GOVERNOR-ELECT CHRISTOPHER CHRISTIE
TRANSITION MEMORANDUM • SUB-COMMITTEE ON HEALTH

January 5, 2009

Dear Governor-Elect Christie,

Thank you for the honor and responsibility of serving as Chair of your Transition Team's sub-committee on Health.

In this report you will find our sub-committee's analysis of the most critical issues currently facing the New Jersey Department of Health & Senior Services (NJDHSS).

Our team focused on the following overarching priorities:

- What NJDHSS issues are urgent (pre-inaugural or by Executive Order), and what action is required?
- What NJDHSS issues will require decision or action within the first 90-days after inauguration?
- Are there prudent budget & structure changes that should be made at NJDHSS? and
- Are there potential cost-savings at NJDHSS to be explored and implemented?

We have also prepared a supplemental report for the incoming NJDHSS Commissioner that includes a more detailed briefing of NJDHSS issues, as well as all reports drafted by the sub-committee members.

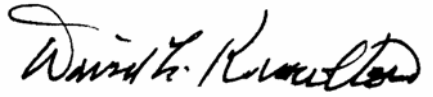
The members of the Health sub-committee have attended countless meetings and have done significant research to contribute to this report. I would like to thank the members of the sub-committee for their time and dedication:

Kevin Barry, MD, Morristown Memorial Hospital
Stewart Berkowitz, MD, Jersey Shore Brachyotherapy
Loretta Brickman, BD Consulting & Public Relations
Judy Burgis, Robert Wood Johnson University Health System
Dr. Alan Carr, Comprehensive Pain Management
Annette Catino, QualCare Alliance Networks, Inc.
Joseph Clemente, MD, Medical Health Center
Ryan Graham, Fairview Insurance
Robert Hariri, MD, PhD, Celgene Cellular Therapeutics
Patricia Kelmar, AARP NJ
William McDonald, St. Joseph's Healthcare System
James Orsini, MD, Essex Oncology of North Jersey
Gary Puma, Springpoint Senior Living
Christopher Rinn, Emergency Medical Services
Brent Saunders, Consumer Health Care
John Sheridan, Cooper Hospital

Suzanne Ianni, Hospital Alliance of New Jersey (Volunteer Staff Advisor)
Sarah McLallen, New Jersey Association of Health Plans (Volunteer Staff Advisor)

We hope this report helps direct and guide your priorities in health care and for the NJDHSS over the coming months. Thank you again for this unique honor and opportunity.

Sincerely,



David L. Knowlton

NEW JERSEY DEPARTMENT OF HEALTH & SENIOR SERVICES (NJDHSS)

MISSION STATEMENT

The stated mission of NJDHSS is to foster accessible and high-quality health and senior services, to help all people in New Jersey achieve optimal health, dignity and independence, to work to prevent disease, promote and protect well-being at all of life stages and to encourage informed choices that enrich quality of life for individuals and communities.

BUDGET

NJDHSS FY 2010 Total Budget is $3.6 billion, of which $1.1 billion is State appropriation, and $2.5 billion is Federal and "other" non-state appropriation. Please note that in the chart below the General Fund is comprised of Direct State Services, Grants-In-Aid, & State Aid.

State Appropriation Only		
Direct State Services	$62,244, 000	5.4%
Grants-In-Aid	$911,762,000	78.9%
State Aid	$9,552,000	0.8%
Casino Revenue Fund	$172,463,000	14.9%
TOTAL	$1,156,021,000	100.0%
All Funds		
General Fund	$983,558,000	27.0%
Casino Revenue Fund	$172, 463,000	4.7%
Federal	$2,166,563,000	59.5%
Dedicated – Special Revenue	$299,045,000	8.2%
Revolving	$17,625,000	0.5%
TOTAL	$3,639,254,000	100.0%
State	**$1,156,021,000**	**31.8%**
Federal& Non-State	**$2,483,223,000**	**68.2%**
TOTAL	**$3,639,254,000**	**100.0%**

EMPLOYEES

Since 2006 the number of NJDHSS FTE's has decreased by 17.8% as of 11/6/09 (from 2,146 to current 1,783).

	FUNDING SOURCE			
DIVISION	**STATE**	**FEDERAL**	**OTHER**	**TOTAL**
OFFICE OF THE COMMISSIONER	35	4	43	82
HEALTH INFRASTRUCTURE PREPAREDNESS & EMERG. RESPONSE	13	59	37	109
PUBLIC HEALTH AND ENVIRONMENTAL LABORATORIES	82	24	95	201
FAMILY HEALTH SERVICES	25	159	14	198
HEALTH FACILITIES EVALUATION AND LICENSING	88	95	21	204
EPIDEMIOLOGY, ENVIRO. & OCCUPATIONAL HEALTH SERV.	101	120	47	268
HIV/AIDS SERVICES	17	100	-	117
MANAGEMENT AND ADMINISTRATION	70	37	109	216
SENIOR BENEFITS AND UTILIZATION MANAGEMENT	164	18	-	182
AGING AND COMMUNITY SERVICES	83	99	24	206
TOTALS	**678**	**715**	**390**	**1,783**

The NJDHSS average employee age is 50, salary is $67,080, and Length of Service is 14 years. This is not markedly different from the total state government workforce average age (45), salary ($60,008), and Length of Service (13 years). The high average age suggests that some succession planning take place for essential roles at NJDHSS.

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I. INTRODUCTION

The NJDHSS oversees public and environmental health issues, and regulates many health care facilities and providers including 73 hospitals, more than 200 ambulatory surgery centers, and over 350 nursing homes.

New Jersey experiences some of the highest costs in health care in the nation yet New Jersey has lower levels of quality than the dollars invested imply.

New Jersey ranks ninth in state health spending per capita and has the highest hospital charges in the nation, according to the Kaiser Family Foundation, and the state's health programs put significant and growing demands on taxpayers.

The hospital industry in New Jersey is in very poor condition as a whole. In the past two years, nine (9) acute care hospitals have closed their doors, and six (6) have filed for bankruptcy, leaving New Jersey with 73 acute care hospitals. The major factors driving this fiscal crisis are (1) New Jersey requirements exceed federal regulations by requiring hospitals to provide necessary medical care to all regardless of their ability to pay. New Jersey has approximately 1. 3 million uninsured of which 300,000 are entitled to some governmental medical benefit but not currently enrolled and 400,000 are "undocumented residents." (2) The low level of payment received by hospitals for care delivered to Medicaid (lowest reimbursement levels in the nation) and Charity Care eligible patients. (3) The proliferation of ambulatory care and ambulatory surgery centers in competition with hospitals without any obligation to care for the uninsured or underinsured. As a result, these facilities have siphoned paying patients away from hospitals.

There has been no adequate plan developed by the State or the hospital industry to address the precarious financial status of hospitals in New Jersey. However, in 2008 a NJ study from the Commission on Rationalizing Health Care Resources chaired by the James Madison Professor of Economics at Princeton University, Uwe Reinhardt, Ph.D. (The Reinhardt Report) cited "gross underpayment from public payers" as the major reason for NJ hospitals' financial distress. On the one hand, hospitals need to diminish their reliance on state or federal subsidy and focus on creating a stable business model within the mix of health plans and governmental programs they serve. Viability completely tied to additional subsidies like the Health Care Stabilization Fund is not a workable business model. On the other hand, the State needs to work with hospitals to develop models and lay a regulatory groundwork that levels the health care playing field and maintains access. Developing an overall plan will be difficult given the State's budgetary constraints but failure to do so could have dire consequences in the near future, including more hospital closures leading to significant access concerns and political fallout requiring even further resources.

Our recommendations must be considered in the special context of regulations imposed on health care services which, unlike other areas, have several distinct purposes, including:

- Limiting proliferation of duplicative health care resources;
- Reducing unnecessary spending that would increase health care costs across the board; and
- Ensuring access to care for all New Jerseyans.

For these reasons and because of the close ties to federal funding, any regulation or deregulation at the Department of Health & Senior Services (NJDHSS) must be approached cautiously and thoughtfully to avoid unintended consequences that could negatively impact patient care and actually increase the percentage of state funds required. We believe the following recommendations have met these conditions.

II. PRE-INAUGURAL

There were a number of issues that required pre-inaugural attention by the new Administration, including the distribution of Health Care Stabilization Funding to distressed hospitals, decision-making regarding the continuation of Pascack Valley Hospital, and the impact of federal health care reform on New Jersey. Our sub-committee provided a number of recommendations regarding these issues over the course of the Transition process.

HEALTH CARE STABILIZATION FUND

The purpose of the Health Care Stabilization Fund is "to issue emergency grants to ensure access and availability of necessary healthcare services to residents in a community served by a hospital facing closure or significantly reducing services due to financial distress."

We believe that Health Care Stabilization funding is critical for the viability of some of NJ's most essential hospitals and the patients they serve.

However, its intent is to "stabilize" a hospital and prevent an access to care problem until the hospital can better position itself financially; its intent is not and should not be to temporarily float a failing hospital without a sustainable business model that would close as soon as such funding ended.

On December 22, 2009, the Corzine Administration announced $40 million in Health Care Stabilization awards to 9 hospitals. While many of the hospitals receiving aid met the above criteria, at least one hospital, Hoboken University Medical Center, will close in the next few months even given this grant funding. We view this as a misuse of limited state resources for health care stabilization. Additionally, NJDHSS allocated the entire stabilization pool instead of prudently holding back some funds to address additional fiscal crises that will arise. There is a critical need for the new Administration to have input into the conditions that will be applied to the individual hospital awards. If budget limitations necessitate a reduction of these awards, the new Administration will be able to recoup unexpended funds based upon fund availability, but can only apply any such recoupment to all awards equally; one facility cannot maintain funds while another loses theirs.

PASCACK VALLEY HOSPITAL

Pascack Valley Hospital filed for bankruptcy and subsequently closed on December 28, 2007.

On August 6, 2008 Hackensack University Medical Center (Hackensack) filed a Certificate of Need to transfer ownership of the hospital, but later deferred their request.

On December 28, 2009 Pascack Valley's Certificate of Need for use as a hospital or ambulatory surgical facility expired (i.e., it may no longer be considered a hospital, and its property value diminishes to that of an empty building and related real estate).

Attorneys for Hackensack requested that NJDHSS apply the Permit Extension Act to Pascack Valley Hospital, which would automatically extend Pascack's Certificate of Need for six months beyond December 28, 2009.

On December 22, 2009 NJDHSS denied their request. Since this was an action of the current administration, further redress rests with the court system; Hackensack plans to appeal this decision before the Appellate Division.

IMPACT OF FEDERAL HEALTH CARE REFORM

An early analysis of the federal health care reform bills indicates that New Jersey will benefit from increased federal reimbursement for the population covered under Medicaid & SCHIP (called "FamilyCare" in New Jersey).

From 2014-2016: New Jersey will draw down approximately $1.8 billion each year from the Federal Government in Medicaid reimbursement, which represents an increase of $183.7 million each year over our current allocation. In our view, since New Jersey already meets many of the proposed requirements of reform (guaranteed issue, uncompensated care, no pre-existing condition exclusion, etc.); the real opportunity rests in our State's ability to position itself to implement federal reforms in a manner favorable to us. Once the elements of federal reform are made final, representatives from NJDHSS, NJDOBI and NJDHS should meet with Treasury and the Governor's Office to maximize opportunities within the context of this reform.

III. POLICY ISSUES

PUBLIC HEALTH

H1N1 (SWINE FLU)

Management of the H1N1 flu pandemic is a critical policy issue facing NJDHSS and the State.

In the past 12 months, NJ has experienced widespread outbreak of a new strain of the H1N1 virus. NJDHSS has joined with other states and the federal Center for Disease Control (CDC) in considering the outbreak a public health crisis and responding accordingly.

It is important to note that most H1N1 activities are 100 percent federally-funded, including vaccines, most advertising, and assigned staff (such as for call-centers, and etc.).

NJDHSS has been the lead state agency and has assumed responsibility for statewide coordination and response efforts.

If this pandemic follows other flu progressions, the State can anticipate a new spike in the number of cases in mid-February. It is hoped that the early inoculation and intervention which has taken place has reduced the risk of this spike. If a spike should occur, there will need to be an emergency system in place to manage the care of those afflicted.

Recommendation: Our team reviewed NJDHSS' plan and found it to be sufficient, although an early task in the Christie Administration should be to incorporate H1N1 into the State Flu Plan.

Hospitalizations/Deaths: The Morbidity and Mortality Weekly Report (MMWR) for week 51 revealed there were 22 influenza-associated hospitalizations (reported by 15 hospitals). 614 hospitalizations have been reported since September 1, 2009.

Twenty-one influenza-associated deaths have been reported since September 1, 2009:

- 15 adults with underlying disease: 2 of which were associated with an outbreak in a residential facility for the developmentally disabled; 13 hospitalized at time of death.
- 4 adults with no underlying disease identified (One with obesity only). All hospitalized at time of death.
- 2 pediatric deaths, 1 with no underlying disease identified, 1 with underlying disease who was hospitalized at time of death.

Vaccine Distribution: A total of 2,367,700 doses of H1N1 vaccine shipped into NJ. These vaccines were ordered by 1,417 different shipments to providers by placing 3,912 orders (Dec 23, 2009)

In addition, a shortage of seasonal influenza vaccine was reported, which led to the cancellation or postponement of public health vaccine clinics. The shortage appears to be resolved currently and although there is some unequal distribution, most New Jerseyans in priority risk categories should be able to get vaccinated.

POMPTON LAKES

DuPont operated an explosives manufacturing plant in Pompton Lakes, NJ from the 1880s until 1994. Waste management practices at the plant lead to significant contamination of soils, surface water, and ground water, both on and off the site. The groundwater was contaminated with volatile organic compounds (VOCs) and that contamination migrated off-site beneath a residential neighborhood. Approximately 450 homes are situated above the contaminated groundwater.

NJDHSS, in cooperation with the federal Agency for Toxic Substances and Disease Registry, issued a report examining the problem of "vapor intrusion" – gases from groundwater contaminants migrating into residents' homes – and a report analyzing cancer incidence in the community near the contamination plume.

NJDHSS held a meeting in Pompton Lakes to hear the concerns of local residents impacted by the situation. NJDHSS has also agreed to expand its "vapor intrusion" report beyond the 450 homes located within the plume, and has agreed to create a committee comprised of state and local officials who will be available to the residents of Pompton Lakes. NJDHSS has requested that an official from the NJ Department of Environmental Protection (NJDEP) sit on this committee to address issues that fall within NJDEP's jurisdiction.

This public health concern is an issue that will remain high profile, will require interdepartmental (NJDEP, NJDHSS and Office of the Governor) and federal coordination.

NOTE: The State's current plan is to mitigate the damage caused by the "plume" by venting the toxic vapors, while the citizens of Pompton Lakes' would prefer that the problem be remediated by excavation of the "plume" problem directly. Mitigation seems like the appropriate way to proceed given time, cost and benefit, but it will undoubtedly be a political issue.

CHARITY CARE

Charity Care is a safety net program designed to reimburse hospitals for care delivered to New Jersey's 1.3 million uninsured. In 2008, NJ hospitals delivered an estimated $981 million [1] in Charity Care, of which the state reimbursed them $605 million. Every Charity Care dollar provided by the state is matched equally by the federal government.

The current reimbursement formula is variable by hospital. Hospitals are placed in "tiers" and "corridors" to determine their level of funding – the tiers place hospitals in groups based on what proportion of a hospital's total patient care volume is delivered to individuals qualified for charity care. Corridors limit funding increases and decreases based on the hospital's previous year funding instead of their most recent charity care experience.

Charity care allocations are often political and based on data favorable to a politically connected hospital or group of hospitals, rather than to the most recent available data. A 2007 report released by the State Commission on Investigation pointed out that state budget language inserted on behalf of those with the most political clout resulted in a situation where "those with increased charity care face a reduction – exactly the reverse of how the programs is supposed to function."

Recommendation: It is critical that healthcare "policy," not "politics" dictates charity care funding distribution. To ensure fairness and to limit gaming the allocation system, charity Care distribution must be based on the most recent data available.

While we do not recommend cuts to this significantly under-funded program, we recognize in these special times, they may be necessary. If they should become necessary, it is even more critical that limited funding be concentrated among hospitals with the highest proportion of charity care patients relative to the total care they provide and recognizing a hospital's overall operating margin without past or anticipated charity care subsidies included.

[1] Calculation based upon care actually delivered if reimbursed at the Medicaid rate.

LEVELING THE HEALTH CARE PLAYING FIELD

THE OUT-OF-NETWORK PROBLEM

Health insurers contract with providers as a means to control health care cost for their members by negotiating favorable rates with selected providers in exchange for allowing the provider access to a greater volume of patients. Health plans and purchasers view such networking as critical to the ability to manage the cost of health care.

Out-of-network providers are becoming more prevalent in NJ as providers have discovered that they may be able to increase their reimbursement by terminating participation in carrier networks. In NJ, if an insured person receives non-emergent care at an out-of-network facility or by an out-of-network provider, the provider is able to bill any charge regardless of the actual cost of services, and the carrier is required to pay the charge. Some hospital-based physicians (especially radiologists, anesthesiologists, pathologists, and emergency room physicians) remain out-of-network and, as a result charge extraordinarily high fees. And, one New Jersey hospital, Bayonne, has moved to eliminate virtually all carrier contracts, and has raised its rates dramatically. Some out-of-network Ambulatory Surgical Centers (ASCs) and Ambulatory Care Centers (ACCs) engage in these egregious billing practices as well. Those centers that do, often select patients with good insurance or with low risk and send the remainder to local hospitals leaving those affected hospitals with a disproportionate share of complex and high risk patients that are more costly and for which there is inadequate or no payment. There is no requirement that these ambulatory centers treat the uninsured, Medicare or Medicaid. Some ASCs and ACCs are organized and owned by a group of in-network specialty physicians who perform the surgical or other procedure at the out-of-network facility. By waiving the out-of-network deductible, coinsurance or co-payment, the out-of-network provider eliminates the disincentive for a patient to use an often more costly provider. Medicare considers the waiver of member liability *per se* fraud except in hardship cases.

Recommendation: NJDHSS, in collaboration with the Board of Medical Examiners, should explore placing a cap on out-of-network charges and should prohibit the waiver of member liability (deductible, coinsurance or co-payment) except for hardship cases. This was addressed through the following recommendations made by the Reinhardt Report in this regard:

- Ambulatory care facilities do not have the same regulatory requirements as hospitals. Regulations should be evenly applied across all facilities competing with the same services in the same market.
- The State should require all ambulatory care facilities to report cost and quality data similar to requirements currently imposed on hospitals.
- The State should require public posting of list prices charged to uninsured patients by all ASCs/ACCs.
- Additional Ambulatory Assessments to provide financial support to distressed, essential hospitals whose market share has been affected by the proliferation of ASCs.

ADULT MEDICAL DAY CARE REGULATIONS

Adult day health services (ADHS), better known as Adult Medical Day Care is a Medicaid plan administered by NJDHSS designed to create a less expensive and better quality of life alternative to nursing homes. ADHS participants receive medical, nursing, social, personal and rehabilitative services, as well as a meal and transportation to and from the facility. There are approximately 136 ADHS facilities currently licensed in NJ serving approximately 12,100 participants. Due to a rapid proliferation of new providers, NJDHSS placed a moratorium on new providers. ADHS facilities receive $78.50 per day per participant, which was a 10% reduction from the prior year. NJDHSS proposed a 20% reduction but relented in response to significant industry push back. NJDHSS has concerns regarding the cost, over-utilization and possible fraud and abuse from some providers and has active investigations underway with the Office of Medicaid Inspector General.

NJDHSS has retained an outside vendor to examine if the current daily reimbursement rate is overly generous. The report is due in January and without question will be front and center during the next rate negotiation.

The SFY 2010 Budget is $88.2 million with the federal government providing an equal amount of matching funding. NJDHSS appears exceedingly interested in reducing ADHS program costs, primarily in two ways: (1) further reduction of the daily rate; and/or (2) modifying the ADHS regulations to make the eligibility standards more rigorous by requiring a higher level of clinical condition in order to qualify for participation which would have the effect of reducing the number of participants. In fact, some within NJDHSS believe that adopting the same eligibility standards used for nursing home admissions would be appropriate and which should reduce the number of ADHS participants by one-third.

The industry appears uniformly opposed to rate reductions and enhanced eligibility standards. The industry has argued that the program's growth (1) is consistent with the design and intent of program; (2) that the growth of the program has led to a leveling off of state nursing home expenditures; and (3) fraud and abuse is committed by a distinct minority of the community, should be vigorously prosecuted; it should not serve as grounds to reduce reimbursement (either through rate reduction or eligibility standards).

NJDHSS staff has indicated that it will, in deference to the Governor-Elect's request, not promulgate the New Regulations until the new Administration has had an opportunity to review the issues.

Recommendation: There is no immediate action required since the moratorium has not created an access problem and NJDHSS has agreed to defer promulgation of the new regulations to the new Administration. However, because ADHS rate setting is done through the Budget, the next rate negotiation is not far off and focus on the program is warranted during the Administration's first 90 days. If the NJDHSS consultant's report indicates that facility costs are significantly below ADHS reimbursement, the new Administration may consider further rate reductions balanced such that these rate reductions and/or tighter eligibility standards do not serve to undermine the intent of the program. Both the Department and the industry note that nursing home admissions have leveled off and that this is a positive development. Identifying where the tipping point lies is the issue.

UN-IMPLEMENTED RECOMMENDATIONS

REINHARDT'S COMMISSION ON RATIONALIZING HEALTH CARE SERVICES

The Commission on Rationalizing Health Care Resources (the "Reinhardt Commission") was tasked in 2006 with addressing (1) why so many hospitals in this State are struggling financially, (2) which hospitals approaching the State for financial assistance warrant that assistance and (3) what steps might be taken to rationalize the functioning of New Jersey's hospital system and other components of the health care delivery system.

Their report was issued in 2008 and only some of the recommendations have been implemented.

Recommendation: NJDHSS should make it a priority to implement the remaining recommendations.

GOVERNMENT EFFICIENCY AND REFORM COMMISSION

In April 2006, Governor Jon S. Corzine signed an Executive Order creating the Government Efficiency and Reform Commission (GEAR) (New Jersey Executive Order 9; April 7, 2006). The GEAR Commission had a Health Care Task Force directed to look specifically at health care issues:

> The task force concentrated on Medicaid and related programs for low-income populations and on the state health benefit plan, as these programs comprise nearly three quarters of state spending on health care. The state is expected to spend $14 billion on health care in fiscal-year 2007, including $5 billion in federal match money for Medicaid. The remaining $9 billion represents nearly 30 percent of the state's budget. Of that $9 billion, about 51% is spent on Medicaid and Medicaid-associated programs, while 22% covers active and retired public employees; these represent the two largest types of health spending. State health expenditures have risen considerably faster than other components of the state budget. For example, spending for government worker and retiree health benefits have increased 45% over the past four years, and spending for Medicaid and related programs has increased 27% (including both federal and state contributions) over the same period. In both the state health benefit program and Medicaid-related programs, spending on prescription drugs has risen faster than other areas; and within the Medicaid program, nursing home care is a second area of exceptionally rapid spending increase.

We have reviewed these recommendations and find that the vast majority of the recommendations have merit but have not been implemented.

Recommendation: The new Administration should examine the potential cost-savings achievable by implementing these recommendations.

Potential Cost-Savings: The task force identified approximately $190 million in potential annual savings where estimates were available.

IV. REVENUE ISSUES

NJDHSS REVENUE GENERATORS

HIPPOCRATES

HIPPOCRATES is a management/health information technology program developed by NJDHSS and whose intellectual property is owned by the State of New Jersey.[2]

It provides to over 4,000 users critical health information including the location of ambulances, flu outbreak patterns, locations of white powder incidents, etc. There is discussion of using *HIPPOCRATES* to track availability of scarce mental health beds, which we would support.

Recommendation: Outside interest in attaining access and use of the *HIPPOCRATES* software has been expressed by the City of New York, the Federal Department of Homeland Security, Microsoft, and a number of other states. The sale or licensure of *HIPPOCRATES* to the federal government, other states, or private companies would produce a substantial revenue stream to the State.

Potential Cost-Savings: The exact revenue the lease or sale of *HIPPOCRATES* could generate requires additional research. However, there are a number of vendors or other government entities interested in acquiring access to the program, and the State should assume that it would make back a multiple of the approximately $5 million it put into developing the program.

STATE LABORATORY

In 2006, NJDHSS approved construction of a new State Laboratory to be built on the grounds of the State Police complex in Ewing Township, NJ in order to replace its 45 year old facility in Trenton, NJ. NJDHSS spent approximately $156 million to build the new facility, expected to be operational in the fall of 2010. An additional $19 million is required for capital equipment and moving costs.

Recommendation: Before additional spending is committed to the new facility, the State should consider opportunities to privatize the new laboratory and outsource state lab services to the Public Health Research Institute at UMDNJ in Newark or to another well-equipped lab.

Potential Cost-Savings: $19 million in capital investment and moving cost savings, plus the additional and long-term receipt of dollars to lease the multi-million dollar property[3].

[2] Intellectual property concerns surrounding this issue were discussed with an intellectual property attorney. Based upon that conversation, it appears that the *HIPPOCRATES* program is the property of the State of New Jersey and can be transferred licensed or sold.

[3] The new laboratory was built on the campus of the New Jersey State Police headquarters in Ewing Township, where they may object to privatizing activities on the premises. However, consolidation of other state leasing obligations may be an option.

NURSING HOME RATE-SETTING

Currently NJDHSS employs 12-15 staff in a unit dedicated to setting rates for nursing home providers. In addition, NJDHSS contracts with an outside vendor to create their case-mix rate setting system. Stakeholder groups involved in this issue support the use of an outside vendor to set acuity-based rates for nursing home providers.

Recommendation: All rate-setting could be outsourced to the vendor with the support of all relevant stakeholders groups.

Potential Cost-Savings: At a minimum, the State could achieve savings by the reduction of dedicated staff and resources within this 12-15 person unit. Vendor costs would only be accrued periodically. Consideration could be given to incorporating the cost of rate-setting into the rates themselves (i.e., the industry would financially support this state service).

CALL CENTERS

Currently NJDHSS operates or supports call centers for several of its programs including PAAD & Senior Gold, NJ Poison Information & Education System, eligibility determination for AIDS/HIV, Flu information, consumer complaints etc.

Recommendation: The State could achieve cost-savings and better quality of service if it outsourced its call centers to a vendor that specialized in those services. Consolidation of call center activities could be explored as well.

NJDHSS POTENTIAL COST-SAVINGS

BOARDS & COUNCILS

NJDHSS currently operates and staffs 37 Boards and Councils: 11 are Governor's Appointments with the Advise and Consent of the Senate; 11 are Governor's Direct Appointments, and 15 are Commissioner's Appointments. They each require staff time and resources that could be eliminated or redistributed. Many of these were established by statute to respond to a specific problem that may no longer exist**.**

Recommendation: We recommend that the new Administration evaluate this list to determine if these boards and councils are still relevant and necessary, or if they could be consolidated or eliminated. Some may require a statutory change to do so.

REPORTS & STUDIES

There have been 30 reports or studies issued by NJDHSS within the last 12 months.

Recommendation: The new Administration should evaluate this list to determine if these reports provide useful and necessary health information which is "mission critical" to the NJDHSS. Each report requires significant staff time and resources that could be eliminated or redistributed. Reports that provide important information but fall outside of the department's mission could be reassigned to and funded by an external body.

CONSOLIDATION OF MATERNAL-CHILD HEALTH CONSORTIA

The Consortia are non-profit foundations focused on perinatal and pediatric prevention services. There are 6 Consortiums located across NJ, operating with funding ranging from 41 percent to 81 percent State dollars. Current state budget appropriation for the Consortia totals $6m and is spread unevenly among the 6 consortiums. The remaining funding comes from an assessment on hospitals, with one receiving federal dollars.

Recommendation: It has been suggested that many of the Consortia are providing duplicative services already provided by NJ hospitals. The new Administration should ask the Consortia to demonstrate why they should not be eliminated or consolidated. If some funding is maintained, fund recipients should target cost-savings, streamline services, and establish clear goals and deliverables so that accountability is possible. The new Administration should also explore whether NJ could draw down federal matching dollars for these programs.

Potential Cost-Savings: Up to $6 million

PRIVATIZING AIR AMBULANCE SERVICES

JEMSTAR (Jersey Emergency Medical Services Trauma Aero-medical Response) is the New Jersey Emergency Medical Services Helicopter Response Program. In addition to the JEMSTAR program helicopters, three NJ based private helicopter medical transport services (HEMS) hold licenses in the state to provide inter-hospital movement of critical patients and to supplement the JEMSTAR program.

Currently, the program is provided through a joint operational venture of the NJ State Police, providing the aviation component (pilots, helicopter, equipment, and mechanics) and two of the state's MICU (Mobile Intensive Care Unit) providers who supply the medical flight teams, equipment and supplies.

Recommendation: The new Administration should explore privatizing the MedEvac System. The State could save considerable cost by privatization. However, there are concerns that without JEMSTAR, patient safety might suffer, cost to patients could increase, and reductions in service could occur in remote areas of NJ that will undermine our regional Trauma System. There is also a concern that the Motor Vehicle fees currently generated to the State may be lost because the legal basis to collect the fees could be compromised if the State no longer provides the JEMSTAR service. So while we should explore real opportunities for cost savings, change must be approached cautiously.

Potential Cost-Savings: The MICU providers cost for the programs are reimbursed through a grant program administered by the NJDHSS. The award for both programs is roughly $2.8 million per year. The JEMSTAR program is supported through a state subsidy derived from a motor vehicle fee, but has historically cost somewhat less than the monies collected. Patients receiving service from JEMSTAR are also billed a state-determined fee of about $1,300 per flight, which covers a small portion of the actual cost. The remainder of the program's expenses is subsidized by the motor vehicle fee fund. Excess funds in this earmark have been routinely redirected in the past to other non-JEMSTAR and non-EMS purposes in the State Budget. About $21 million a year are collected from the earmarked motor vehicle fees, but none are paid to the private HEMS providers in the state, nor does NJ limit the charges of the private providers.

NEW JERSEY POISON INFORMATION & EDUCATION SYSTEM (NJPIES)

We understand that NJPIES, which was established in 1982 prior to the Internet, may no longer be necessary in its current form, since most medical providers and hospitals search the Internet directly to find poison information. Furthermore, NJPIES is supported in large part by the hospital industry through fees on emergency department visits. Funding also comes from CDC grants, NJDHSS Health Service Grants, HIV/AIDS hotline funds and a specific line item in NJ's Budget.

Recommendation: This service could be eliminated, or if there is need for consumer telephonic access, the State could consolidate with adjacent poison control centers with shared services (e.g. Philadelphia & New York).

Potential Cost-Savings: In SFY 2009, the state appropriation was $569,000.

HOSPITAL INSPECTIONS

Until recently, NJDHSS had been annually inspecting acute care hospitals. In order to reduce cost, NJDHSS agreed to accept inspections performed by the nationally-recognized Joint Commission in lieu of a separate inspection carried out by the Department of Health and Senior Services. Inspection staff has been reassigned to other duties. NJDHSS chose not to promulgate separate rulemaking on this change because the Hospital Licensing Regulations are set to expire July 22, 2010.

Recommendation: NJDHSS should promulgate language implementing this operational change in the formal rulemaking process in the Hospital Licensing Regulations.

Potential Cost-Savings: Cost-savings would be achieved by the elimination of staffing and resources dedicated to routine inspections.

MAXIMIZING FEDERAL DOLLARS

MAXIMIZING FEDERAL DOLLARS UNDER THE UPPER PAYMENT LIMIT (UPL)

Medicaid is the chief government-subsidized form of health care insurance for citizens with income at or below poverty level. Medicaid is funded, generally, on a 50/50 basis between the Federal and State Governments. Federal Policy allows states to claim federal matching funds up to an Upper Payment Limit (UPL). The UPL is based upon the principle that NJ Medicaid cannot pay more for its programs in the aggregate than what Medicare would pay. New Jersey's funding is currently $259 million below the UPL, 50% of which is federal funds.

Recommendation: We believe that Medicaid has aggressively attempted to draw down all possible matching funds; however, the new Administration should investigate if there are funds already being appropriated in the current Budget that could qualify. NJ could also pursue a program such as a "Medicaid Enhancement" plan that could raise Medicaid rates by utilizing hospital assessments to draw down additional federal dollars. The result would be increased Medicaid rates for providers, as well as additional federal dollars available to the State.

Potential Cost-Savings: Up to $127 million in federal matching funds are available to NJ and NJ providers under the UPL that are not currently being captured.

AMERICAN RECOVERY & REINVESTMENT ACT (ARRA/STIMULUS FUNDING)

NJDHSS has received or been awarded ARRA funding as follows: $12 million for Early Intervention, $45.5 million for Federal Qualified Health Centers, $2.8 million for Senior Nutrition/Meals on Wheels, $7.4 million for NJ's vaccine vendor, $11 million for Regional Coordination of Health Information Technology, $3.1 million for Women Infants & Children (WIC), $217 thousand to develop a State Plan for Healthcare-Associated Infections, $500 thousand to survey ambulatory surgery centers, and $34 thousand for the Office of Primary Care, totaling $82.5 million.

Two important points: 1) Much of this funding goes directly to the providers it is ultimately intended for.

2) Drawing down NJ's full award amounts is contingent upon the State spending the full award amount for its dedicated purpose.

For example, the State has only captured $45 thousand of the $500 thousand available to survey ambulatory surgery centers with an enhanced infection control protocol. NJDHSS attributes this to lack of staff to perform the surveys. While ARRA funds can be used to support the compensation of additional staff, it prohibitively burdens the State with the funding of employee benefits. The State could draw down the remaining $455 thousand of this money by hiring temporary ARRA-funded staff (not entitled to benefits) in order to meet this need. As an added benefit, the NJDHSS could either reallocate some of the existing employees that now perform surveys to other duties, or eliminate the positions altogether.

Recommendation: We urge the new Administration to explore what opportunities and untapped available federal funding exist under ARRA using creative solutions in order to access those funds.

NOTE: It is critical for the new Administration to consider how state and federal dollars are tied together when making cuts to any programs or state spending. The new Administration must be cognizant of the federal dollars the State would forfeit if the wrong programs are cut.

1115 MEDICAID WAIVER

The State of NJ has applied for an 1115 waiver from the Center for Medicaid and Medicare Services (CMS) to capture federal funding in areas that currently utilize 100% state funding, including issues in Accountable Care Management, Community Health Center coverage of low-income adults, and the development of a Health Information Exchange.

Potential Cost-Savings: If the State's waiver is approved, NJ will gain $24.6 million in additional federal funding for NJDHSS. NJ Medicaid stands to gain an additional $200 million. We believe these numbers have already been booked for SFY2010. It is unclear whether Treasury has this number scored as part of the reported deficit number for the current FY creating a substantial budget gap if the waiver is not approved.

PAAD & SENIOR GOLD

The Pharmaceutical Assistance to the Aged and Disabled program (PAAD) and Senior Gold program are prescription assistance programs to supplement Medicare for seniors in NJ. There are nearly 167,000 seniors enrolled in these programs. The cost of this program has been reduced by over $400 million in the last two years as a result of Medicare Part D changes so further cost cutting would seem detrimental. However, there is an opportunity to streamline other program eligibility processes into PAAD & Senior Gold benefit determination processes.

Recommendation: NJDHSS should begin integrating the eligibility process for the federally-funded Supplemental Nutrition Assistance Program (SNAP) formerly called the Food Stamps Program with the PAAD & Senior Gold eligibility process. This would enable the State to convert its current state-paid employees to the federal payroll, thereby achieving state savings.

340B PHARMACY PROGRAM

The 340B Drug Pricing Program is a federal initiative that limits the cost of covered outpatient drugs to certain federal grantees, federally-qualified health center look-alikes and qualified disproportionate share hospitals. Significant savings on pharmaceuticals may be seen by those entities that participate in this program.

There are 12 entities in NJ that are eligible for the 340B Program. The primary entities are HIV patients, Children's Hospitals and Disproportionate Share Hospital Outpatient Clinics. Two other entities are those with Black Lung and STD Clinics.

Recommendation: The new Administration should consider 340B as a potential solution to lower pharmacy costs.

Potential Cost-Savings: The State would save a significant amount of money through use of this program to cover all eligible patients. The acquisition cost of medications under the 340B program is significantly lower than the acquisition cost for all other programs. By way of example, an HIV medication that currently costs $1,000 under the Medicaid program would cost approximately $450 under the 340B program.

DEPARTMENT COORDINATION COST-SAVINGS

CENTRALIZING HEALTH INFORMATION TECHNOLOGY

Currently NJ has many departments that oversee Health Information Technology issues, including: DOBI, DHSS, DHS and OIT. Most of our interviews in both the Department of Health & Senior Services and the Department of Human Services have indicated that the Office of Information Technology is not effective.

Recommendation: The new Administration should address the duplicative responsibilities and streamline these roles to allow for better coordination and action on federal HIT initiatives. This arena is the focal point for significant federal dollars and could qualify the State for additional funding under ARRA if it were better managed.

ELECTRONIC PAYROLL

We were surprised to learn that NJDHSS is one of only a few state departments or agencies that use automated payroll services.

Recommendation: We urge the new Administration to call all departments to move from a paper-based payroll system to an electronic system. Relying on paper payroll systems and dedicated staffing is a timely, costly, and unwise use of resources and makes it difficult for the State to track the application of these resources.

SYSTEM FOR ADMINISTERING GRANTS ELECTRONICALLY (SAGE)

NJDHSS currently processes and tracks all grant awards through a paper-based system. In January, they plan to implement a new software program called "System for Administering Grants Electronically" (SAGE), an off-the-shelf grants management software. This automation project provides a web-based application to accept and approve grant applications and manage executed grants. It will enable counties, municipalities, hospitals, non-profits, educational institutions and all other eligible grantees to submit their applications and manage their grants online. The implementation of this software will provide the necessary tools for the Department to continue to award and administer grants with improved efficiency and quality control provided through the application.

Recommendation: We urge the new Administration to call on all departments to move from a paper-based grant tracking system to an electronic system, achieving significant savings in cost, staff and resources.

EQUAL EMPLOYMENT OPPORTUNITY COMMISSION (EEOC)

Each state department and agency has their own EEOC unit dedicated to resolving equal employment complaints.

Recommendation: The State should consider streamlining EEOC into one statewide unit available for all state employees.

OCCUPATIONAL SAFETY & HEALTH ADMINISTRATION (OSHA)

NJ currently duplicates and supersedes federal OSHA requirements.

Recommendation: The new Administration should evaluate oversight and regulation of NJ businesses in this instance to ascertain if the State is spending unnecessary resources on these efforts.

Potential Cost-Savings: The total budget for State OSHA is $2.4 million. The State may not be able to totally eliminate State OSHA but it is likely that some of this spending could be reduced.

CONSOLIDATION OF MAINTENANCE CONTRACTS

Each state department and agency currently negotiates their own vendor contracts for maintenance services on a time and materials basis for services such as copiers, printers, and technical repairs.

Recommendation: States such as NY, RI, PA, and KS currently use one vendor to consolidate all equipment maintenance contracts. NJ could do the same.

Potential Cost-Savings: The experience of other states has been that vendors guarantee a 15-23% savings to the state from current fee-for-service equipment charges.