Bay Medical Center - Old Bridge	$330,906
St. Clare's Hospital - Dover	$1,713,942
AtlantiCare Regional MC - Mainland	$4,883,152
AtlantiCare Regional MC - City	$8,987,335
Jefferson Washington Twp Hospital	$740,145
Jefferson Cherry Hill Hospital	$725,653
Jefferson Stratford Hospital	$605,526
TOTAL	$372,032,055

b. To what extent does the recommended FY 2020 Charity Care appropriation take into account the effects of the 2017 federal health insurance policy changes on hospitals' uncompensated care claims, including any trends in the uncompensated care claims and in the insurance market observed since 2017?

Discussion Points

The FY 2020 Charity Care appropriation is maintained at $262 million, rather than continuing the trend of funding reductions, demonstrating continued support of hospital funding and anticipated increases in documented charity care. The department continues to monitor trends of uninsured throughout the State and we will recommend adjustments accordingly. The department continues to work with other State departments to improve access to quality care throughout the State, including reaching out to all hospital stakeholders to help promote GetCoveredNJ during open enrollment for the national health insurance exchange.

c. To what extent does the recommended FY 2020 Charity Care appropriation take into account the effects of the restoration of the individual mandate under P.L.2018, c.31 on hospitals' uncompensated care claims, including any trends in the uncompensated care claims and in the insurance market observed since 2017?

The base of the charity care formula includes the proportion of charity care charges to overall gross revenue for each hospital. The use of this ratio is to provide those hospitals with the greatest relative charity care percentage with the highest proportion of charity care subsidy. Due to the need to audit claims and revenue, the charity care formula is dependent on data from two years prior. In time, the effect of the individual mandate will impact the charity care charges that are submitted by the hospitals.

d. Has the department studied the likely impact of the 2017 federal health insurance policy changes and P.L.2018, c.31 on the finances of New Jersey hospitals? If so, please detail the findings of the analysis.

The Department continues to monitor trends that affect the uninsured population and charity care provision throughout the State. The Department also closely monitors the financial health of acute care hospitals throughout the State and will continue to do so as federal policies change.

e. Please project the likely impact over the next five fiscal years of the 2017 federal health insurance policy changes and P.L.2018, c.31 on uncompensated care services provided by New Jersey hospitals and, in turn, the State's Charity Care Program.

The Department continues to monitor trends that affect the uninsured population to ensure that all individuals in the State have access to quality care. The department cannot predict five years into the future due to uncertainty of other federal or state changes in that time. A downward trend in charity care as a result of an upward trend in individuals with insurance due to the State initiative would benefit individuals by increasing access to quality care.

f. Please discuss any policy responses the department is currently developing to the 2017 federal health insurance policy changes and P.L.2018, c.31.

The Department continues to monitor trends that affect the uninsured population to ensure that all individuals in the State have access to quality care.

Discussion Points

g. **To what extent, if any, does the Charity Care program allow hospitals to include in the amount of uncompensated care hospitals report to the program amounts owed by underinsured patients who cannot afford to pay their share of the cost of treatment?**

N.J.A.C.10:52-11.5 details the screening and documentation requirements that hospitals must use when determining eligibility for charity care. The Charity Care program permits patients who have health insurance, but their insurance is unlikely to pay the bill in full to be considered for Charity Care eligibility. All applicants must meet the same eligibility requirement whether uninsured or insured. If the hospital determines the insured patient is eligible for charity care, the electronic claim submission must include all third-party payments (ie insurance). The program does not have statistics on the extent that this occurs, but believes it is low volume.

Graduate Medical Education

24. The Governor's FY 2020 Budget includes a total appropriation of $242.0 million for Medicaid Graduate Medical Education (GME). The total FY 2019 appropriation was $242.3 million, which included an original appropriation of $218.0 million plus $24.3 million for supplemental Safety Net GME pursuant to P.L.2018, c.116. The budget displays the FY 2020 recommendation as a General Fund appropriation, but only $87.1 million of the total represents State funding. The remaining $154.9 million comes from federal funds. The program's funding level has experienced a long-term trend of growth. In FY 2011, for example, GME was funded at $60.0 million and in FY 2012 at $90.0 million.

P.L.2018, c.116 appropriated $24.3 million to the new Safety Net GME pool and specified a distribution formula for the funds. Eligible for disbursements out of the pool were only those acute care hospitals with a residency program that ranked in the top third of all acute care hospitals with a residency program after calculating the ratio of a hospital's gross revenue from Medicaid patient care divided by the hospital's gross revenue from patient care.

Historically, Medicaid GME was supported with 50 percent federal funds, but beginning in FY 2015, the State received a higher federal matching rate under the Affordable Care Act for certain patients seen by the hospitals. The recommended FY 2020 appropriation anticipates a 64 percent federal match, which is virtually unchanged from FY 2019. Medicaid GME pays hospitals under two related systems: direct GME which makes payments to hospitals to cover the costs directly related to educating residents; and indirect GME, which is payments to teaching hospitals intended to account for higher costs of providing specialized care to highly complex patients.

The Governor's FY 2020 Budget retains language that was included in each of the FY 2017, FY 2018, and FY 2019 Appropriations Acts requiring each hospital receiving a GME allocation to provide a report to the DOH indicating the total number of physicians who completed their training during the preceding calendar year, and the number of those physicians who plan to practice medicine in New Jersey. The department responded to an FY 2019 OLS Discussion Point that approximately 23.4 percent of medical residents planned to stay in New Jersey following their residencies, and that the department was still determining the best policy response to these data.

• ***Questions:***

a. **Has the general upward trend in GME funding been associated with an increased number of residents in hospitals? Please provide the number of residents for FY 2016 through the most recent year for which such data are available.**

Discussion Points

Analysis of the data indicates an increase in the number of residents that is associated with the increased trend in funding over the previous year's data.

The number of full-time residents for NJ hospitals (source – Medicaid Cost Report)

2016	2017
FTEs	FTEs
3,522	3,560

b. Please report, in the aggregate and by hospital, the data that Medicaid GME-receiving hospitals submitted in FY 2019 regarding the number of physicians who completed their training and the number of those physicians who planned to practice medicine in New Jersey. What conclusions does the department draw from these numbers? Please describe any policy responses the department has implemented, or plans to implement, based on the data.

Discussion Points

Hospital	Completed Residency Training FY 2019	Physicians Practicing in NJ FY 2019
AtlantiCare	18	3
Atlantic Health System (Overlook)	23	3
Capital Health Medical Center Hopewell	0	0
Capital Health System at Fuld	11	3
CarePoint Health - Hoboken University Medical Center	8	3
CarePoint Heath - Bayonne Hospital	0	0
CarePoint Health - Christ Hospital	5	2
CentraState Medical Center	6	3
Cooper University Health Care	72	11
Deborah Heart and Lung Center	12	3
Englewood Hospital and Medical Center	13	1
Hackensack Meridian Health (HUMC)	30	14
Hackensack Meridian Health Jersey Shore University Medical Center	45	15
Hackensack Meridian Health Mountainside Medical Center	14	8
Hackensack Meridian Health Palisades Medical Center	48	Not Available
Hackensack Meridian Health Raritan Bay Medical Center Perth Amboy	8	1
Hunterdon Medical Center	6	3
Inspira Health Network (Vineland)	52	11
Inspira Health Network (Woodbury)	4	2
JFK Health	13	4
Jersey City Medical Center	28	7
Kennedy Health	36	Not Available
Lourdes MC Burl County (LMCBC - Lourdes Health System)	1	Not Available
Monmouth Medical Center	35	6
Morristown Medical Center	59	6
New Bridge Medical Center	11	4
Newark Beth Israel Medical Center	56	28
Our Lady of Lourdes MC (OLOL-Lourdes Health System)	12	Not Available
Princeton HealthCare System	24	Not Available
RWJBarnabas Health Somerset	7	4
Robert Wood Johnson University Hospital	90	Not Available
Saint Barnabas Medical Center	55	13
Saint Michael's Medical Center	18	1
Saint Peter's University Hospital	30	34
St. Francis Medical Center	9	0
St. Joseph's Healthcare System	53	14
St. Luke's Warren Campus	6	2
St. Mary's General Hospital	1	1
Trinitas Regional Medical Center	15	5
University Hospital	163	32
Virtua Memorial Hospital of Burlington County	7	Not Available
Virtua West Jersey Health System	9	8
TOTALS:	1,113	255

Discussion Points

c. Please provide, in the aggregate and by hospital, the number of additional residencies that will be funded in FY 2020 using the Safety Net GME pool.

The GME Supplemental subsidy, established by P.L.2018, c. 116 is intended for the top 1/3 of hospitals with the highest Relative Medicaid Percentage.

d. Please provide for FY 2019 and FY 2020 the actual or planned allocation of Safety Net GME funding among hospitals.

	Actual (5.4v)	Proposed
Hospital	**SFY 19 Payment**	**SFY 20 Payment**
New Bridge Medical Center (Bergen Regional)	$ 15,011	$ 26,305
University Hospital	$ 5,756,118	$ 6,387,308
Newark Beth Israel Medical Center	$ 4,179,211	$ 4,057,003
St. Joseph's University Medical Center	$ 3,120,235	$ 3,315,366
CarePoint Health - Christ Hospital	$ 193,308	$ 198,604
Jersey City Medical Center	$ 1,466,361	$ 1,493,311
CarePoint Health - Hoboken University Medical Center	$ 389,940	$ 428,292
Trinitas Regional Medical Center	$ 590,969	$ 571,467
St. Francis Medical Center	$ 189,124	$ 200,890
St. Michael's Medical Center	$ 852,693	$ 511,760
Capital Health Regional Medical Center	$ 222,617	$ 354,057
Cooper Hospital/University MC	$ 5,066,238	$ 5,899,675
St. Mary's General Hospital	$ -	$ 24,323
Atlanticare Regional Medical Center	$ 504,924	$ 531,639
Inspira Medical Center - Vineland	$ 1,738,967	
Totals	**$ 24,285,714**	**$ 24,000,000**

Delivery System Reform Incentive Payments

25. The Delivery System Reform Incentive Payments (DSRIP) program, a component of the Comprehensive Medicaid Waiver, was established as a five-year federally co-funded demonstration project to be completed on June 30, 2017. In 2017, the federal Centers for Medicare and Medicaid Services (CMS) approved a two-year extension of the DSRIP program, plus a one-year transition period, thus fully funding a continuation of the program for FY 2018 through FY 2020 at $166.6 million per fiscal year.[9]

DSRIP provides subsidies to participating hospitals that carry out approved projects designed to improve the quality of care provided, the efficiency with which care is provided, or population health. DSRIP disbursements are linked to the achievement of specific performance objectives. Forty-six hospitals are approved for participation in the program's third demonstration year.

[9] https://dsrip.nj.gov/

Discussion Points

The Governor's FY 2020 Budget includes language stating that an unchanged $166.6 million is appropriated for DSRIP. The appropriation has three funding sources: $62.6 million from the General Fund (page D-158); $20.7 million from the Health Care Subsidy Fund (a portion of the recommended $296.3 million FY 2020 All Other Funds appropriation on page D-159 and referenced on page H-11); and $83.3 million in federal funding (a portion of the recommended $89.0 million FY 2020 Federal Funds appropriation on Page D-158 and referenced on page H-11). The Governor's FY 2020 Budget also includes contingency language that authorizes the DOH to transfer the recommended $166.6 million FY 2020 DSRIP appropriation to the Charity Care or Graduate Medical Education programs if CMS rejects the State's waiver extension request for the DSRIP program so as to ensure that payments to hospitals continue to include federal matching funds.

In response to an FY 2019 OLS Discussion Point, the department indicated that a draft of an evaluation of the DSRIP program by the Rutgers Center for State Health Policy was due April 30, 2018.

- ***Questions:***

a. **Please provide the distribution by hospital of the recommended $166.6 million FY 2020 DSRIP appropriation.**

Table III Participating DSRIP Hospital	Annual DY6-DY8 Funding Target
AtlantiCare Regional Medical Center	6,676,138
New Bridge MC (Bergen)	14,046,927
Capital Health Medical Center – Hopewell	1,898,860
Capital Health Regional Medical Center	3,535,341
CarePoint Health - Bayonne Medical Center	250,000
CarePoint Health - Christ Hospital	2,203,816
CarePoint Health - Hoboken University Medical Center	1,053,708
CentraState Medical Center	425,804
Chilton Medical Center	250,000
Clara Maass Medical Center	2,755,066
Community Medical Center	452,606
Cooper Hospital/University MC	6,122,062
East Orange General Hospital	2,687,750
Englewood Hospital and Medical Center	404,564
Hackensack UMC – Palisades	897,627
Hackensack University Medical Center	1,479,694
Inspira Medical Center – Elmer	250,000
Inspira Medical Center – Vineland	4,350,233
Inspira Medical Center – Woodbury	763,136
Jersey City Medical Center	7,596,119
Jersey Shore University Medical Center	3,529,681
JFK Medical Center/A M Yelencsics	408,104
Jefferson Health New Jersey (Kennedy)	6,402,389
Lourdes Medical Center of Burlington Cty.	2,047,576
Monmouth Medical Center	7,642,526
Monmouth Medical Center – Southern	4,969,597

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Morristown Medical Center	451,595
Newark Beth Israel Medical Center	12,336,508
Newton Medical Center	250,000
Our Lady of Lourdes Medical Center	2,428,853
Overlook Medical Center	264,483
Raritan Bay Medical Center	2,444,506
Robert Wood Johnson University Hospital	3,927,127
RWJ University Hospital – Hamilton	250,000
St. Barnabas Medical Center	462,214
St. Clare's Denville / Dover	5,530,996
St. Francis Medical Center	1,250,987
St. Joseph's Medical Center	10,705,204
St. Mary's General Hospital	2,302,211
St. Michael's Medical Center	6,635,156
St. Peter's University Hospital	4,532,171
Trinitas Regional Medical Center	9,421,729
University Hospital	13,516,857
University MC of Princeton – Plainsboro	298,872
Virtua - West Jersey Health	887,512
Virtua-Mem. Hospital of Burlington County	710,516
Total Statewide Target Funding	161,706,819
Non-Participating Hospitals*	4,893,181
Total Annual DSRIP Funding	166,600,000
* Non-Participating Hospitals Amount to be redistributed to participating hospitals at fiscal year end.	

This information is based on target funding and does not include the distribution of the Universal Performance Pool (UPP) and the redistribution of funding of hospitals who have chosen not to continue with the DSRIP program. These two amounts cannot be determined until the projects have been complete for the year and the evaluation of metrics has been performed.

b. Please provide an evaluation of the performance of the five-year DSRIP demonstration program. What outcomes made the program a success and what outcomes did not meet initial department expectations? Please provide an update concerning the status of the program evaluation being conducted by the Rutgers Center for State Health Policy.

The Rutgers Center for State Health Policy is currently conducting an evaluation of the DSRIP program. Once that evaluation is complete, it will be made public. It is currently awaiting CMS approval.

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c. **Please provide, in the aggregate and by hospital, the number of DSRIP performance objectives that participating hospitals met during the initial five-year DSRIP demonstration period and the number of DSRIP performance objectives that participating hospitals failed to achieve. Does the department notice significant variations in each hospital's ability to meet performance objectives?**

The Rutgers Center for State Health Policy is currently conducting an evaluation of the DSRIP program. Once that evaluation is complete, it will be made public. It is currently awaiting CMS approval.

Federally Qualified Health Centers

26. P.L.2005, c.237 allocated $40 million annually from the surcharge on each general hospital and each specialty heart hospital to federally qualified health centers (FQHCs). The Governor's FY 2020 Budget includes language which overrides this statute and allocates only $32 million for reimbursements to FQHCs for uncompensated care provided to uninsured patients. This funding level is identical to the funding provided to FQHCs in FY 2018 and FY 2019.

In response to FY 2018 and FY 2019 OLS Discussion Points, the department reported that the number of uncompensated care visits to FQHCs was 301,066 in FY 2016, 304,873 in FY 2017, and an estimated 315,953 in FY 2018 and 333,330 in FY 2019. The year-to-year estimates and actual figures represent an upward trend in the number of uncompensated care visits over the last four fiscal years.

FQHCs provide comprehensive primary health care services primarily to uninsured, underinsured, Medicaid, and Medicare patients. Services are charged on a sliding scale based on patients' income. According to the department website, there are currently 24 FHQCs operating 117 healthcare delivery sites in New Jersey.[10]

- ***Question:*** **Please provide the actual or estimated number of visits to FQHCs which were or are estimated to be reimbursed through uncompensated care funding in FY 2018, FY 2019, and FY 2020.**

FY2018: 310,422
FY2019 (estimated): 316,832
FY2020 (estimated): 316,832

Health Care Facilities

27. N.J.A.C.8:43E establishes the general licensure procedures and standards applicable to all licensed long-term care and acute care facilities. The department, or its designee, may conduct periodic or special inspections of licensed health care facilities to evaluate the fitness and adequacy of the facility and to ascertain whether the facility complies with all applicable State and federal licensure regulations and statutes.

[10] https://web.doh.state.nj.us/apps2/fhs/cphc/cphcList.aspx

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The department, or its designees, may also conduct surveys of facilities on behalf of the U.S. Department of Health and Human Services for purposes of evaluating compliance with all applicable federal regulations or Medicare and Medicaid certification regulations.

Ten days after conclusion of the survey, or inspection, the department will provide a facility with a written summary of any factual findings which indicate a violation of licensure. The regulations outline the process for informal dispute resolution (N.J.A.C.8:43E-2.3), implementing a plan of correction (N.J.A.C.8:43E-2.4), and enforcement remedies available to the department (N.J.A.C.8:43E-3.1). Enforcement remedies include a civil monetary penalty; curtailment of admissions; appointment of a receiver or temporary manager; provisional license; suspension of license; revocation of a license; order to cease and desist operation of an unlicensed health care facility; and other remedies for violations of statutes as provided by State or federal law or regulations.

• ***Questions:***

a. **What is the total revenue anticipated to be collected by the department from fines and penalties in FY 2019 and FY 2020?**

FY19: $150,000
FY20: $250,000

b. **Has the department had to take action against a long-term care or acute care facility's license in FY 2019? If yes, please indicate the number of actions taken and the number of licensees that were subject to department action.**

For the period from July 1, 2018 to March 27, 2019, the Department has taken 15 enforcement actions against the licenses of nine facilities and has issued seven orders to cease and desist unlicensed activities to seven facilities.

28. On March 19, 2019, the State Commission of Investigation (SCI) released a report on the department's oversight of hospital finances and ownership arrangements and related accountability issues. The SCI identified a number of potential issues at a particular health care system and noted potential ways the department could revise its current regulations and oversight practices to better identify and address potential issues in health care facilities. The recommendations in the report include: requiring hospitals to produce certain financial statements for related parties; clarifying the definition of "related party"; mandating additional disclosures concerning interests held in trust; evaluating related-party management services and requiring documentation of management services for which fees are recorded; expanding the scope of the current Early Warning System and promulgating regulations; expanding the review of audited financial statements to include all hospitals, not just those receiving departmental funding; clarifying the procedures for approving ownership changes; and creating an ownership tracking database. The SCI noted the department's stated plans to adopt extensive new regulations and the potential challenges in implementing a number of these recommendations, including the large number of facilities overseen by the department and staff and resource limitations.

• ***Questions:***

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a. Does the department agree with the findings and recommendations set forth in the SCI report on hospital oversight and accountability?

The findings of the SCI report are being carefully considered by the Department. Specifically, the second phase of the transparency regulations are under discussion and a review of the current scope of information that is collected through the Early Warning System is being conducted. Additionally, the department is undergoing a transition to a new HSB licensing system that is all electronic and will streamline the collection and retention of information required during the licensing process, including the ownership data highlighted by the SCI report.

b. What steps does the department anticipate taking in response to the issues raised in the SCI report? What is the status of any current department initiatives that would address these issues?

A draft of the second phase of the financial transparency regulations is under discussion by key department staff. Staff is reviewing the current information that is collected through the Early Warning System. The new HSB licensing system is being tested and is planned to be live by the end of this calendar year. The first group of licensees to submit information to the portal, the Ambulatory Care Facilities Annual Financial Report submission is currently being implemented.

c. Would additional staff and resources be necessary to fully implement the recommendations included in the SCI report? If so, please detail the anticipated number of additional personnel that would be needed, the types of duties to be performed by such personnel, and any additional resources that would be needed. What would be the anticipated cost of any such additional personnel and resources?

The SCI recommendations would require specialized attorneys and professionals in the financial field. The Department would most likely need to seek contracts with individuals with experience in these areas.

d. Please provide an estimate of the length of time that would be needed to fully implement the recommendations included in the SCI report.

The actions the Department is undertaking and references in response to question a. of this discussion point should be complete by the end of 2020.

29. The DOH surveys long-term care facilities on behalf of the U.S. Department of Health and Human Services for purposes of evaluating compliance with all applicable federal regulations, including Medicare and Medicaid certification regulations. If during these surveys the DOH identifies violations by the facility, it may recommend to the federal department Civil Monetary Penalties (CMPs).[11] CMPs are imposed for either the number of days or for each instance a facility is not in

[11] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/CMP-FAQs.pdf

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substantial compliance with one or more Medicare and Medicaid participation requirements for long-term care facilities. A portion of CMPs collected from facilities is returned to the state in which the CMPs were imposed. State CMP funds may be reinvested to support activities that benefit nursing facility residents and that protect or improve their quality of care or quality of life. Each state has its own process for facilities to request funding from CMPs.

The department replied to the FY 2018 OLS Discussion Points that it received about $9 million in cost reimbursements from the U.S. Department of Health and Human Services in each of FY 2014 and FY 2015. In addition, the department noted in response to FY 2018 and FY 2019 Discussion Points that it received $176,000 in CMP funding in FY 2016 and $533,000 in FY 2017.

- ***Questions:***

a. **What was the amount of federal funds received by New Jersey from CMPs for allocation to requesting long-term care facilities in FY 2018 and FY 2019 to date?**

FY18: $399,129.93 received from CMS
FY19: $464,562.35 received from CMS

b. **What was the amount of funding provided to approved long-term care facilities from federal CMP revenue in FY 2018 and FY 2019 to date?**

This is not provided to Long Term Care facilities, it is provided to the organizations that submit approved proposals:

FY18: $83,418.78 expended
FY19: $9,900 expended

c. **How many facilities requested funding from CMPs in the State in FY 2018 and FY 2019?**

Eight in SFY 2018; six in SFY 2019 so far.

d. **How many facilities were granted funding from CMPs in the State in FY 2018 and FY 2019?**

Three were granted funding in SFY18 and one is still under consideration/revision; two were granted funding so far in SFY19 and two are still under consideration/revision.

e. **What is the amount of cost reimbursements that the DOH received in FY 2016, FY 2017, and FY 2018 from the U.S. Department of Health and Human Services for surveying long-term care facilities for compliance with applicable federal regulations?**

	2016	2017	2018
S&C (Medicare)	$ 5,309,413.00	$ 5,992,984.00	$ 6,188,459.00
Medicaid	$ 3,732,751.00	$ 3,959,520.00	$ 4,107,469.00
Total	**$ 9,042,164.00**	**$ 9,952,504.00**	**$ 10,295,928.00***

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* FY2018 has not been closed out so this figure is subject to change after the final report is submitted.

Health Care Facility Licensing

30. P.L.2017, c.294 requires the DOH, effective on February 1, 2019, to establish a new integrated health care facility licensing system under which facilities will provide primary care, mental health care, substance use disorder treatment, or a combination of such services under a single license. In December 2018, the Administration transferred $2.6 million out of the $100 million FY 2019 Expanded Addiction Initiatives appropriation to the Department of Health for the single license for facilities providing integrated primary care, mental health care and substance use disorder treatment services. No readily identifiable funding for the single license is proposed in the Governor's FY 2020 Budget, although the $100 million appropriation to Expanded Addiction Initiatives in the Department of Human Services is recommended to be renewed.

- ***Questions:***

  a. What is the implementation status for the single license for facilities providing primary care, mental health care, substance use disorder treatment, or a combination of such services?

  While comprehensive regulatory reform takes place, DOH has convened stakeholder groups to help parse through barriers to integrated care, released guidance for healthcare facilities to better integrate services, and identified ways to streamline the licensure process.

  - Healthcare facilities are currently providing integrated care:
    - 80 facilities offer at least two modalities of care. Dually licensed Mental Health and Substance Use Disorder facilities will soon be offered a single license and license number.
    - Seven Federally Qualified Health Centers (FQHC) offer multiple modalities.
    - Seven Certified Community Behavioral Health Clinics (CCBHC) have all three license types.
  - Stakeholder meetings have helped to identify the best routes to integrated care:
    - Monthly meetings with the Integrated Health Advisory Panel (IHAP)
      - The IHAP is comprised of representatives from the provider community as well as experts in integrated care, evidence-based practices, and barriers to care. Stakeholders on the IHAP identified that guidance documents and regulatory waivers would be the most effective first steps to help healthcare facilities provide the care that is needed in the community. Based on this feedback, DOH has released several documents addressing direct provider concerns.
      - DOH also convened smaller groups of the IHAP to focus on specific service types.

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- DOH has released guidance and waivers to more quickly and efficiently help providers provide integrated care:
  - Reorganization plan: DOH released guidance in December 2017 alerting facilities to pending changes to the regulatory landscape. Facilities were advised that licensing and inspection functions are unified under DOH; facilities may continue to provide integrated services without an additional license if they received permission to do so; and that facilities may share clinical space pursuant to DOH guidance.
  - Medication Assisted Treatment: DOH issued clarification in November 2018 that "drug abuse treatment services" in Ambulatory Care Facilities (ACFs), as set forth in its rules, includes buprenorphine and other medications so that ACFs with licenses that include outpatient drug abuse treatment may prescribe buprenorphine. This provides ACFs with added flexibility of how to treat primary care patients with substance use disorders.
  - Shared clinical space: In 2015, DOH's Division of Certificate of Need and Licensing issued a waiver to permit DOH-licensed facilities to share clinical space when offering behavioral health services. The Governor signed PL 2017 into law permitting the sharing of clinical space. DOH released additional guidance in March 2019 for dually licensed substance use and mental health facilities to clarify that there is no restriction in NJ regulations to prohibit the sharing of clinical space within a single legal entity.
  - Deemed status: In March 2019, DOH released a waiver opportunity for substance use disorder facilities to receive deemed status in lieu of required periodic inspections when the facility is accredited by an accrediting body recognized by the Department. Up until then, deemed status was available for mental health facilities but not for substance use facilities. Making these waivers available will help to harmonize licensure requirements and procedures across facility types, particularly those with multiple licenses.
  - Frequently Asked Questions: In March 2019, DOH released a Frequently Asked Questions chart identifying the services that healthcare facilities can provide under current regulations. Stakeholders commended the usefulness of the chart in clarifying common misperceptions about regulatory barriers but asked for more guidance on reimbursement mechanisms.

- Technology Upgrades at DOH will streamline an integrated licensing system.

- DOH is working on comprehensive regulatory reform to develop a single licensing system for Ambulatory Care, Mental Health, and Substance Use Disorder Facilities.
  - DOH is reviewing licensure requirements including the application process, fee schedule, inspection schedule, medical records, client rights, staffing, physical plant, infection control, and facility policies in each facility type with the goal of creating a single license. DOH anticipates having proposed rules by the end of 2019.

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b. Does the department anticipate an allocation to the single license program out of the $100 million recommended FY 2020 appropriation for Expanded Addiction Initiatives? If so, in what amount? If the program is not intended to receive an allocation out of the recommended FY 2020 appropriation for Expanded Addiction Initiatives, will the program receive funding from another source?

The allocation for single license that was set for FY2019 was intended to be spread over two years. There is neither a new ask or expectation around money single license for FY2020.

c. Please specify what costs the $2.6 million FY 2019 transfer to the account for the single license covered. Were the moneys used for one-time start-up costs only? Have recurring administrative costs been charged to the account?

In FY19, the $2.6m, funded through Mental Health is to start up the program and supports a combination of IT consultants and IT FTE as well as IT costs.

Data Migration Cost	97,000	Developers (2)	720,000
Dynamic Software	180,000	Developers (2)	540,000
Development tools	150,000	QA Staff (2)	480,000
IT Costs	427,000	Scrum Master (2)	350,000
		Lead	50,000
		Manager	33,000
			2,173,000

d. What were the total start-up costs for the single license?

Startup costs for the single license is projected at $2.6 million.

e. What are the anticipated administrative costs associated with the implementation of the single license in FY 2020?

The majority of the costs for the single license will be with Information Technology and it is estimated that administrative costs will fall in the 10% range.

University Hospital

31. Executive Order No. 32 of 2018 directed the department to install a monitor to review the expenditures of and assess the level of care provided at University Hospital in Newark. On December 17, 2018, the Monitor's Report on the Assessment of University Hospital was released. The report identified a number of issues at University Hospital, including leadership deficiencies, the lack of a strategic plan, poor internal accountability and coordination, and limited oversight by the Community Oversight Board.

The report included a number of recommendations, including: utilizing and involving the Community Oversight Board in hospital operations and decision-making consistent with the board's statutory role; enhancing efforts to educate and involve the Hospital's Board of Directors; enhancing

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the role leadership plays in establishing quality and safety strategies, embracing transformational leadership, and improving communications throughout the organization; improving quality and safety protocols, including implementing enhanced reporting, regular reviews of quality and safety reports, holding daily safety huddles, incorporating quality and safety goals at all levels of the organization, implementing infection control recommendations, and developing a quality and safety reporting dashboard; expanding the emergency department and considering the establishment of a new urgent care center to divert appropriate emergency department patients; improving community engagement; coordinating with the Department of Health to improve regulatory compliance; and developing a financial improvement strategy, including eliminating redundant positions.

Additionally, at least two pediatric deaths occurred in 2018 resulting from bacterial infections acquired in the neonatal intensive care unit at University Hospital, prompting the department to order a Directed Corrective Plan of Action for the hospital that included hiring a Certified Infection Control Practitioner.

- ***Questions:***

  a. **Please describe the role the department currently plays and is expected to play in the oversight of University Hospital. Will the department be given any permanent oversight responsibilities?**

  The University Hospital Board of Directors has oversight of University Hospital.

  b. **What steps has the department taken to facilitate implementation of the recommendations included in the Monitor's Report on the Assessment of University Hospital?**

  The University Hospital Board of Directors has oversight of University Hospital.

  c. **Is University Hospital in compliance with the Directed Corrective Plan of Action? If not, please note any deficiencies or specific areas of noncompliance, and any efforts the department has instituted to ensure compliance.**

  University Hospital is currently in compliance and the directed plan of correction was lifted on 3/14/19.

Emergency Medical Services

32. P.L.2017, c.116 (N.J.S.A.26:2K-66 et seq.) establishes certain data reporting requirements for emergency medical service (EMS) providers and dispatchers. The law requires the department to create an enhanced system to accept and process the reported data, which, to the extent possible, is to be compatible with existing systems used by EMS providers and dispatchers. The department is additionally required to provide the system software to EMS providers and dispatchers without charge. The requirements of this enactment took effect January 17, 2018. In response to an FY 2019 OLS Discussion Point, the department indicated that implementation was on schedule and data collection had commenced. The department indicated two full-time employees would be needed for the implementation and staffing of the electronic Patient Care Record data component of the system, and that one full-time employee would be needed to administer the dispatch data collection

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component. The department estimated the annual costs of operating and administering the system to be $506,000.

- *Questions:*

  a. **Please provide an update concerning the implementation of the enhanced EMS reporting system. Has the department incurred any additional costs to develop or upgrade the system?**

The Electronic Patient Care Reporting System

The NJ OEMS electronic patient care report system consists of multiple parts: EMS clinicians (users), electronic patient care report (ePCR) software, ePCR hardware, data quality filter, data storage, and data sharing. The system has been in place for 8 years as a voluntary system before becoming mandatory in 2018 requiring all National EMS Information System elements, and ePCR submissions have gone from under 800,000 in 2014 to more than 1,750,000 ePCR submissions annually by more than 500 EMS programs in 2018.

Data sharing consists of:

- ePCR data flowing to hospitals so that they can access the ePCR for patient brought to them by EMS;
- ePCR data flowing to Highway Traffic Safety so that they can investigate serious and fatal roadway crashes;
- ePCR data flowing to the trauma registry to document care provided to serious trauma patients;
- ePCR data related to opiate overdoses provided to multiple agencies and programs; and
- Data published monthly by the Department.

(*All partners have a signed and executed data sharing agreement.)

Public EMS Data

Since 2018, OEMS has gradually increased the amount of public data on EMS response. Beginning in January 2018, OEMS began publishing monthly, county-level data for 90th percentile response times, call volume by county, and call type by county. In February 2018, OEMS began separating regional Mobile Intensive Care responses from community-based EMS ambulance response. In March 2018, OEMS began publishing a monthly blinded table so community-based EMS ambulance leaders could compare their organization's response times to municipalities with similar density and area. In addition, certain data at the county and municipal levels has been released pursuant to the Open Public Records Act. In June 2019, OEMS will begin publishing statewide mobile intensive care compliance with STEMI and Stroke Bundles of Care.

Non-Public EMS Data

As part of the Certificate of Need process for Mobile Intensive Care, OEMS is mapping municipal-level data for Mobile Intensive Care response times (where the goal is to arrive at the scene within 15 minutes, 90% of the time) and percentage of requests for service completed (where the goal is arrival and assessment for 90% of requests not cancelled by community ambulance EMTs.)

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State-Level Costs of the Electronic Patient Care Reporting System
NJ OEMS pays for one commercial version of ePCR software (Imagetrend) so that EMS programs have a zero-dollar alternative, although there are over 15 different NEMSIS-compliant commercial vendors used by NJ EMS programs. NJ OEMS paid a one-time cost of $50,000 for ePCR hardware for volunteer agencies adopting ePCR in 2017-18, data quality filters, data storage, and data sharing are managed through a $152,000 annual contract, and annual salary costs and consultant costs total $210,433.

b. **Please provide an update concerning the anticipated annual costs of operating and maintaining the enhanced EMS reporting system.**

The department is currently in year one of a three-year vendor contract to provide quality filters, data storage, data sharing, and front-end software for an annual cost of $152,000. Labor costs are expected to increase moderately to $343,182 as additional staff are needed for dispatch data collection component.

c. **Has the department hired the expected full-time employees to implement and administer the EMS reporting system, and does the department anticipate the need to hire any additional staff in FY 2019 or FY 2020? If so, how many additional staff will be hired and at what annual cost?**

The department anticipates needing another full-time specialist to administer the dispatch data collection component as well as further personnel actions totaling 132,748 in additional costs.

d. **Has the department initiated any system-wide policies with regard to emergency medical services based on the data reported to the system?**

This is the first time in New Jersey history that EMS response time data has been published, and it has gradually become more granular within 14 months of the law's effect by separating mobile intensive care and adding a blinded comparison function. With media coverage that 90th percentile community-based EMS response times vary from 10-23 minutes and regional Mobile Intensive Care times vary from 11-25 in different counties across the state, the public had become more aware of EMS system performance. OEMS will continue to add clinical performance parameters this year to provide the public with more insight.

Family Planning Services

33. P.L.2018, c.2 made a supplemental appropriation of $7.5 million for Family Planning Services, which appropriation was continued in the FY 2019 Appropriations Act and is recommended for continuation in the Governor's FY 2020 Budget. These appropriations restore funding that was eliminated in FY 2011.

In response to an FY 2019 OLS Discussion Point, the department indicated that it awarded $9.6 million in family planning funding ($7.5 million in State funds and $2.1 million in federal funds) to the New Jersey Family Planning League, and that an unspecified portion thereof was anticipated to be

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directed to Planned Parenthood. The department indicated further that the New Jersey Family Planning League was then in the process of conducting a needs assessment throughout the State and reviewing Guttenmacher Women in Need data to determine the need for an increased number of family planning and reproductive health care service providers in New Jersey.

In February 2019, the federal government published a final draft of a rule that would revise the Title X program, which provides birth control and other reproductive services to low-income individuals, in a number of ways, including prohibiting federal funds under the program from being awarded to any organization that provides or refers patients to abortion services.

- ***Questions:***

a. **What is the total amount of State funding that the department anticipates directing to family planning services in FY 2019 and FY 2020, either directly or indirectly?**

DOH anticipates directing the entire state budget line for family planning services of $7.453m in grants-in-aid to family planning services in both SFY 2019 and SFY 2020. This is done in through a grant to the NJ Family Planning League (NJFPL), which subgrants the funds to 10 provider agencies that oversee 47 services sites.

b. **What is the total amount of federal funding that the department anticipates receiving for family planning services in FY 2019 and FY 2020?**

DOH anticipates receiving $2.1m in federals funds in FY 2019 and FY 2020. This $2.1m is comprised of $1,557,000 of Social Services Block Grant (SSBG) funds, passed through from the Department of Children and Families (DCF), and $543,000 of Maternal and Child Health (MCH) Block Grant funds.

c. **Does the department anticipate that the receipt of federal funding for family planning services will be affected by the proposed changes to the federal Title X program? If the department anticipates a decline in federal funding as a result of the proposed changes, does the department have contingency plans to increase State funding for family planning services and ensure continuity of services for patients?**

The federal funding for family planning services may be affected by the changes to the federal Title X rules. As the State's Title X grantee, the NJFPL may need a supplemental SFY19 appropriation of approximately $1.32 million to cover the period May 3 to June 30. The potential SFY2020 funding need resulting from the lost Title X funds would total $7.55 million.

d. **Does the department consider plans to disburse family planning funding directly to family planning and reproductive health care service providers?**

The Department is considering all options when it comes to ensuring the provision of quality, comprehensive, medically accurate family planning services in New Jersey.

e. **Has the Family Planning League recommended any increase in the number of family planning and reproductive health care service providers or other changes to family planning services**

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in New Jersey in FY 2019 or FY 2020? If so, what actions, if any, has the department undertaken to implement these recommendations?

With the restoration of state funding, the NJFPL is assertively working to regain the lost patients and service sites after 8 years of defunding. To that end, providers have already seen over a 10% increase in patients over last year; more than 8,000 additional patient service hours have been added at family planning centers; over 50 providers and staff were hired to fill critical vacancies supporting increased access to care; over 80,000 additional free STD tests were provided; and the NJFPL service network expanded to include 5 additional health center sites.

In addition, the NJ Family Planning League is working diligently to reopen a service site in Atlantic City as soon as possible and the NJFPL has committed to ensuring Pre-Exposure Prophylaxis (PrEP) counseling in each of their service sites by the end of 2019 in line with the Administration's commitment to Ending the HIV Epidemic by 2025.