P U B L I C H E A R I N G

before the

NURSING HOME STUDY COMMISSION

on

(Personal Care Facilities For The Elderly in New Jersey)

Held:
Assembly Chamber
State House
Trenton, New Jersey
April 16, 1975

COMMITTEE MEMBERS PRESENT:

Senator John J. Fay, Jr., Chairman

Senator Wayne Dumont, Jr.

Senator Anne C. Martindell

Assemblyman Joseph L. Garrubbo

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I N D E X

J O H N J. F A Y, JR., (Chairman): Good morning. Members of the Commission and ladies and gentlemen, I would like to have your attention now. The hearing will please come to order. On behalf of the members of the Nursing Home Study Commission and myself, I want to welcome you to our first public hearing on nursing homes and personal care facilities for the elderly in New Jersey.

My name is John Fay, and I am the Senator representing the 19th District, Middlesex County, and Chairman of the Nursing Home Study Commission. The other members present as of this moment are Senator Anne Martindell, Mercer County, and Assemblyman Joseph Garrubbo. The purpose of this hearing, being the first of many on the subject, is to inquire into the current conditions of nursing homes and personal care facilities for the aging in our State.

For the record, the Study Commission was established pursuant to Senate Concurrent Resolution Number 15, an offical copy reprint. The duty of the Commission is inquiring into the current conditions of health care facilities for the elderly in our state and to investigate the organization, the operation, standards and policies of such facilities, the adequacy of such facilities in meeting the social needs of our State and the sufficiency of the state standards for the regulation and supervision of such facilities.

As a result of this massive duty, and in light of the importance of the subject area which the Commission will be studying, there is no doubt that our responsibility is to have public hearings and to hear from everybody directly or indirectly concerned with this problem.

In essence, the Commission wishes to be exposed to more thoughts on health care for our elderly citizens, and hopefully, we will be enlightened by the testimony we will hear.

My role today, as well as that of the Commission, is to

learn and to hear and eventually to make definite recommendations for legislative and administrative changes. I will, therefore, leave a more detailed explanation of this most complex and extremely important subject to everyone concerned. Your cooperation and assistance in this matter is obviously evident, not only by your presence here today, but by the hundreds of people who have written to us and called us, and the hundreds of people who can't be here, but certainly are the most important people concerned with this Commission, the elderly who are in these facilities, and eventually those who will be in those facilities.

If I may, I would like to exercise the right of the Chair and establish several guidelines for the orderly operation of this hearing. First, we would very much appreciate it if you would limit your remarks to a maximum of thirty minutes, and while the questions the Commission may ask following your testimony may extend over the time allotment well beyond this period, we respectfully reserve this expansion to our discretion. As you can see, there are a number of people who have been invited to testify today. I would like to provide everyone with an opportunity to be heard. We already have scheduled a second public hearing, and one of the people who will testify at our second public hearing will be the Public Advocate, Mr. Van Ness.

The second point concerns our hearing reporters. As you know, a transcript of these proceedings will be prepared and will become a matter of public record. Therefore, in order that your comments can be recorded accurately, we ask that you speak in a clear and distinct voice, and I would very much appreciate it if the reporters would indicate to me if they are experiencing any difficulty in recording the speakers.

Additionally, if you should have copies of your prepared testimony, please give them to John Kohler, who is sitting at Assemblyman Hurley's desk, who is the staff aid to

the Commission. He will distribute your testimony to the Commission.

In conclusion, allow me on behalf of the Commission to again thank you for your appearance and your concern, and we will now hear our first scheduled speaker, Dr. Joanne Finley, Commissioner of the State Department of Health.

J O A N N E F I N L E Y: Thank you, Senator Fay. I really wish to congratulate this Commission, and I am particularly impressed that the Resolution by which you were established sites your responsibilities as going beyond nursing homes as bricks and mortar, per se, and includes a review, to quote you, "of the adequacy of such facilities to the social needs of the State."

I say this particularly, because I feel, and I know you do too, that the real issue is, are we meeting the long-term care needs of New Jersey citizens. Some would say that nursing homes have become the whipping boy for our dimly perceived sense of guilt that something is totally wrong, that we have lost our sense of direction and we have failed, I think, to involve the elderly and the chronically ill and their families in planning and asking them what they really need. And yet the originally intentional social policy backed by huge financial resources, as your Resolution points out, for Medicare and Medicaid has put what I call an over-emphasis in this society on the institutionalization of the chronically ill and older people.

For a time, I think we viewed nursing homes as the great panacea. I think in the United States we have a tendency to happen on a solution and become very proud of it, justifiably, but things kind of stop there, and I think the intention of your Commission is to see if we shouldn't start doing something again.

So, in other words, there is no ultimate solution. Needs change and bricks and mortar and institutionalization are not,

in my opinion, the only answer. Nevertheless, when we get fixated, in this country, on something - and often it is buildings, and I think that is unfortunate - and pour a good deal of public money into it, unfortunately a good deal of money often brings abuses, and abuses are followed by regulations and then it falls to the fate of state agencies to become the regulators. We become so busy correcting abuses and punishing abusers, while social policy may have actually have encouraged them in the first place, that we lose our fundamental perspective.

We forget to look beneath the surface and ask what is a better way, and what is the other way. So I will attempt to spell out in considerable detail the roll of the Health Department, the roll in relation to other state agencies, as the regulator, which certainly is part of your Resolution. But I would certainly hope that we can all keep underlying the questions that I am trying to raise in my introduction. I know that I for one would much rather be a planner and a developer together with the people who have the needs than just a policeman over abuses.

We have had from Mr. Kohler a series of things that you probably would like us to address in detail, and I also am quite willing to be interrupted at any time for any questions you might have. I will deal now with the role of the New Jersey Department of Health as a regulator.

SENATOR FAY: Dr. Finley, before you start, Senator Wayne Dumont, a member of the Commission, is also present at this time.

DR. FINLEY: First, I will give you some facts and figures, by and large, on nursing homes per se. I'm sure, as you recognize, insitutionalized long-term care is provided in this State in a variety of health facilities, not just nursing homes. There are long-term care units in special hospitals, general hospitals, intermediate care facilities, homes for the aged and a

number of different names. Strictly speaking, there are 212 nursing homes in the State of New Jersey of which - and I am astonished myself by this statistic - 202 are proprietary.

To arrive at a better understanding of the total picture of institutional long-term care, the subject of participation must be introduced, participation really with Federal funding sources, and therefore the roll of the State. Many health facilities have entered into agreements to participate in Federal Medicare and Federal-State Medicaid cost reimbursement programs. Some facilities participate in Medicare only; some participate in Medicaid only; some participate in both, and there are facilities in this State that participate in neither, which I also think is an issue you may want to go into, because in some instances, perhaps - I can't document this - there are homes, which, for example, refuse Medicaid patients.

As a condition of participation, the facility must agree to comply with all applicable Federal and State regulations and standards, and in the administration of these programs, there is, of course, a designated State agency which must inspect and ultimately certify to the Federal Government that these are acceptable institutions to participate in the reimbursement program. I have, for detailed questioning later, a table on the 212 homes, and how many participate in different kinds of programs.

Participation status, of course, affects our inspection and licensing procedures. Now, when discussing nursing homes in the generic sense, only the first three categories of facilities, that is, the intermediate care facility, the skilled nursing facility, and homes for the aged, are eligible for participation.

I have a lot of rather difficult to explain details on what the Federal Government requires. If you are going to get reimbursed as a skilled nursing facility, basically it is the number of hours of care certain types of staff give. You are

going to get reimbursed at a slightly less level as an intermediate care facility and so forth. To me it is a lot of hair splitting, but later, if you want to ask me questions, I can give you these details.

Recently, the Health Department, working together with the Medicaid Program, conducted a study and also worked with the Federal Government, and there is a regulation now passed by the Health Care Administration Board which permits the lumping of the skilled nursing bed and the intermediate care bed within one facility. There are certain advantages to patients and to the facility, and to the whole review process of this.

SENATOR FAY: Doctor, is it premature at this point to say, how does one start a nursing home? How does one get into this industry? Does the owner approach the State? Is that premature, that phase of the industry?

DR. FINLEY: No, I don't think so. I have a back up document that gives this in considerable detail. I also have with me the Chiefs of all of the programs in the Department. If I stumble, they will rescue me.

If you are talking in this state about somebody who has a gleam in the eye to build -- do you want me to go back that far?

SENATOR FAY: Yes, build or own.

DR. FINLEY: Well, as you know, the building and/or physical or service expansion that costs a substantial sum of money, and, therefore, would eventually cost a patient or a payer something is subject to the certificate of need process in this State, and actually, the Federal Government has recently passed legislation that will require all states to have certificate of need programs. So if you were somebody from another state who had decided you wanted to come to New Jersey and build a brand new facility, or take over a facility and spend a sizeable sum of money changing it into a nursing home, one would first

apply through the Regional Planning Agency's review process for a certificate of need. Now, on the assumption that the certificate of need is granted, then there is a procedure in the Health Department for granting a temporary permit to operate. For the first six months inspection takes place, and people have a chance to tool up and so forth. After the first six months with the temporary permit and a complete inspection that will insure the facility will be operated in the manner required by the Health Care Facilities Planning Act and rules and regulations adopted by the Department of Health, a full license may be issued at the end of this six-month trial period, if the facility has been operating in substantial compliance. And then I can go into the details of that.

What I am prepared to do is give a little more detail on how the inspection standard setting program works and also some of the kinds of problems we do find, deficiencies -- or do you have a question that you would like to ask?

SENATOR FAY: The question I had was, you know, about some of the difficulties we have found. Just who are the owners; who are these people who move into this industry, and just how does the State determine who the owners are, and how does the State license these people who are owning and operating the nursing homes?

DR. FINLEY: All right. Licensure -- I would agree that there is a real problem in finding out certain things. If I may say so, I think this kind of gap,which I will discuss and which you have touched on, relates to the knowledge we have of all kinds of health facilities. There is a good deal about hospitals that we also are not now empowered to find out on the revenue side, on the possible conflict of interest and trustees, this kind of thing.

Presently, licensure standards , as you can understand, are handed down by the Federal Government, and of course State standards and Federal standards can't be in conflict. Our standards

have to be at least as good as the Federal standards. Licensure standards presently have to do with the staffing, administration, records, physical safety, physical sanitation, physical adequacy of the facility. There are no processes through the licensure procedures to find out the kinds of questions you are asking. I mean, who really stands to make a profit; what really are the interrelationships of stockholders; what are the possible conflicts of interest? But, as I stressed, this is true of all health care facilities, not just nursing homes.

I think I feel that providing the powers in the Health Care Facilities Planning Act to continue in the rate setting field are left untouched or strengthened, that it is through that avenue, it is through the uniform accounting system, it is through the disclosure of financial interest that you would be able to find out the kind of thing you are talking about.

In other words, I do not tie it to the licensure process. I tie it to another side of learning about -- and as I say, presently, I think with a little strengthening, this State's law would permit a responsible department to learn that kind of information, but we do not know it now.

ASSEMBLYMAN GARRUBBBO: Do you consider the fact that you have the legal ability now to regulate that disclosure of information, or do you think that you need statutory support?

DR. FINLEY: I think that we should look at Section 18 of the Health Care Facilities Planning Act, which is the financial disclosure side of the act. I have a general feeling that because we don't know these things, it's not that somebody has been incompetent or that somebody has neglected to find them out, but that the law is a little hazy in this area.

For example, in the case of hospitals, as you know, we know their projected costs, but we know nothing about the revenue side of the picture. This is not in the adopted uniform

accounting system. Because health facilities are concerned -- nursing homes at this point just don't know this kind of information at all. I think we may need statutory help or at least clarification.

ASSEMBLYMAN GARRUBBO: You think you are going to need further legislative action?

DR. FINLEY: That is generally my feeling.

SENATOR DUMONT: Doctor, I would like to ask you a question on that score. There is a bill before the Senate right now with a number of co-sponsors, sponsored primarily by Senator Maressa, that would take you right out of the rate setting procedure; wouldn't it?

DR. FINLEY: I think that is one of the things that's intended in Senator Maressa's bill, yes, Senator Dumont.

SENATOR DUMONT: Well, having been the prime sponsor of the Health Care Facilities Planning Act of 1971, I am extremely concerned about that legislation, because we were trying very hard to make sure that you - and I am not talking about you individually, but whoever is the Commissioner of Health at the time - will also have something to say about rate setting in addition to the Commissioner of Insurance. We had to fight that provision through in opposition to the Hospital Association, I might add, when we passed the legislation initially.

DR. FINLEY: I hear you, and this, I think, is exactly what I meant when I answered Senator Fay. First of all, we need to preserve Section 18, and secondly we need to look at Section 18 and make sure that -- perhaps there are additional powers in the financial disclosure area that are needed. That I would call clarification of language or possibly some support in simply passing the regulations they are under. But right now it does seem that we need to preserve that section of the bill in order to proceed, and certainly the present Insurance Commissioner and I have the closest and most compatible of relationships. He would

be the first to admit that in the health field he needs and relies on health expertise to analyze health accounting, health facilities, and so forth. This is not a specialty of insurance people per se.

SENATOR DUMONT: That is exactly what we were trying to accomplish by the act of 1971, to get everything in the logical place, namely, the Department of Health, and stop the proliferation that had existed prior to that time among various departments.

DR. FINLEY: There has recently been a national study done for HEW by one Lawrence Lewin which has interestingly recommended that the Federal Government bite the bullet and begin to not only support states financially that have rate setting programs, but begin to mandate that all states have such programs, and it definitely recommends that planning, certificate of need, rate setting, et cetera, be all in one department, and that insurance departments be consulted, but be periferal.

SENATOR MARTINDELL: You mentioned that 202 of the 212 were proprietary, and that seemed to surprise you. In other words, it is very different from other states?

DR. FINLEY: That's my general impression. I mean, 202 of 212, that's practically all of them. And I would like to be understood as not knocking all proprietary nursing homes. We all know that in every profession, every facility, there are good people and bad people. I think we have some good proprietary nursing homes in this State. But most of the places where I have been, there is at least a 50-50 mix or more, and I really don't understand what the history is in New Jersey. There are very few church related or voluntary or civically sponsored, community sponsored, whatever you want to call it, and that's only 9 or 10 non-profit -- in other words only 10 are non-profit voluntarily sponsored by charitable groups. I think that is an astonishing statistic.

SENATOR MARTINDELL: It's distressing too, because from what I understand, the volunteers that have been asked to go in and help the older people will not do it for the proprietary homes, so I think we do need legislation encouraging the not for profit that are really not for profit.

DR. FINLEY: That is certainly part of what I meant in my introduction. I think legislation not only encouraging the voluntary sector, but voluntary other kinds of programs. I happen to be a big fan of the home health agency. I think that is part of what I am trying to get across. I think if we really talked to the elderly, the chronically ill and their families, many, many of them would tell you that they just really would rather not be stuck out in the country where people can only visit them once a week, no matter how nice it is. They would really rather be maintained in familiar surroundings.

So, that's what I meant when I said we have become so enamored of bricks and mortar or putting people inside something to take care of them, inside a hospital, or inside a nursing home, when maybe preventive care or home care or something like that would really be -- I know it would be less expensive, and I certainly feel it would be more humane, which doesn't rule out the need for some institutions.

SENATOR MARTINDELL: I read recently that in England, only 2% of the people over 65 are in nursing homes. They are in day care centers and that kind of thing.

DR. FINLEY: Right. I recently attended a Council of State Governments' meeting at which -- he is called the Commissioner of Human Resources of the State of Vermont was present -- long term care was being discussed by several states on the eastcoast. And this Commissioner from Vermont made the statement that he felt in his state only 50% of the people who are in nursing homes needed to be there, and the other 50% really could have profited and stayed active and felt useful in some community based program.

ASSEMBLYMAN GARRUBBO: Doctor, I heard your remark concerning the over-emphasis that Medicare and Medicaid has caused in institutionalization, and I heard you refer to home health agencies as one alternative. Is your department presently in the position to make recommendations to the legislature or to enact any regulations that might guide us in creating alternatives to institutionalization?

DR. FINLEY: I don't think -- again, if you can preserve and keep in tact the Health Care Facilities Planning Act, that we have been speaking about, that you need new legislation. We may need a slightly different budgetary emphasis, and so forth. The one problem I see - and this has been discussed in the Department - is that since that Act encompasses everything from planning in the beginning to the licensure of a program or a service or a facility after it is planned, we have a couple of problems that I find discouraging - and I would use that word, discouraging - the community base, the home health agency type program. And one is the staffing problem in the Department, and the other is that our - and I am saying this personally. Nobody in the Department has said it to me - regulations adopted under the 1971 Act, which could be regulations to encourage something, must go through the Health Care Administration Board, as provided in that Act. And this is a group with very little interest, at this point, in alternative programs.

We have a good deal of difficulty, if I can use the kind word, educating them to allow me to publish the kind of regulations you have in mind.

SENATOR DUMONT: Well now, Commissioner, that board which was established under the Act and which organized in the late summer of 1971 for the first time consists of people who are nominated by the Governor and confirmed by the Senate to help you in an advisory capacity. So that the Commissioner of Health alone will not direct all of the regulations in regard to health care planning facilities. So, I don't know exactly what you

find wrong with the group, but this is the way we usually create boards, the members of which are to be nominated by the Governor and confirmed by the Senate. We don't usually pay them any salaries. We expect and we get from the people of this State a great deal of volunteer help, which has saved the State and the taxpayers a tremendous amount of money over the years. Exactly what are you driving at in saying that it ought to be changed?

DR. FINLEY: I am very admiring of the volunteers in New Jersey. I think this is tremendous. I think that one has to tackle the issue of the composition and representativeness of boards and, in my experience, this board also views its role under the law as more than advisory. It views its role as having - which I believe the law is fairly explicit on - veto power over the publication of regulations. We are talking about regulations that would encourage, by flexible standards, by being able to spend one's energy -- in other words, one of the reasons that home health agencies, to me, do not flourish in this State, is that we have been backward, not gotten around to the publication of standards and licensure regulations for same, although this is expected under that Act.

I have been told by staff that such standards and regulations have been difficult to get passed by the Health Care Administration Board. This is before I came, and I can't really psychoanalyze why.

SENATOR DUMONT: Well, the licensing prior to the adoption of the Act, at least for hospitals and nursing homes, was in the Department of Institutions and Agencies, where some of the facilities would have liked to have had it remain, incidentally, because I&A is such a big Department that it was not really equipped to handle licensing as well. So, logically it seemed to us that the licensing requirement ought to be in the Department of Health. Now, do you object to having it there?

DR. FINLEY: No, sir. I am saying that my staff has told me -- the original question was, what could be done to encourage what we would call the alternative community program to institutionalize long-term care. And I am trying to explain what my staff has told me, in that they have felt hindered in carrying out the departmental encouragement of these sorts of programs because the Health Care Administration Board, for reasons that I do not understand, has not chosen to allow the publication of certain regulations.

SENATOR DUMONT: Well, in the four years we spent drafting that final legislation - it took at least four years, and I am well qualified to speak on that, because I spent at least that long on it - we finally decided not to name the groups that would be represented on the Health Care Administration Board, because we had so many groups who wanted to be represented that we couldn't possibly please them all, and it would be up to the Governor to make selections. He would get plenty of nominations, and plenty of names submitted by various groups that wanted to be represented. It would be up to him to decide, along with the confirmation power of the Senate, who would sit on that board.

So that if you get into the question of changing the law to provide for representation of various groups, I think you are going to have the same problem that we had drafting the legislation.

ASSEMBLYMAN GARRUBBO: I just want to ask you, Doctor, how do you conceive that the home health agencies would function, if you were to create regulations to empower them?

SENATOR FAY: There is one bill - I don't know whether your Department is aware of Senate Bill 989. Senator Menza has one bill in dealing with home care.

ASSEMBLYMAN GARRUBBO: That's the reason I asked, because I wondered if you were familiar with that bill, and how your own notion of how it should function would square with Senator Menza's proposals.

DR. FINLEY: I am not thoroughly familiar with Senator Menza's bill, so I will say how I think they would and do function in many places, and then perhaps you can clarify some of the things in his bill.

I generally conceive of the home health agency, just as does Medicare legislation. I think this usually is a group of public health nurses who may be associated with a local health department or a visiting nurse society or a visiting nurse service, or a merger of the two. There are many exciting projects in the United States, Philadelphia being one of them, in which the private and the public agency have merged, so that the whole spectrum of, if you wish, home nursing services are joined. Therfore, this means there must be some tax support, just as there must be some philanthropic support.

Obviously we are talking about something governed by a community type board of directors, as to its policies that are actual national policies which will go down to these agencies, and they are acceptable to Medicare for Medicare Part B coverage or what we call certified home health services. They have to work under a doctor's plan for the management of the patient, but the plan can be very wide. It can include health education of the family; it can include sitting down and counseling the family and the patient together. Certainly it can include physical therapy, which can be done in the home. It can include even some of the good and well financed agencies. It can have physical therapists, occupational therapists, speech pathologists on their staff, and some of these agencies incorporate homemaker services under the supervision of nurses too.

I'm giving you sort of the ideal, but in lots and lots of places these are fabulous agencies, and while I am not yet elderly, I would like to tell a little story, because it seems often to be the physician who has to be educated.

I had a son who was hit by a car while riding on his bicycle, who was fourteen weeks, incidentally, in a New Jersey

convalescent hospital, Children's Seashore House, in a body cast. I had to go bang on the physician to explain that I could bring him home. I didn't have to be paying that expensive per diem for a hospital. We had a service like I'm describing in Philadelphia, including the physical therapist, who, for a very low cost would come into my home and help us, so we were able to bring this boy home just as you could bring an older person home much, much sooner, because we had a good home health service.

SENATOR FAY: Doctor, we would appreciate it if you would consider this bill and be ready to report to the Commission your pros and cons on Senate 989.

DR. FINLEY: Fine.

ASSEMBLYMAN GARRUBBO: I would think that in dealing with the home health agency approach that part of the problem may be the unwillingness of the relative to cope with the problems that are naturally attendant to home health care, and I suppose that part of your development of this type of program will have to involve educational programs of persons who will be in these homes. I think it would be, not unsurmountable, but difficult.

DR. FINLEY: I think, as I said earlier, unfortunately part of the problem is educating the medical profession, as in my own case. I am a doctor, but I was the one who really had to tell my child's doctor that he could order the home health service.

ASSEMBLYMAN GARRUBBO: Dr. Finley, apart from home health care, do you have any other alternatives to institutionalization?

DR. FINLEY: Oh, the whole array -- sometimes little things. The meals are on wheels, or the cooperative centers for the elderly, the public health program in -- well, again, New Jersey is not full of large public housing projects. I am used to many, many large projects with mixtures of age groups, high rises for the elderly, and on the first floor, down the

elevator is the Public Health Department, which sponsors a program that is sort of multi-purpose, including some health services for the older people.

I think some of the most exciting projects in the United States are the hospital-rehabilitation-long-term care housing complexes, such as Long Island Jewish Hospital, Albert Einstein-Moss Rehabilitation Center Complex in Philadelphia, and so forth, where you have your acute medical care for the occasions that you need it. You have at the same time housing for the elderly. In other words, the home for the Jewish aged is on the grounds of the acute care hospital and there is a rehabilitation facility; there is a sheltered workshop. There is all this sort of thing. But actually people basically feel they are home; they are in their apartment or homes.

This is the kind of thing I am hearing so much about in Ocean County, and the problems of the building of so-called leisure towns, the building of housing for retired people without any thought being given to the kinds of health services I'm talking about. I think we ought not let people build for older people without also requiring - which I think would be county responsibilities - that services be considered.

ASSEMBLYMAN GARRUBBO: You have indicated that there are certain nursing home facilities which have refused Medicare or Medicaid patients. Are you in the position to identify those?

DR. FINLEY: No. No, I said that may be, and I do not have this kind of detail for New Jersey. I think we could find it if you want it. I simply have a feeling in my bones thatit may be a problem in some instances, because it has been every place else that I have ever worked.

ASSEMBLYMAN GARRUBBO: I have another area of concern, and that is in the area of inspections of nursing homes. We may have, by putting questions to you, taken you out of your intended sequence, but I have prepared for introduction a

bill that would mandate certain types of inspections, for example, unannounced inspection upon complaint. What is your Department's present policy and practice concerning inspection of ongoing nursing home facilities?

DR. FINLEY: All right. Since most of the facilities in New Jersey participate in Medicaid and Medicare programs, the Health Department's inspection protocol in part has to be based on Federal requirements and guidelines. There is a Federal regulation that states, "Regular scheduled surveys should not be conducted without advance notice to the facility."

ASSEMBLYMAN GARRUBBO: May I interrupt for a moment?

DR. FINLEY: I have some qualifications on how we deal with that.

ASSEMBLYMAN GARRUBBO: My question is, what constitutes a regular scheduled visit?

DR. FINLEY: To insure or to try to deal with this issue - and with lots of communication back and forth with the Regional Office in New York City - we are interpreting the regular scheduled inspection as the annual visit, which again, the Medicare regulations require. There is more than an annual visit. That you can establish, number one. Number two, if on the annual visit any deficiency is found, then there will be reinspections, so other than the regular annual visit, we are interpreting all other visits as not within that regulation, and therefore unannounced, and we are making unannounced inspections in nursing homes.

ASSEMBLYMAN GARRUBBO: Is this as a matter of practice rather than a reaction to a complaint, for example?

DR. FINLEY: Yes, as a matter of practice.

ASSEMBLYMAN GARRUBBO: What type of staffing do you have for such inspections?

DR. FINLEY: Not enough. What was handed to me is that we have 25 1/2 people. I have to go back and see what

happened to the other half. We have 15 nurses, 6 dieticians, 1 1/2 pharmacists, 1 paramedic, 2 building inspectors, and then in addition the sanitarians do the food service inspection. Of this group of 15 nurses, 3 of them do complaint investigations, and that leaves the rest for what you and I are talking about, both the regular and the unannounced inspections.

ASSEMBLYMAN GARRUBBO: During the last 12-month period, do you have any statistics as to how many nursing homes were visited on an unannounced inspection? I mean of the 212. I don't mean how many times, but that will be my next question.

DR. FINLEY: Mr. DuShane.

A R R I E J. D U S H A N E: From the period of January 20th until February 28th there were 48 unannounced inspections of various facilities. I can't break that down into the actual number of nursing homes. There may have been some boarding homes in there, but this is the roving surveillance team we have which investigates complaints and follow-up situations that exist in facilities.

ASSEMBLYMAN GARRUBBO: Have you inspected or do you inspect as a matter of practice every nursing home in the State during the course of a given year?

DR. FINLEY: This is Miss Hutchison who is the coordinator.

E L I Z A B E T H T. H U T C H I S O N: More than 50% of the facilities had unannounced revisits on the basis of deficiencies. We go back and follow up as to whether these had actually been corrected and what progress was being made and corrected.

SENATOR FAY: Will you give your name and title for the record.

MS. HUTCHISON: Elizabeth Hutchison, Coordinator, Medicare Certification.

ASSEMBLYMAN GARRUBBO: What you said was that 50% ---

MS. HUTCHISON: More than 50%.

ASSEMBLYMAN GARRUBBO: More than 50% of the homes had unannounced inspections in response or reaction to a deficiency that was found.

MS. HUTCHISON: Those which had been cited at the time of the annual inspection.

ASSEMBLYMAN GARRUBBO: Now, my question is, Miss Hutchison or Dr. Finley, each and every one of the 212 homes in the State of New Jersey is visited at least once each year on an unannounced basis?

DR. FINLEY: I don't think we could say so yet. Most of the staff here is new or changed or moved into. One of the things that I have had to do in the first few months that I have been here is an intensive reorganization of this particular staff, so that you will have to forgive them if they can't answer all the questions. But our goals, as you can see, are vast improvement over what went on before, and the kinds of inspections that we are talking about are part of my policy, but they are not in response to a newspaper article or something like that. They would be part of my policy wherever I was.

ASSEMBLYMAN GARRUBBO: Have you developed any data that you can give to the Commission as to the types of the most prevalent kinds of deficiencies, the numbers, and how your Department is dealing with them?

DR. FINLEY: Yes. I can give you the most common deficiencies found, and in each instance the one I read first under a category will be that which we regard as most serious. I can't give you numbers at this point. What the staff has done is give me a list of the most common, which means it is very frequent, and perhaps in almost -- well, I better not say in almost all, I am not sure of that. But the most common deficiency is nursing service. In meeting the requirements for State licensure and/ or Medicare

and Medicaid nursing services - which means a certain number of trained nurses for a certain number of hours - this is one of the most common areas in which deficiencies are found. Within that category the most serious deficiency that is found is insufficient nursing coverage to conduct proper patient care. Then,in addition, still in the category of nursing services, they frequently find inadequate records as to treatment and administration of medications, and inadequacies in the spelled out nursing care plan. After all, we are talking about a long-term care patient. We are not just concerned with what you are going to do at three o'clock in the morning or two o'clock in the afternoon. We are talking about the whole general plan to keep the person up, well, active, and so forth.

The second category for consideration is pharmacy. The deficiency ---

ASSEMBLYMAN GARRUBBO: Before you move on, am I correct in understanding that the application for reimbursement for nursing services or payment generally is made on the basis of certain reports or representations made by nursing home facilities as to the number of nurses available and their identities, perhaps; is that a fact?

DR. FINLEY: Oh, yes.

ASSEMBLYMAN GARRUBBO: Have you uncovered, in your investigation or in your inspections, any misstatements, any fraudulent representations as to the number of persons available and their identities?

DR. FINLEY: Yes, we have removed the license of one nursing home in which -- actually there was a phone call to the Department of Health. You could call it a complaint. There was a nurse being carried on the payroll, and therefore an examination of personnel and payroll records would have portrayed the trained nurse there - because there would have been a requirement to meet - and the individual had not been actually working in the home for sometime. It is to the credit of the nurse that she called this team in the Health Department, and then on checking up, it was found that this was fraudulently carried.

ASSEMBLYMAN GARRUBBO: Was that an isolated case, or have you found more instances of that?

DR. FINLEY: I'd have to -- again, it is kind of a recent effort to do these things. Miss Hutchison is saying that there are other instances. She did use the word "occasional." Ask me six months from now when this new team has had more time to do its thing.

ASSEMBLYMAN GARRUBBO: Well, I hope you find no more.

DR. FINLEY: I do too. I really do. I'm sure we all do.

SENATOR FAY: I would like to pose a few questions pertaining to my original statement. I think what is basic to the whole problem is the initial question which I posed on the problem of knowing who owns these homes in our state; and, secondly, just how these people are licensed. For example, in the 15 months that you have been here you have made specific recommendations as to the need of the State to know exactly who owns the nursing homes, and as to whether the licensing procedures are adequate for the administrators and the staff, and the professional help. The very problem you are talking about, using an R. N.'s license even if the R. N. is not employed there is bad enough. But the actual quality of care is what I am questioning. Is there a need to have Federal regulations with cooperation from the State, or can the State itself move in here and say, "Yes, you have to have more R. N.'s on, or you have to have more aides on."

DR. FINLEY: The State can do it. There are certainly responsibilities such as the waivers, the decisions about waivers from the fire resistance standards in the Safety Code that the Federal Government is really taking over or taking away from the States. And certainly the Federal Government won't say,

well, this is because in many states a poor job was being done, but my feeling is the states can do it.

SENATOR FAY: Does the punishment fit the crime in some of these areas that we are talking about? Are the fines adequate? Are the number of homes that you have taken the accreditation away from somewhat of a deterrent? Are there any specific recommendations being made along the lines of policing as far as the status quo is concerned?

DR. FINLEY: That's hard to answer, because I feel so much like we got ourselves off in the wrong emphasis in long-term care that -- in other words, I guess I'm not the kind of person that feels that a bigger and bigger fine or a stiffer and stiffer sentence is necessarily a deterrent. I would like to see us turn around and plan better for long-term care needs in the first place; nevertheless, I would say, in this State, that if properly used, which does mean due process --I mean, due process is, after all, the fair and democratic way. You don't just go in and take someone's license away. But in this State, I feel you have outstanding legislation. The taking away of a license after due process does deprive a person of doing business. I don't know how much stronger you can be.

In other words, the really fraudulent, the really improper, the really unsafe, the really unsanitary can under the laws of this State be asked to cease to operate.

SENATOR FAY: And this statement on the number of inspections, 48 unannounced and over 50% of the nursing homes, has this been true just for 1974 or is it true for 1973? Do you have statistics going back two or three years?

DR. FINLEY: Yes. These would be true for just the last four or five months. I have not been here 15 months. I have only been here for 9. So what you have is the reflection of the policy since I have been Commissioner.

SENATOR FAY: Are there any other specific recommendations? For example, you mention that there are not nearly enough. Just what would you consider the appropriate number of inspection teams? Just what would be sufficient? What would be adequate?

DR. FINLEY: Rather than try to give a number or be one of those -- I am not the kind of person, as I was telling Senator Martindell earlier, that feels that more is necessarily better. I would really rather mention for a moment that Commissioner Klein and I do agree that there is the possibility of some duplication between I & A which does many of the kinds of things I've been describing where Medicaid patients are involved. Where Medicare and Medicaid patients are involved, the Health Department does it and passes the information on to I & A, so I would think that maybe something that is administrative would be the way that you would solve it, and there would be no need for legislation.

What Commissioner Klein and Mr. Reilly and the Health Department and I are doing, anyhow -- we are improving communication; we are improving studies on how to end the duplication between Health and I & A, and I think this is the answer to efficiency. You just shouldn't have two staffs doing practically the same thing. I also think this is unfair to institutions. It's like the school nurse and the visiting nurse both showing up in the house on the same days. It's kind of crazy.

SENATOR FAY: Are any of these people assigned to a night shift? Are any of the nurses or any of the inspectors assigned to a night shift? I know that quite a few of the complaints that we have received were problems in the evening hours.

DR. FINLEY: Well, I would like to answer this by telling a story which I just learned about my own staff, which I think is a compliment to them. Some of the nurses and the

nutritionists and the pharmacists that I have just been telling you about in this newly pulled together reorganized team have been doing things like -- the dieticians, for example, are stopping by the nursing homes they are responsible for fairly late Friday evenings. We hear all this stuff about State employees all going home at four o'clock on Friday, but I am talking about seven or eight o'clock or five, five-thirty, whatever is the feeding time in the home, they have been watching the food being prepared; they have been watching the patient's reactions to it; they have been talking to the patients. These are trained dieticians.

In other words, yes, people are not just working nine to five. The nurses that have been going around have spent a great deal of time not just looking at the nursing orders and the records but have been sitting down talking with the patients. You know, "Who comes to see you; who takes care of you; do you understand what they explain to you." All of this, again, -- as I say, I am really rather anxious for the Health Department not to be seen as a Gestapo. The unannounced inspection isn't just for punitive purposes, but, yes, it is happening. It is happening at unusual hours. It is happening at the times when they get a chance to talk to the patients.

ASSEMBLYMAN GARRUBBO: With what results?

DR. FINLEY: In terms of what?

ASSEMBLYMAN GARRUBBO: In terms of discovery. What are you discovering when you are talking to the patients?

MS. HUTCHISON: I think we are looking at and are seeing a truer picture of the day-to-day operation of what goes on. If an announced visit was made, I'm sure - just like when each of us knows when company is coming, we clean the house up a little extra - that efforts are being made to show a good picture when we come, and in the same way, though, I think our professional surveyors have the know-how to recognize a certain amount of

dressing up. If they feel that there is reason for an unannounced revisit or revisits to be certain that they are seeing the true picture of the daily operation, this can be very revealing.

ASSEMBLYMAN GARRUBBO: Are you finding differences?

MS. HUTCHISON: In some instances, yes, we are finding a difference in the operation from the annual visit. We are going back and finding a different mode of operation when they are not expecting us.

SENATOR FAY: Thank you very much. Doctor, this has been very, very helpful to us, and we will be in touch with you, and we will be calling upon some of your division heads and your specialists for our other hearings. Thank you very much. We appreciate your testimony very much.

(Prepared statement begins on page 1x in the appendix.)

Commissioner Klein will be our next witness.

A N N K L E I N: Good morning. Thank you very much for the opportunity to be here. I would like to introduce Gerry Reilly sitting next to me, who is the Director of the Division of Medical Assistance and Health Services, which includes the Medicaid Program. We will be speaking from the point of view of the Medicaid recipient.

There are really three major points to focus on as I have said in my statement. One is national public policy with regard to nursing homes; two is the responsibility of the Division of Medical Assistance with regard to patients requiring nursing home care; three is the quality of nursing home care available in New Jersey.

I would like to comment, before continuing with my statement, on the testimony by Commissioner Finley regarding home health care services. I think that she has made a very excellent point on this, because it is not only true, in terms of the elderly, or those who need nursing homes, but in general it is true of all handicapped people. Public policy has more or

less concentrated on providing for them within some kind of an institutional framework. And, as you know, there has been a strong movement in this State, and I think you could say nationwide, to try to serve people as much as possible outside an institutional environment, because we have to accept the fact that, while institutions can provide very good care, they also do subject the person to institutional life, which is different from normal living, and which does take its toll on individual personality.

We certainly see that in the State hospitals, and the schools for the retarded, and in the nursing homes, I think -- although I am not that familiar with nursing homes -- even if you go back and read Thomas Mann's Story of the Magic Mountain, which talked about sanitariums for tuberculosis, that book strongly brought out the institutional aspects of this kind of care. So I think that its relevent, in terms of the efforts that are being made throughout the State, to treat people in minimum security, or with minimum security, or with the minimum protective environment that they need. I think that would also apply to elderly people.

Certainly public policy has, without any question, gone in the direction of encouraging the more maximum type of care and not really encouraging such things as home care, which Dr. Finley spoke of. As an example of that I would like to point out that an elderly person without resources can go into a nursing home and the nursing home will receive full Medicaid reimbursement for their care, and the family does not have the responsibility financially.

If the person has as much as $460 a month of personal income, they still are entitled to Medicaid or medical assistance while in a nursing home. However, if they are not in a nursing home, if they are living with their family, if they have an income in excess of $160 a month, they are not eligible for medical assistance.

ASSEMBLYMAN GARRUBBO: That's a pretty sound inducement to put them in an institution.

COMMISSIONER KLEIN: Yes, it really is, and that's what I mean when I say our public policy encourages this, as Dr. Finley has mentioned.

For instance, we do provide Medicaid payments for certain home nursing care and skilled care. We provide Medicaid reimbursement for nurses going into the homes, for physician visits, for home health aides, such as homemakers, and for medical equipment and supplies. But, again, the person would not be eligible to receive this help in the home unless his or her income was less than $160 a month, and so, you can see, we are not really encouraging families to try to care for people at home in giving them the kind of assistance that might make it possible.

Dr. Todd, who is the Director of the Division of Retardation, has pointed out frequently that sometimes a family with a severely retarded child will provide for that child up to the point when they can no longer lift them into the bathtub, and that if in fact you provide them with simple things, such as a hydraulic chair or something that would make it possible for them to handle the child for a while longer, they might not have to place him in an institution as quickly.

I think that as we look at this whole problem of how to care for people who are helpless in one degree or another, that we should always be looking to try to encourage the minimum total custody that we can, and to build resources into the family that is trying to provide for the person at home, help the elderly person who is living alone to stay independent as long as possible with the degree of assistance that is required.

I wanted to emphasize that point, because I think the financial reimbursements and the Medicaid eligibility point out very strongly how public policy has gone in this direction of encouraging more maximum care.

With the advent of the Medicare program, closely followed by the Medicaid program, the provision of nursing home care, predominantly for elderly citizens, was given great impetus. Two important factors began to operate. One, obviously, was the infusion of substantial amounts of money into the long term care system, and second, was extensive Federal involvement in establishing standards of care and life safety. At the national level, partly out of necessity and partly out of our traditional reliance upon private sector management, the policy of permitting Federal Financial Participation in proprietary nursing homes was sustained. Any situation in which government purchases services on a large scale, especially from the private enterprise system, is always fraught with pitfalls as legitimate private profit motive comes into contact with public accountability and responsibility. In most situations government relies on competitive bidding systems to insure that the public is safeguarded. Such a system is inappropriate when applied to a health care delivery system, especially when that health care system is providing a scarce resource and the demand for the services far outdistance the available supply. These factors, together with rapid growth in both the supply and demand for long term care, brings us to 1975 and the recognition that it is now time to take a careful look at the whole system for providing nursing home care. We must make certain that we are paying a fair and reasonable amount, consistent with the requirements of good care.

THE ROLE OF THE DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

The Division of Medical Assistance and Health Services exists for one fundamental purpose, and that is to provide high quality health services at reasonable cost for the indigent citizens of New Jersey.

Consequently, with regard to nursing homes, our primary goal is to purchase services as needed, and as appropriate, for people who need long term care. The Division is not designed to be a regulatory agency although, to reasonably discharge its public responsibility, the Division does exercise some regulatory functions in connection with nursing homes. These functions are of two kinds. First, the Division sets the rate of reimbursement which we pay to the 230 participating nursing homes, and, second, the Division, through its medical, nursing and social services staffs, evaluates individual patients with regard to the medical necessity for nursing home care and with regard to the quality of care being provided.

The rate setting function is one that will eventually move to the Department of Health, which is charged by law with setting such rates. The Division, by agreement with the Department of Health, has been setting the Medicaid rates since 1971. It is our expectation that once the Department of Health has completed its revision of the hospital rate setting system they will be able to assume the nursing home rate function.

Our patient assessment responsibilities are focused on the individual needs of each patient, as compared to the Health Department's inspection and licensure function which focuses on the basic capability of a facility to provide services.

However, this really does mean that a lot of visits are being made to nursing homes where Medicaid patients are housed by these nurses who go in for these regular reviews, and they have to go in at least once in four months for each patient. These are unannounced visits, by the way.

During the current fiscal year our nurses will perform approximately 45,000 individual assessments on about 16,500 people. That doesn't mean -- you can't divide that and come up with four visits a year, because some of these patients are there a very short time and others may be there longer.

The patient assessment system is the backbone of our efforts to assure that good care is being provided and we believe that such a system is essential to the prevention of abuse.

I think that you may hear some testimony today about the service that these nurses provide in these nursing homes, because they are not only -- and there are social workers who are going in too to assess the patient. And they are not only going in to see what the nursing home is doing, but also to help the nursing home in developing programs for the patient.

The quality of nursing home care in New Jersey is, of course, what you are mainly interested in. I would have to say, based upon the information in our Division of Medical Assistance and the people that are going into these homes where Medicaid patients are, that the quality of nursing home care in New Jersey is probably not as good as we would want it to be, and certainly not as poor as some generalized criticisms would imply.

On balance, we have a fairly good program that has made substantial progress over the past few years both in terms of correcting life safety problems and the provision of basic care.

This is not to say that there are not instances of neglect and, in rarer instances, problems of abuse. I'm afraid these things are unfortunately true of any human effort. But I think we must be careful, in our legitimate efforts to eliminate problems, that we don't rush to judgement with regard to appealingly simple solutions that may have unanticipated, long-term, adverse consequences. We are dealing with an important health care delivery system, which must be supplemented, and which must remain vital and growing.

I and Director Reilly would be very happy to try to answer any questions within the area that we are familiar with.

ASSEMBLYMAN GARRUBBO: I noted that you indicated that there were 16,500 Medicaid patients presently ---

COMMISSIONER KLEIN: This year there will be. They may not all be in the homes the whole year.

ASSEMBLYMAN GARRUBBO: Do you know what the total number of nursing home patients is in nursing homes, in the general sense, in the State of New Jersey?

DIRECTOR REILLY: I believe its about 22,000 or 23,000. I think we account for about 60%, but I'm not sure about that.

ASSEMBLYMAN GARRUBBO: How large a staff do you have, Commissioner Klein, with regard to inspections and visits?

DIRECTOR REILLY: We have currently 48 nurses in the field and 12 physicians, 22 social workers. We have authorizations for more social worker positions, but that got caught up in the budget crunch, and they haven't been filled.

ASSEMBLYMAN GARRUBBO: I noted that Dr. Finley indicated that her Department was doing some unannounced inspections. Do you note any overlapping in the services or the function of her Department with yours?

COMMISSIONER KLEIN: I think Mr. Reilly can respond to that because he has more familiarity with that.

MR. REILLY: I think, on the face of it, when first looking at it, that's a logical question. But I think we have to understand the purposes for which the Health Department goes into homes, and the purposes for which we go into homes.

As I view it, the Health Department is essentially taking a snapshot. They are going in at a fixed date and time, assessing the capability of a home to provide services against certain criteria. As Commissioner Finley commented, they largely follow Federal stipulations and have a very, very comprehensive check list and format. It is entirely different from the purpose for which our nurses go into homes.

We are required by Federal regulations to assess the medical necessity of each stay in a nursing home; that is, that the person needs the care at the level provided, for purposes of paying the home, and so that we assure the Federal Government that we are utilizing the service properly. But that is just the entrée reason. All kinds of benefits flow out of this initial visit.

In some states, they comply with this certification of need requirement simply by a physician reviewing charts remotely, or based upon the data provided by the home, and no one looks, touches or feels or talks to the patients. We don't do that in New Jersey. Our nurses go in and physically lay hands on, touch, see, talk to each patient that they assess. I think that is so fundamentally superior to the system of paper certification.

Our nurses are also involved in the development of programs in homes, such as reality orientation. They are in there in a dual role. They are in a sense inspecting, but they are also helping. They are a positive force in the homes.

ASSEMBLYMAN GARRUBBO: You have some 82 people in the field. The Commissioner of Health indicated that she had 25. She is dissatisfied with the number. It seems to me that if we have separate agencies with that available manpower,

you might be able to coordinate an effort, so that some of your 82 might supplement the 25.

MR. REILLY: They do. In effect they do, because when our nurses are going in to look at Mrs. Smith, they can't help but observe situations in the home. If we do observe a situation in a home, we have a mechanism where we will share that discovery with the Department of Health. I think, yes, we have to coordinate. It is important to coordinate.

The criticisms and concerns of the homes are that they feel put upon, because here comes the Health Department on one day, and here comes Medicaid on another day. I think it is a somewhat small price to pay for having a variety of people going into a home day in, day out, week in, week out. These are vulnerable elderly people for the most part, and I think our nurses are in each home once every two weeks, because they see a different patient on each given day. I think this kind of outside objective look at a home is particularly important.

COMMISSIONER KLEIN: I would like to say, in answer to your question, Assemblyman, that Dr. Finley and I have discussed this, although only recently and rather briefly. I know that the staffs of the agencies have been discussing it. We are most interested in cutting down anything that would in any way be a duplication. I feel it is important that our nurses or our people who are going in to see patients should report to the Department of Health what they see about the nursing home that doesn't pertain to that particular patient, but to the level of care.

We are going to have meetings to see how we can coordinate our activities and get the most for the effort that is being made. I don't really see how,with the assignment that we have of really evaluating each patient as an individual, we can also do the very comprehensive kind of annual inspection that is required in evaluating a hospital or nursing home for licensure. That seems to be almost a separate function.

SENATOR FAY: I hope it is not a simplification, but I personally would like to see, and I think the public would like to have some type of a night chore, some form of professional investigators who can be on duty through the week, and not only can react to written complaints and phone complaints, but also can let the whole industry know and let the public know they are being protected on a 24-hour basis.

MR. REILLY: I think we can do that. Some of our nurses, I am told, voluntarily do this. They drop in at odd hours just to see We have not as yet developed a formal program of doing some of our visitation in the evening hours and on weekends. Perhaps there are some impediments to that, because the assessment function couldn't go forward if the appropriate people aren't there with the charts readily available and so forth. But I think it is something that we could do, and it might have a salutory impact just as if it was done on a rather small scale, but on a random small scale.

ASSEMBLYMAN GARRUBBO: Can I get on to another area. That is, you have commented about rate setting. We have received a report from the State Commission of Investigation concerning reimbursement formulae, but before I ask you about the reimbursement formulae and its origin, and what your feeling about it is, I would like to ask you about something that I have personally been aware of which may be totally unfounded.

I always recall hearing that there were certain nursing homes that required as a part of your residency the surrender of assets; is there such a rule or law in the State of New Jersey?

MR. REILLY: If they are recipients of Medicaid, one must make income available to the Medicaid program. If you are a supplemented Social Securityincome recipient, you can retain personal assets of $1500 plus a car of moderate price, plus a home of $25,000 value. You don't have to liquidate those assets

under the SSI Program, but any income you are receiving would come back to the program, except for $25 personal incidental allowance.

COMMISSIONER KLEIN: I don't think that's what you were referring to, though. I think you are talking about contracts that are made by people -- private arrangements with institutions where you surrender or you will your assets, and then you go in and you are cared for. I do not have personal knowledge of that because we are involved with the Medicaid Program, which is really dealing with people who don't have these kinds of assets, but I would assume these kinds of arrangements are made, because they are made in other states. I may be assuming wrong, however. I really don't know. The answer is I really don't know.

MR. REILLY: We are not regulating private nursing homes.

ASSEMBLYMAN GARRUBBO: What about the reimbursement formula, is your Department involved in dealing with that formula?

COMMISSIONER KLEIN: Well, our Department, as I said, has stepped in and with an agreement with the Department of Health has been setting the rates for Medicaid reimbursement.

ASSEMBLYMAN GARRUBBO: The State Commission of Investigation in its report details the origin of the present formula, which was hastily snatched from the New York structure; is that your understanding?

COMMISSIONER KLEIN: I wasn't here at the time and I know that one of the people testifying is the former Medicaid Director, Mr. Jones. He may be able to comment on that.

SENATOR FAY: Let me say this for the record. Obviously, Commissioner Klein has not had an opportunity to go through the whole SCI report yet, and the fact that it is

controversial, at the next public hearing, which is in two weeks, the SCI will be here testifying on their report, and the industry will be here to question their report, and I would hope that Mr. Reilly can be available that day for that public hearing.

COMMISSIONER KLEIN: I didn't realize -- I sort of assumed that since it is an ongoing investigation, and this was a preliminary first draft, that it really wouldn't be the subject for public discussion. We searched it out, and we have prepared some response for them, because we do feel that there are some areas ---

SENATOR FAY: I think everyone needs the opportunity of two weeks to digest this.

COMMISSIONER KLEIN: You do plan to have this as the object of a hearing in two weeks, though?

SENATOR FAY: In two weeks, that will be one of the topics for discussion.

ASSEMBLYMAN GARRUBBO: Just a few more questions. Do you feel that the nursing homes can play a role in caring for discharged mental patients?

COMMISSIONER KLEIN: Certainly they can, and certainly they do.

ASSEMBLYMAN GARRUBBO: In what respect do they presently serve in that role?

COMMISSIONER KLEIN: Some patients who do not require psychiatric services are sometimes placed in nursing homes as a substitute for a state hospital. We have a group in the Division of Welfare who at the recommendation of the hospital that is discharging the patient, goes and finds a nursing bed for that patient and arranges for the patient to be moved to the nursing facility.

Now, I don't believe that we have done this to a very large extent, partly because nursing homes, and Medicaid beds

are not readily available. We are more likely to be moving patients into other types of facilities, such as sheltered boarding homes or family home care. Right now we are trying to set up a transitional residence for patients and move them into supervised apartment-type living where they will get social services that enable them to function in the community. This is all part of the whole question of trying to reduce the size of our state hospitals and the number of people living in those state hospitals, and to reevaluate, you know, what some of these patients really require in terms of supervision and care.

I do think that some have been moved to nursing homes, but I don't think that this has been a very large activity.

SENATOR FAY: Where have they been moved to?

COMMISSIONER KLEIN: As I said, they are more likely to be going into a sheltered boarding home or into a family foster home type of situation.

SENATOR FAY: This is another phase of this whole problem, the boarding homes; isn't that correct?

COMMISSIONER KLEIN: I agree. This is not something that is in Mr. Reilly's division, but it certainly is within our Department to the extent that the Division of Welfare is responsible for the support of numbers of people who are in sheltered boarding homes.

Of course, since the aid to the assistance of the elderly was placed under SSI and the Federal program, we don't have that direct responsibility for their support. But we do - with the agreement of the Legislature - set the rates for Social Security supplement. Now, we ran into a tremendous problem earlier this year because these sheltered boarding homes were only receiving $5.50 a day for the 24-hour care of people who don't get medical care, but who have to have their meals served to them. In fact, with the inflation and fuel costs and the cost of food, combined with the fact that the new Federal Labor Law does not permit these

residents to participate in any way in the housekeeping chores of the facility, like setting the table or things like that, they were faced with a very severe crisis.

We have done a study to try to determine, you know, whether in fact they could support people on $5.50 a day, or whether they required more. And we did agree with them that the rate was too low. That rate has been raised to $7.00 a day, and in the new budget, it will be $9.00 a day. Now, this is for licensed sheltered boarding homes, and it is made possible by our increasing the Social Security supplements for people living in licensed sheltered boarding homes. So, they have the resources to pay more than the $5.50 a day.

We do get into this, and we think it is very important that - in conjunction with trying to get people into less custodial type care, and trying to raise the rates sufficiently so proper care can be provided -- these homes also should be subject to licensure and to standards and rates just as the nursing homes and hospitals are.

SENATOR DUMONT: How many licensed sheltered boarding homes are there in New Jersey?

COMMISSIONER KLEIN: I didn't know we were going to be getting into this, and I don't have the figure. I really don't have the figure. I think there are quite a few, though.

MR. REILLY: I think there are about 200 licensed facilities in the State.

SENATOR DUMONT: You have said in your statement, Commissioner, that there are 230 participating nursing homes, and Commissioner Finley said there are 212 nursing homes in New Jersey, and 202 of them are proprietary. What accounts for the difference in the figures?

COMMISSIONER KLEIN: We don't know, and we were kind of riving about it and didn't quite know what to say, because we don't really know. I mean, it may be just semantics or somebody is wrong, but we do know that we have 69 voluntary homes

that we have patients in, and these are non-proprietary, voluntary homes; and we also know that there are 30 governmentally run homes that we have patients in, so we add up to 230 homes that we have patients in. But we don't have patients in all of the nursing homes.

SENATOR DUMONT: You account for 69 voluntary homes, and she only has 10.

COMMISSIONER KLEIN: It occurs to me that she may be speaking about homes that don't take Medicaid patients. I don't know. Is that possible?

MR. REILLY: I don't understand the difference. When that figure came up, I did double-check with people in the room who do know, and we do have 69 voluntary homes in the program. And we do currently carry approximately 230 provider agreements. That goes up and down daily, and we do know that there are 30 governmental homes. So I think it is probably some classification problem. I can get together with them and we can compare notes and work it out.

People are here from the Voluntary Association, and I think they will tell you that they have 69 members true and good.

SENATOR DUMONT: Any way, it points out a need for further cooperation between the two departments.

COMMISSIONER KLEIN: I would say that was right.

SENATOR FAY: We would like specific recommendations in the boarding home area, because this is an area which we haven't touched upon at all. I think one of our public hearings will deal with this problem alone, as opposed to the nursing homes and the government county operations. But I think this is an area which no one - outside yourselves - has taken a very close and penetrating look at. As far as the regulations on protecting the people in there, and maintaining decent levels of diet and the living conditions and the like, you can be most helpful in

recommending legislation and in recommending the needed changes.

COMMISSIONER KLEIN: I think this is definitely an area that we should be moving in. In the absence of special licensing requirements for various levels of provider care, what happens is you have to fall back, usually, upon hospital requirements. For instance, if you want to have a group home for more than four people, there just isn't a set of regulations for that, which after all is going to be similar to a familial situation, and so you run into all kinds of requirements such as lighted exit signs, fire escapes and things that may not be necessary in this kind of a family-like institution. But there are really no separate regulations for these things, and I think if we are really going to be serious about alternate care facilities, that we have got to address that question, what is really necessary for them to provide, and how can we enforce them.

SENATOR FAY: Commissioner, I wanted to commend Mr. Reilly to you and to the public, because he did a very fine job at our first meeting, when we started to go into the basics here. He did bring a few revealing facts to light; number one, the problem with auditing these homes. I think the point was made that only 80% of the homes in the State have been auditied so far. Is that still the fact of the matter?

MR. REILLY: Yes, I think a word of explanation, one of the reasons why only 80% have been audited is because the program is still relatively young and they haven't gotten to them all yet. When they do audit them, they audit them for the whole period.

There has been a policy of excluding those homes from the audit who are substantially above the administrative ceiling on the premise that there is not likely to be any recovery of funds available, because if you disallowed certain costs, they would still be above the ceiling. I have altered that policy, and have suggested that - particularly among some of the larger

homes that are above the ceiling that have not been audited - we make them a priority to get in their and do the audit as promptly as possible.

SENATOR FAY: Also, the matter of the profit motive - I think the point was made that it was very difficult to tell just what is the return on the dollar in these homes, to try to determine just how much profit is made on the individual or at least yearly, because of the fact that the private patients were not being included; is that the problem?

MR. REILLY: Well, the fact that homes are a mixture of public patients and private patients is a complicated factor. I think it's one that with good accounting practices can be overcome.

SENATOR MARTINDELL: Isn't that true in other states?

MR. REILLY: Surely.

COMMISSIONER KLEIN: We don't audit homes that don't have Medicaid.

MR. REILLY: No; no, but in a home that has Medicaid patients, more often than not there are also private patients, and one must look at the total expenditures of the home and then stop down to the Medicaid population in order to set rates and audit against those rates. It is a complicated factor, but it is not a crippling factor in dealing with audits. Recoveries this year, I think, are running at a rate in excess of $2.5 million on these kinds of audits.

SENATOR MARTINDELL: But there are not any fines. You just would cover ---

MR. REILLY: Well, this is a problem. Many of these audit recoveries are a function of an honest mistake in error, or a misunderstanding of regulations. There are others that are quite fairly fraudulent, and in those cases, they will be referred to the Attorney General for action. There are other cases that are in a grey area, because there is not sufficient prima facie evidence

to warrant a criminal prosecution but we feel perhaps it was not common error. We would like to have the right to invoke administrative penalties, and we have prepared draft legislation paralleling the Federal False Claims Act that would let us invoke such penalties in such cases as a disincentive for misbehavior, and that is an important piece of legislation that will be coming to you.

SENATOR DUMONT: Do you conduct these audits through your own personnel or through outside auditors?

MR. REILLY: Fundamentally through our own personnel. When I first came to the Division several months ago, I asked why we did not require an annual CPA audit, and the answer was that this can be extremely expensive, about $30,000 per audit, and we would have to pay for it, and we do have a team of very good auditors. I think we are moving to a compromise position where we may require an annual CPA audit on homes over a certain size, but to date, the audits are conducted in-house.

ASSEMBLYMAN GARRUBBO: Are you preparing specific legislative recommendations that will improve the quality of long-term health service?

COMMISSIONER KLEIN: Do you mean across the spectrum, or are you talking about nursing homes?

ASSEMBLYMAN GARRUBBO: Nursing homes.

COMMISSIONER KLEIN: As a matter of fact, we have been working for some time with the cabinet committee and the staff from the Governor's office to develop modifications to Title 30 in the State statute, and these are ---

MR. REILLY: There are a lot of things that you can do by way of regulations within current law, and I think that out of these kinds of hearings regulatory outcome can emerge, and we can address ourselves to them, and there are probably things that will require legislation, after we have exhausted the administrative remedies.

COMMISSIONER KLEIN: One new development that we are working on, which I think you might find interesting, is a pilot project to develop medical day care for some patients. There are cases - there may not be very many of them - where people could care for somebody at home if they were able to place them in a day care situation. We have this for retarded children and for other handicapped people, and we feel that day care centers in nursing homes could be a big benefit and would be less expensive than 24-hour care, and we have been working with the voluntary nursing homes to work out a pilot project in this area.

I only heard of a case this week where a man literally gave up his job to stay home with his ailing wife, although they are both in their 40's. She is very, very sick. It would be possible in a case like that, for instance, for him to be with her at night and still have a place where she could be during the day where she would receive care, and he could continue to function as the breadwinner.

SENATOR FAY: Are any states doing this now?

MR. REILLY: New York State has a couple of demonstration projects going. Region II, Dr. Bernstein and her staff, is very interested in helping us with this, and we are looking to get going on it.

SENATOR DUMONT: Do you do any of this today in the day care centers that have already been established throughout the State?

MR. REILLY: There are senior citizen day care operations around the State. Many of them are under the auspices of the Division on Aging in Community Affairs, but what we are talking about is something very specific, a person with a medical need, a health need,that,if it were not for the day care center, would probably be institutionalized, but who has a family at home who can take care of the basic needs during the evenings and the weekends and so forth. There are a lot of senior citizen

day care centers but not nearly enough. This day care would be focused on people with particular health needs. It wouldn't be a generalized day care program.

SENATOR DUMONT: Yes, but you have day care facilities now in some of the counties. Are they just for children, or are they used also for senior citizens?

COMMISSIONER KLEIN: Our own facilities that we operate are not for senior citizens, I don't believe. We do have day care for retarded children and day activities centers for older retarded people. We do operate those -- to some extent we operate them, and to some extent we purchase those services from groups that provide it. Senior citizen day care centers or day centers usually, I believe, function under either local or county auspices or private auspices with grants through the Division of Community Affairs, which has the Division on Aging.

SENATOR MARTINDELL: Commissioner, those day care centers are not related to health, though, they are just for ---

COMMISSIONER KLEIN: That's right. They are for social services, although they may provide the physical examination or they may provide X-rays, or dental care. Some of them do. There is one is Morristown, for instance, which is located in the senior citizen housing project. And I know about it because it is my town.

They provide a lot of different services including a hot meal, and I think a lot of these are not called day care centers. They call them senior citizen activity centers. They do provide a variety of services, but what we are talking about developing here is really a program where a nursing home could provide nursing care for partial hospitalizations, and I think this would be ---

SENATOR MARTINDELL: It would be like a day student in a boarding school, that sort of idea.

COMMISSIONER KLEIN: Well, yes, it would. But, of course, you can understand that this is going to present some problems in terms of transportation of a seriously handicapped person, which could be a problem, but there are also people who need things like physiotherapy, and instead of having somebody coming every day to the house, you might be able to place them in a nursing home for this care during the day, and then have them come home with the family at night.

SENATOR MARTINDELL: That would be a lot less expensive than either day care or home care, wouldn't it?

COMMISSIONER KLEIN: Probably our costs for the day care would be less expensive, because there would not be full around-the-clock coverage. However, I think that when you add in the transportation and if you consider the fact that the family is still basically caring for the needs of the patient, it is really not going to be less expensive. We just think it is going to be better. I think we have to be aware of the fact that most of the things we try to do that will provide better care don't necessarily turn out to be less expensive. I am finding, for instance, in the efforts to get people out of the institutions that if you just take them out of the institution and plunk them down some place and forget about them and just let them get their medicine, hopefully, that is going to be cheaper. It would be cheaper in dollars. It won't be cheaper for society in the long-run.

If you really try to build in the services to keep that person functioning at their level of ability, and if you keep them busy and involved and provide the things that you should provide, then I don't think it is going to be cheaper than putting them on a ward some place in an institution. This is a problem. I don't think we can sell this type of thing on the basis that it would be cheaper. I think that would be a mistake. But I do think it is a higher level of human care.

I was terribly impressed with the Scandanavian countries, a couple years ago, when I visited some of their centers for elderly and sick people. You can see there a tremendous range of care. I mean, they pay people, for instance, to go into the homes of elderly people to go shopping for them, which is similar to the visiting homemakers, but on various levels.

They have sheltered apartments where couples can live with different kinds of services available to them, and then if they get to the point where they need more care, there are other places where they can move into. But they are tremendously advanced in the way they meet the social needs of the people. Of course, they pay very high taxes, and I think they do get something back for it, in that they have these kinds of services when they need them.

SENATOR FAY: Thank you, Commissioner. Our next witness is Mrs. Mary Adelaide Mendelson. Mrs. Mendelson is the authoress of Tender Loving Greed. She spent ten years on this subject, and I am very happy and proud to have her come to New Jersey to testify. Thank you, Mrs. Mendelson.

M A R Y A D E L A I D E M E N D E L S O N: Thank you. Members of the Committee, I feel a personal satisfaction that the New Jersey Legislature, as well as some other states, is interested in reviewing the nursing home program, and of course, I thank you for the opportunity to address your Committee.

Perhaps the best contribution that I can make in a formal presentation is to point out the critical areas which are constant throughout the United States, and to conclude with my specific experience in New Jersey.

The foremost critical area is the substandard care, abuse and neglect of patients found in too many homes across the nation. This fact is being substantiated not only by state investigations, but in the report of the United States Senate Subcommittee on Long-Term Care entitled the Litany of Nursing

Home Abuses and An Examination of the Roots of Controversy, and finally in the guarded wording of an interim report on the nationwide survey of nursing homes by the Department of Health, Education and Welfare. My comments are a partial explanation for a neglect of patients who are not just the elderly, but the remaining population in nursing homes, the mentally retarded, the drug addict, the useful multiple sclerosis patient, even the alcoholic.

A major factor I have found is the potential for excessive profit which has encouraged many owners to take seemingly unlimited advantage of private paying patients and of government funding. One of the ways in which these owners bilk us all and impair services to increase the profits is through undisclosed ownership. By Federal law those persons owning 10% or more of a nursing home must declare their names. The interpretation of the law evades the intent of the law and leaves a vast gap in our knowledge of ownership.

Only the company which operates the nursing home must report the ownership. The land, building, and even equipment may be owned by still another group whose identity is not disclosed. Furthermore, every time the managing company changes hands, it must report the new ownership, but this requirement is often not enforced. Changes in ownership of the actual facility, of course, are never reported.

Each nursing home facility is identified as a single entity. The keeper of the records does not know the number of facilities with which any individual may have an operating interest, nor can it be known to what extent an operator of one facility may have an interest in the bricks and mortar of another facility. With so little known about the ownership of a specific nursing home, it should come as no surprise that nothing is known about the providers of services to nursing homes, the laboratory, the pharmacy, the laundry, the janitorial service, the bookkeeping

service, the construction company, the equipment company, the consultant company. I am repeatedly told that physicians are owners of nursing homes. Rarely do they show up in the records that I have seen, because only the interest of 10% or more must be reported. The physician required by law for each nursing home can have a financial investment in the operating company and be undetected. Thus, disclosure of ownership is a meaningless ritual. Perhaps because of its impotence the enforcing authorities pay only token effort to enforce the regulation, and for undisclosed reasons, the regulatory agencies are reluctant to share even their meager and often inaccurate information with the public.

The argument frequently given to me for the veiling of ownership secrecy is that there is no significance in ownership and therefore no need for the public to know. But then why the urgency to conceal the information if the information is immaterial. Or, turned around the other way, what advantages do the owners get in the obfuscation and hiding of ownership. Of course, when the ownership of the realty differs from that of the managing corporation, there will be a lease arrangement. To the extent that the lease is fairly bargained, our only concern should be the effect the amount has on the quality of care provided to the patients. Is the monthly rent too high to leave enough of the per diem rate to stretch over the cost of food, staffing, and housekeeping?

But when the lease is a sham arrangement, then there is the additional question of the legality of the amount paid. In a sense one can say that what is good for business is not good for the patient or the taxpayer. When the daily rate paid by the patient is paying an excessively high lease, then there will be shortcuts taken in the kind of care provided. Because many patients cannot pay their own way, Medicare and Medicaid pick up the tab, so the taxpayer pays that lease.

Whatever amount the New Jersey Legislature decides upon for the daily rate for its Medicaid patients, it

may as well recognize that it cannot be sure it is buying health care until it has acknowledged the distinction in ownership and concomitantly has found a workable method to determine the percentage amount from each dollar that should go towards rent.

Medic Homes Enterprises, a publicly owned company in which Bernard Bergman was apparent, decided in 1972 to cease operation of its homes and to lease them instead. So successful was its decision, that its president reported a year later a 100% increase in its pre-taxed income. This may have seemed good for the investor, but it suggests to those concerned with health care that the patient lost some more dollars in rent that should have gone for his comfort, safety, and even health; or it really tells the taxpayer that he has paid the company in rent enough to declare a 100% increase in income.

An illustration from the New Jersey records can suffice to exemplify several of these points. One home, Cranford Health and Extended Care Center, was licensed as a non-profit home. The state records give the names of the board of directors at the time of the application. Only these names were available to me. Information in the files told that the non-profit group leased the home from another group. By means of another source of research, I learned that there were 16 limited partners, almost all from New York, and 3 general partners.

The non-profit group paid the limited partnership - assuming that the figures I was given are accurate - $2, 086,400 over a period of ten years for an investment which cost roughly $1,500,000. In addition, the daily rate paid, either by the government, or the private paying patient, included rental for the parking lot, and for the equipment. At the end of just ten years, an investment costing approximately $1,500,000 would be repaid with a profit of almost $1,000,000. In judging the fitness of the profit, it should be remembered that nursing homes are usually a non-risk investment, because of the guaranteed government

support from Medicare and Medicaid. When a home can find all private paying patients the income is, of course, higher than the Medicaid rate, but it is in a sense also guaranteed. Should a private paying patient run out of funds, she will either be replaced with another private paying patient, or be supported by non-risk government payment.

Another method of analyzing the figures at Cranford is the bed cost. At the time of construction in 1968, the bed cost, including equipment, was about $12,000, the same year that the Bergman company kept construction cost to $5,000. At the end of ten years, the leases would bring the cost to approximately $20,000. The home was constructed with an FHA insured mortgage. The equipment replacement figure was stated as approximately $70,000 but the alleged rental figure was $30,000 annually.

In short, Cranford Health and Extended Care Center may have been a good investment, but it was costly to both patients and taxpayers. The general partners in the venture were also involved in a similar kind of project with at least two other homes in New Jersey. The medical director at Cranford was an investor in one of the other homes. The architectural design for Cranford was the same for that of Troy Hills. The cost savings of using the same design was not passed on to Cranford; instead, it was sold to Cranford. The non-profit group operating Cranford is affiliated with a third home, and at least the president of the non-profit group was connected with still a fourth home.

When I tried to get the names of the partners and officers and directors of the non-profit organization of these other homes, I met with resistance from the Bureau of Community Resources.

The attitude of the State is, of course, my point on the failure to disclose the needed information. The records I saw did not include the limited partners for Cranford. The Bureau refused to cooperate fully on Princeton House or to do anything about a fourth home in Jersey City, other than to verify its existence.

That meant that there was really no way of knowing who really owns the nursing homes or where the patient dollars were going, and whether non-profit was a guise for profit.

With what little information I had, I could detect instances of conflict of interest. One financial reference - references are required by the State - was also apparently a limited partner. The president of the non-profit board was a chairman of an HEW Advisory Committee on licensure of nursing home administrators, a point not publicized by HEW. Another member of the board was a civil servant in the nursing home branch at HEW.

We have heard a great deal about influence peddling. In the New Jersey files for several other homes with references - one from a judge, and several from Congressmen - from the point of view of the nursing home owners, that choice of political names is tactically smart. For that reason, it can be suspected that the move has an impact on the writing and the enforcement of regulations.

I am particularly sensitive to the power of the industry throughout all of my experiences, including that with Senator Moss, Chairman of the United States Subcommittee on Long-Term Care, who did his best to stop the publication of my book, Tender Loving Greed.

The state file on Cranford showed still another weakness in the state's enforcement of its own good intentions. Like other states, it required an estimated budget for operation. The rental figure for Cranford was figured at almost $100,000 less than the figures of the FHA. Cranford was not the only home to submit figures that differed from other sources. Nor is New Jersey the only state where the estimated budget seems to be a set of fictitious figures.

The whole area of cost to operate a nursing home remains virtually unexplored. Nursing homes submit to government agencies their own figures. These are usually untested by a field audit. My organization attempted to get an idea of the cost of nursing home care by applying a dollar tag to the state and Federal

regulations. We found that the then existing reimbursement rate for a skilled nursing home more than paid for the requirements and included a substantial profit. That profit could have been as high as 40% of the per diem daily rate.

Needless to say, the Nursing Home Association has fought the report, even threatening a lawsuit if the report was not retracted. The analysis firm hired to do the study understandably failed to take into account the subordinate mortgages so often placed on nursing homes. This use of the realty as collateral for loans is still another advantage facilitated by the failure to disclose ownership.

Some of the indebtedness is so preposterous as to suggest that the principal was never intended to be given. Nevertheless, the patients dollars for care will be used to pay off the interest either directly or indirectly through an inordinately costly lease.

Oddly enough, the indebtedness may also increase the market value of a home. Since homes are bought and sold frequently, the indebtedness is passed on to a new owner who may have an undisclosed interest in other homes in other states where he is inflating the value and selling the homes. Medic Homes Enterprises, which happens to be headquartered in New Jersey, illustrates an example of the inflated value of a home. According to the prospectus, Oak View Nursing Home, constructed in 1963, was valued in 1968 at $608,766, a figure inclusive of land, buildings, equipment, and automobiles, less depreciation. It was purchased by Metricare from Frank and Vincent Gabriel for $2,250,000 a price inflated by $1,641,234. The prospectus continues, and in addition, Frank Gabriel was offered the right to purchase 15,000 shares of common stock of the company at 15¢ a share, the same shares offered to the public at $12 a share.

Mr. Gabriel was described as a Vice-President of Metricare, the Executive Administrator of Oak View Nursing Home,

and a half owner of Monmouth Convalescent Center. In addition to giving substantially full time to Metricare, the prospectus warned that Mr. Gabriel has still other business interests to which he may have to give some time.

Lest we think a nursing home is a small business, Metricare may dispell that myth. Metricare expanded its health care business to include hospitals, pharmacies, retirement homes, management services for condiminiums, and management consulting and data processing services to the health care industry. Its assets in 1968 were $1.5 million. In 1973 they are almost $38.5 million.

One other interesting side light on Metricare, or Mr. Gabriel its Vice-President, since the first prospectus his name has disappeared in all the FCC records which I have seen. But Metricare is illustrative of the ownership requirement peculiar to New Jersey. By New Jersey law the owner of the nursing home has to live in New Jersey. As President of Metricare, now in possession of Oak View, Philip Levy signed an affidavit swearing that he was the President of Oak View, both the business and the real property and that he maintained a residence in Gloucester, New Jersey, care of Joseph Caterina. At the same time, as the principal stockholder of Metricare, he disclosed in the prospectus his address as a resident of New York City.

Mr. Levy was not alone in finding a mailing address in New Jersey. I came to New Jersey from Albany where I was told about a man who was a member of the New York Hospital Review and Planning Council who had a nursing home in New York City, but in New Jersey I learned that he leased a home in New Jersey. How, I asked, did he beat the residence requirements? He had an apartment in the nursing home, I was told.

Incidentally, in that file was a trivial side bonus for the failure to record good ownership records. The administrator from this man's home in New York wrote a reference for a principal in his home in New Jersey, much as and unidentified father might

write a reference for his son. In that same file there are references to Bernard Bergman's associates operating in Utica, New York. In fact, one of the things I had hoped to ascertain in my visit to the New Jersey Department of Institutions and Agencies was Bergman's interests in New Jersey homes.

I had read in the prospectus for Medic Homes Enterprises that Mr. Bergman had homes in New Jersey, as well as in other states. The number and location were omitted. As it turned out, Bergman was unknown to the agency, just as he was unknown in Albany and denied in New York City. I found instead the interrelationship of names that has always made me question the number of truly independent homes that exist.

In the meantime, back in the securities and exchange files appeared a copy of an equipment lease given by a subsidiary of Medic Homes to a New Jersey home operated by National Hospital and Institutional Builders Corporation. The signature of the leasee was Ann Weiss, wife of Bernard Bergman. Was the lease arrived at fairly? Is it an example of a related provider charging an unfair amount for the service?

Another problem found across the country that has received very little public attention, as dubbed by me, is the nickel and dime thievery Do the dates of admission reflect the actual date of admission or are they pre-dated? Are the nursing homes receiving patients for patients after they have died? Was the last 11% increase in Social Security fully recorded as a part of the patient's income? Was the use of the personal expense money ever field audited? What arrangements are made at death for the unspent funds? When the tax rebate money comes through to recipients, who will receive that money?

I do not know how much of this thievery exists in New Jersey, but I can speculate that because the Towers in New York managed by Bergman's wife took advantage of Medicaid money, that a similar pattern could be found in New Jersey. There are many ways

that the cheap thievery is conducted. Perhaps a print-out of expenses for a Medicaid patient in Ohio can suggest a few.

The patient went to three nursing homes in a period of 22 months. At the first home, the home was reimbursed for 10 days more than the patient was in the home. The Social Security income was continuously understated, varying from $86.26 to as high as $189.24 in the third home. There is no record of a physician ever seeing the patient, although drugs are ordered. Including, incidentally, one drug labeled miscellaneous. Drugs are never ordered in the standard package amount, which means an additional cost to the Medicaid program. Only once do the drugs show a clear pattern of medication to treat an illness. But most interesting, after using another set of data, I found out that the patient's name and sex on the print-out differed from that recorded as the recipient in the nursing home. A suspicious person might wonder if the patient did indeed exist.

One final observation I would like to make: The quality of care is criticized in all states. The amount of reimbursement or per diem rate varies from state to state. Some states like New York have built in an incentive system, but we do not know the number of New York homes that bilk the Medicaid funds in the name of non-existent, improved services. Does this not suggest that each state should review the method it used to arrive at the per diem rate, the method it uses to audit the submitted costs, the connection between its per diem reimbursement and the regulations it demands. And, finally, should the state continue to question the feasibility of enforcing its regulations? Maybe it can even consider raising its demands.

Now, I turn to my own experience in your state office of the Department of Institutions and Agencies. The day I came, having called for an appointment, all but one of the professional staff was out. This particular nurse left behind could not have been more helpful nor more concerned about the ownership of the homes. She, as a nurse, was more disturbed about the quality of care,

about the violations of the regulations, but like me, she felt that the quality of care had something to do with the persons who owned the homes. She told me that the nurses thought the mafia had an interest in the homes, but she could no more document that statement than can anyone else. To have more than a suspicion would mean cooperation from the Justice Department, which so far appears like a sphinx.

The nurse criticized the Department's failure to enforce its own regulations, such as the residency requirements for the owners. She told of a nursing home owner who had suggested that he could make it profitable to her, should she cooperate with him by giving names of homes that might be available for his purchase.

The staff then returned to the office. The Chief told me that I had been there long enough. Some time after that I telephoned from Cleveland to check some information on ownership of several homes. The nurse who had been so cooperative had told me that she could not talk to me, and turned me over to another person. This person answered some of my questions when abruptly she informed me that her boss had just told her to give no further assistance. The Department, like so many states, had closed the door. Though ownership information must be public information, the law was ignored. Obviously for the researcher, this can only mean that he must tread lightly with his material.

Nevertheless, to that one nurse who dared to spend those hours with me that day, I pay my respect today. I dedicated Tender Loving Greed to civil servants like her. I hope that your Legislative Committee can find the way to help those few employees who earnestly try to help the aged, but who are so often rebuffed by their superiors. Thank you.

SENATOR DUMONT: This agency that you spoke about in the beginning of your testimony, is it a Federal or State agency? You mentioned some bureau.

MRS. MENDELSON: That was your agency.

SENATOR DUMONT: Bureau of what?

MRS. MENDELSON: Institutions and ---

SENATOR DUMONT: Well, the Department of Institutions and Agencies you mentioned at the end. In the beginning you mentioned a bureau where you met with some resistance, as I take it.

MRS. MENDELSON: That was the same place.

SENATOR DUMONT: You were not able to identify the nursing homes - or where they are located - that Mr. Bergman has an interest in in New Jersey; is that correct?

MRS. MENDELSON: No, I was not. I was only able to find from the FCC files a reference to this National Hospital and Builders Corporation of his. And they were the ones that received the lease from the subsidiary that I mentioned. That nursing home is in Wayne, New Jersey.

SENATOR DUMONT: Alps Manor, by any chance?

MRS. MENDELSON: At that time, I think the name was Lake View, although the names, as you know, change frequently.

SENATOR DUMONT: I have heard that he has an interest in one in my own home town, and I was trying to check that out.

MRS. MENDELSON: Well, I don't think I have a copy of the lease with me, but I do have that name in my records.

SENATOR DUMONT: Thank you.

SENATOR MARTINDELL: Mrs. Mendelson, do you have a picture in your mind pretty clearly of what kinds of kickbacks are the most common countrywide?

MRS. MENDELSON: The various providers, particularly the pharmacy, the funeral home, the ambulance company, these are the ones that are said to give kickbacks. There has been some documentation of this in reports of the Justice Department in the State of California. It seems to take a different kind of investigative team than is connected with the Health and Welfare Departments to bring out this actual information.

SENATOR MARTINDELL: Could you give an example of what you would recommend?

MRS. MENDELSON: Well, again, I think if we knew the names of the providers of these services, we would be in a better position to trigger the investigation of that particular provider.

I might point out that I have some reservations on the drugs, as to whether it is completely a kickback or whether the drugs ever get to the nursing home at all.

SENATOR MARTINDELL: Would that be true in other areas, too, like laboratory tests that are charged for and not made?

MRS. MENDELSON: Yes. As a matter of fact, I know of one lab where clearly Medicaid was billed, and the work was not performed. The owner of that particular lab told me that if it was performed the doctors didn't know how to read it. So it was actually a means of taking advantage of Medicaid.

SENATOR MARTINDELL: To go back to your testimony, you said you had difficulty with the Institutions and Agencies Department. When was it that you were here to talk to them?

MRS. MENDELSON: That must have been 1970, and I would suspect that the telephone call that followed my actual visit here could have been as late as 1971, when I was trying to check out information in terms of the subsequent book.

SENATOR MARTINDELL: Would you recommend legislation other than disclosure, such as, how to stop the so-called gang visits ---

MRS. MENDELSON: Well, again, I think if there were a serious attempt to audit, there are ways in which the computer can turn out material which immediately would show errors. Now, for example, the print-out that I was mentioning earlier, if this had been a home where there were gang visits, there would have been a series of those visits reported here, then it is possible to go back and check the nursing home records, which

would show whether the visit actually made any changes in terms of physical examination or a change in the doctor's progress notes and that kind of thing.

SENATOR MARTINDELL: This would show up on the computer?

MRS. MENDELSON: It would show up simply by the repetition of it.

SENATOR MARTINDELL: And also overcharging for drugs would show up?

MRS. MENDELSON: That's right. The computer can kick out a number of things. For instance, it used to kick out, in our state, the Social Security income that the patient got. Now, Medicaid, as you know, picks up the difference.

That is an invaluable means of checking whether the income is correct or not. And, of course, the auditor has the authority to get that information or those figures verified through Social Security. It is what the computer is programmed for that helps in auditing this.

ASSEMBLYMAN GARRUBBO: Mrs. Mendelson, you have referred to Cranford Health and Extended Care Center, and you also referred to an institution called Oak View, and you have cited certain examples of inter-corporate relationships and certain transactions that have increased the cost of operation. Just how extensive an investigation did you do into nursing homes in New Jersey in terms of numbers of nursing homes?

MRS. MENDELSON: Well, really not extensive in terms of the number of nursing homes. I was attempting -- actually, as I think back on New Jersey, I was interested in Bergman. I was interested in Bergman for purposes of what subsequently became this book. And I was also interested in the fact that I did know that the then President of the Cranford non-profit group was with

the HEW National Advisory Committee on licensure, so that I did have that much interest. When I came here and found that the files disclosed a lot more and received this cooperation from the one nurse, I was interested in a number of other homes.

I can think of the example of one that I would imagine is a Bergman home where there were a number of violations, and the only way it would show up as a Bergman home was that in the FCC records was the signing of a lease by the man who was listed in the State records as being the administrator or having some interest in the home.

ASSEMBLYMAN GARRUBBO: My concern, Mrs. Mendelson, is that just because the Cost of Living Committee of the New York Assembly has discovered much of the same type of interrelationship that you have referred to as existing in these two homes, that we do not draw conclusions on a universal basis without some specific data and evidence. I just wonder, since we do have an instance in this Cranford facility - which is of extreme importance to me because it is within my Legislative district - how prevalent such a practice is in the State of New Jersey.

MRS. MENDELSON: I can't answer you. I can only say that it is prevalent throughout the country and that the pattern was here as well as in other states. You also have a large corroboration of public chains that are headquartered, I believe, in Maryland. One of those corporations had a home here at the time that I was working here in New Jersey. It is all over the country, and I don't know what other interests they have. I know there was one where they built the liner for sewers. Now, that is certainly not interrelated with nursing home ancillary services.

With most of the publicly owned companies - and this is information that you can get without the help of the State, I might say - this is a typical pattern. Now, how much exists in New Jersey, I simply have not sat down with the records to see.

ASSEMBLYMAN GARRUBBO: When was Tender Loving Greed published?

MRS. MENDELSON: It was published April 30, 1974.

ASSEMBLYMAN GARRUBBO: Did your research continue beyond that date?

MRS. MENDELSON: Yes, I have continued, but certainly not in the same field. The emphasis has changed, but for example I did become concerned about the 11% Social Security, how it would show up. My tentative findings, based only on Ohio, were that it didn't consistently go into the income of the patient.

ASSEMBLYMAN GARRUBBO: Have you discovered any lack of cooperation in any other division or department in the State of New Jersey as you recited before?

MRS. MENDELSON: No. I only went to that one.

ASSEMBLYMAN GARRUBBO: And have you discovered any instance since that date in 1970 that you came to New Jersey?

MRS. MENDELSON: No, I have not contacted New Jersey since that time, but where I have followed New Jersey at all would have been in the FCC files, and I might say that at that point I was also writing the book which was none to easy a task.

I would point out one thing, however, which does not concern New Jersey State Government but the FHA located in Elizabeth. They were equally uncooperative.

ASSEMBLYMAN GARRUBBO: I assume you will be able to make a copy of your statement available to us?

MRS. MENDELSON: Yes.

ASSEMBLYMAN GARRUBBO: Are you willing to make available to us any of your work product in terms of the results of your research in New Jersey, or does your recorded statement contain everything that you found?

MRS. MENDELSON: No, it does not. There are other facts, but it is material that is not typed up in any form. There are notes that I took down as I was working with the nurse, and

of course I am willing to share that information with you, but it would have to be understood that, since I have not gone any further with it, I don't -- it would give you some information but it would not necessarily -- I can't vouch for what those scribbles now mean.

ASSEMBLYMAN GARRUBBO: I see. Thank you very much.

SENATOR FAY: Mrs. Mendelson, for your information, this is one of a few investigations going on in the state right now. The Federal Attorney, the Attorney General, the SCI and the Legislative Commission are mostly concerned with only what is wrong, and how can we correct it.

Obviously, I think one of your major predicates and one that I accept is this disclosure of ownership. Do you have any other specific recommendations to make as to licensing, as to alternate care, the industry itself, how -- for example, do we have to go to Washington? What can we do as a State? What can we do within the Legislative process and the Administrative Departments of our state? And on the other side of the street, just what does the Federal Government have to do?

MRS. MENDELSON: Well, those are a number of questions all in one. I think that the state, of course, can go further than the Federal Government has as far as disclosure. In other words, there is no reason why you can't legislatively broaden the disclosure to include such information as the realty and so on.

Now, in New York, I am informed - and I'm sure this is also true in other places, but I know it is in New York - they must disclose any interest in related companies that do business with nursing homes. But it is interesting to me that that does not have to be certified. So it's not necessarily filled out, and it does not have to be accurate.

Again, this is a matter which is perhaps administrative, but certainly the legislature can be involved in making the law of disclosure actually carry a certification that what is said is true.

Now, I don't know how your State would handle the vendor payment made to the nursing home. This is an example of how we do it in Ohio. Each name is given with the patient's number and so forth, and the amount that is paid, and the date of service, first and last date. Now, again, if the nursing home owner who receives this had to sign that, that it was correct, then the fact that he is receiving money for a patient who was never in the nursing home becomes a -- it is a crime. If a penalty clause is attached to this, then one has the means of cleaning up a number of these things that the nursing home owners can do and are doing that make it a rip-off and a lucrative business.

I think you also asked something about other than nursing home care.

SENATOR FAY: Alternate care.

MRS. MENDELSON: I think that if a person really needs nursing home care, then there is no substitute for it. How many people are in nursing homes who do not need that is a question I can't answer. I know there are some. I call it the healthy patient racket. Because, you know, once you get in, you can't get out. The social service departments don't follow up and the hospitals do not follow up to see what has happened with the patient. The money is gone the first of the month; that is taken over by the nursing home owner, so there should be some kind of a check on getting the healthy patients out of the nursing home, or that kind of person can, of course, be taken care of by the home health care services.

I think that nursing homes should be here. They serve a necessary need, but there is no reason that we shouldn't clean them up.

ASSEMBLYMAN GARRUBBO: The Department of Health, Education and Welfare recently issued an interim report that was reported in the New York Times on April the second, 1975. The report cited broad evidence of overdrugging of patients, inadequate medical attention, inadequate diets, poor rehabilitation programs, and

various violations of Federal regulations. Are you familiar with that report?

MRS. MENDELSON: Yes, I am.

ASSEMBLYMAN GARRUBBO: In any of the research that you did with specific regard to New Jersey, were you able to uncover any pattern of such violations?

MRS. MENDELSON: No. That would have taken an entirely different set of records. I do know that there were stated in the bureau -- in any of the files that I saw, the number of violations and the type of violations were there, so that there were records of them. I remember that some homes had a number of violations. There were letters of complaints in the files. There were all the things typical of what I have seen in other states. But to tell you specifically about New Jersey, and a pattern, I cannot.

ASSEMBLYMAN GARRUBBO: Thank you.

SENATOR DUMONT: Mrs. Mendelson, what were the dates of your visits to New Jersey?

MRS. MENDELSON: Well, it has to be approximate. It is my recollection that it would have been in 1970, and it was warm weather, so that should place it in the summer. I know that the telephone calls followed that, and I think they could have been in 1971. There could be a number of changes. I am not in any way trying to say that 1970 is 1975.

SENATOR DUMONT: I understand.

SENATOR FAY: Thank you very much. The meeting will recess now for lunch, and we will go back into session at 2:15.

(Whereupon a luncheon recess was taken.)

Afternoon Session

SENATOR FAY: We are going to start the afternoon session. On behalf of the Commission, I particularly want to thank Mr. William Jones, who has been more than helpful and has volunteered to come before us and present a statement. Mr. Jones, we appreciate it.

W I L L I A M J. J O N E S: Thank you very much, Mr. Chairman.

Members of the Commission, I have prepared my statement in writing. It is 14 pages. But with your permission, I will paraphrase some sections to cut down the time. Others I would like to quote directly.

My name is William J. Jones. At present, I am the Superintendent of the Meadowview Hospital in Secaucus, New Jersey. Prior to my present appointment, I was the Director of the Division of Medical Assistance, which is commonly referred to as Medicaid. So I have had a great deal of input into the formation of the Medicaid program, having come into the State in '69 to write the Medicaid program. And I thank you for the opportunity to testify today.

I believe it is only proper to open my remarks by stating that, in my opinion, the greatest majority of our skilled nursing facilities and intermediate care facilities are doing a commendable job. The few who abuse the patients and the taxpayers through misuse of programs should not be allowed to denigrate the fine work done by the majority. Further, I believe we in New Jersey can be proud of our Medicaid accomplishments. However, in spite of these accomplishments, there have been problems and anomalies which have detracted from patient care and, yes, there are abuses. These abuses have been committed not only by providers but also by the bureaucrats and families of patients. I will attempt to identify some of these for you later in my remarks.

Very briefly, here, I will just synopsize my statement.

I think the Medicaid program is a terribly misunderstood program. First of all, too many people think that it is just a continuation of welfare and it has not been used as a catalyst for change. But with the amounts of money that Medicaid does spend, some $400 million plus, it could be a catalyst for improvement of services.

However, the purchase of service by a public agency from the private sector creates special problems, not the least of which is the assumption that the private sector itself is efficient. Certainly the experience of the New Jersey Medicaid Program, in my opinion, gives little ground for optimism that the health care delivery system, including those regulator agencies responsible for health care, are efficient. It must be recognized that any vendor payment system cannot exist without adequate controls over quality, costs, as well as availability and organization of services.

The New Jersey Medicaid Program attempted to accomplish these goals. However, the dilemma we faced was that the responsibilities, the authority and perhaps the will to accomplish the objectives for the public good are dispersed and diffused in this State. The Health Department, the Department of Institutions and Agencies, the Insurance Department, the Fire Marshall's Office, the Treasurer's Office, the federal government, et al, are busily engaged in making rules and regulations and determining reimbursement without due regard of one to the other.

In my written statement, I have some examples of my premise.

Medicaid deals with the private and public health sectors, where the other programs, themselves, are insufficient. Medicare, for example, does not really

entitle the aged to comprehensive health care -- it presently covers only about 40 percent of the health expenditures of the aged, and Medicaid is expected to overcome the deficiencies. Similarly, if private health insurance were adequately covering the working population, we wouldn't need all the Medicaid coverage we have to provide. Thus Medicaid is a reflection of broader deficiencies in health care and social problems.

Mr. Chairman, you and your Commissioners have a great opportunity to define, clarify and implement a cohesive, effective system in New Jersey through your work. I said "opportunity" where I should have said "mandate." In my opinion, it is time to stop the headline seeking of some individuals who pursue sensation, but cannot offer proof. It is time to weed out the cancer of abuse and restore a healthy system. But,most of all, it is time to stop the innumerable outbursts that stir controversy, then subside without action or change only to revive at a later date to start the circle again.

Mr. Chairman, I felt that I could serve the Commission best by first pointing out some areas that have appeared in the public press and I think some short remarks are due on them.

First, I saw New York Assemblyman Stein on television recently and he made the statement that in his opinion the reason that abuses in long-term care facilities continued in New York nursing homes was because of political interference or influence. I wish to unequivocally state here and now that during my tenure as Director of the New Jersey Medicaid Program no political interference was attempted nor would it be accepted or tolerated. In the statement, I give you three examples of phone calls where there were, in my opinion, in two of them absolutely nothing wrong and commendable actions.

The profit versus non-profit question. The news media has quoted New York and New Jersey officials as advocating the liquidation, if you will, of so-called profit-making facilities. This I consider the height of parvenuism. Consider, if you will, that almost 75 percent of the facilities providing beds for Medicaid patients are profit homes. How will you organize non-profit organizations to replace them? Second, many non-profit organizations have employees who are paid more than the Governor of this sovereign state, plus automobiles, country club fees, etc. At this rate who wouldn't want to be a so-called non-profit organization? Third, profit-making facilities pay taxes, non-profit generally do not. Fourth, government facilities are non-profit. Res ipsa loquitur.

As far as the SCI report, Mr. Chairman, I will just say that I have made comments and I think I have answered what I have seen in the newspapers. I haven't seen the full report. I don't think the report truly reflected what happened in Medicaid or the complexities of Medicaid. And I disagree with their findings completely. If you wish me to expand, I would be glad to do so, sir.

SENATOR FAY: At our next public meeting, we do intend to have the SCI here to enlarge upon and justify and explain their report. We certainly would like to get a detailed answer to them so we can pose questions to them.

MR. JONES: I would be pleased to do that, Senator, if you could assure me of getting a copy of the report.

SENATOR FAY: Of course, before you leave here today.

MR. MARTIN: Quality of care. As I stated before, I don't believe that Medicaid should be just a conduit for paying bills, but rather should take action. We constantly reviewed and evaluated our system. A substantial effort was directed toward nursing homes. In May of 1973, we

published a report on three years of our experience. This report was developed by using sound research principles and scientific methodology. I highly recommend to you that you obtain copies of this report. It is entitled, "An Examination of Nursing Homes under the New Jersey Medicaid Program, January 1, 1970 - December 31, 1972."

I would like to synopsize sections of this study. The outcome o this evaluation of the homes was generally very favorable. "More than half (56.1%) of the homes were found to be in the 'Good' or 'Excellent' category. Thirty point six (30.6) percent were classified as 'Average.' Only 13.3 were found to be 'Poor.'"

Quote, this is from the report: "It is conceded that long-term care facilities rated as 'Poor' in New Jersey might be termed acceptable elsewhere. Mr. Val Halamandaris, Associate Counsel to the Sub-Committee on Long-Term Care of the Special Committee on Aging of the U. S. Senate, acknowledges that New Jersey is known as one of the most progressive states in long-term care and that State Standards for nursing homes are among the highest in the nation."

Not resting on this 1973 comment, the New Jersey Medicaid Program instituted a medical review system based on individual patient's needs and services. This system rates a facility on patient service rather than a facade of bricks and mortar. Consequently,if a similar study were done today, I am convinced that the 13.3 percent homes found to be poor in 1973 would be reduced to less than 5 percent. I would not be satisfied, however, unless that figure is zero.

Another important finding of that report is: "There is practically no relationship between the per diem rate paid and the quality of care rendered by these institutions."

As to the deficiencies found in the report, I would recommend you do get that report because they are listed in full detail. There is a lot of information in there. But, as was stated this morning, the most glaring deficiency was found in nursing service areas. "In physicians' services, cases were observed where patients were not seen by a physician. . .

"The sanitary conditions . . . were the most serious deficiency found in the area of dietary services.

"In pharmaceutical services, two major deficiencies were detected. First, not all medications administered to patients were ordered in writing by the patient's physician.

"Second, patient's medications were not always properly labeled and stored in a locked cabinet at the nurses' station.

"Some facilities did not provide sufficient housekeeping and maintenance personnel . . . Insects and rodents were also found in several facilities."

As I said, a complete list of the remaining deficiencies can be found in that report.

Question has been asked this morning about tranquilization and overtranquilization. Part of the study had to do with that very question. In the report the methodology was: In order to determine the accuracy of the overtranquilization allegation, the Division of Medical Assistance and Health Services instituted an investigation of Medicaid nursing home patients.

The findings suggest that New Jersey Medicaid nursing home patients were not indiscriminately receiving tranquilizers. Of the 840 patients observed, 563 - that is 67 percent - were not being tranquilized. As prescribed by the attending physician, 277 or 33 percent were receiving tranquilizers for medical reasons. The dosage given to these patients fell well within accepted norms.

Whereas Senator Moss' allegation may be valid elsewhere, the evidence does not support overtranquilization in New Jersey nursing homes.

Physician Service. There are several additional points I would refer to your attention on the question of quality of care. The most glaring reason for deficiencies, in my opinion, is the lack of physician service in nursing homes. Many of the patients do not have private attending physicians. Many of the homes cannot obtain adequate physician coverage; hence, the patient is, too often, left to the prescribing of nurses or worse to laymen. Quite frankly, if a patient is ill enough to be in one of these facilities, he or she is ill enough to require physician services. However, the blame for this situation extends beyond the facility. It should be shared by Medicare whose ruling to pay a physician for only one visit per month has caused alienation of physicians. It should be shared by regulatory agencies for not insisting on adequate physician coverage in standards and reimbursement.

If you were to ask the Medicare people about this phenomenon, they will tell you physicians can be paid for more than one visit per month if medically necessary. But ask physicians. They will tell you no. I, as former Director of Medicaid, will also tell you no. For all the period that I was Director, we couldn't break this problem. If you are interested in this aspect, you can request all pertinent documentation from the Division.

One last point on quality for your consideration - it has to do with the certificate of need program.

While the concept of the certificate of need program has many desirable aspects, it has memorialized some poor facilities. This occurs because bed needs are determined by population census and beds in the community. Hence, if a poor facility provides a percentage of listed beds, a potentially excellent facility cannot build in the area. Consequently, the less desirable

facility reigns. This should be changed. Competition should be reinstalled so that the patient and family have a choice.

One last point on the certificate of need. I had stated previously in the written statement which I did not read -- but I pointed out that in nursing homes in the State of New Jersey, there are over 2,000 New York City residents and over 600 New York City Medicaid patients, for a total of over 2,600 people from out of state. I don't have figures on how many Pennsylvania people come into New Jersey. The New Yorkers represent about 12 percent of available beds. Yet the planners who use New Jersey population figures do not take this into account. As a result, many counties in this State must "bus" patients to distant locations because of a lack of beds in their home area. Couple this phenomenon with the discharge of institutionalized patients that is being contemplated and we have problems in the area of availability of resources.

Regarding abuses, the most obvious abuse to the patient is the failure of some facilities to provide a full range of competent professional services. This cannot be tolerated and a deficiency in patient care noted by inspectors and adjudicated to be valid must be immediately corrected. At present, the rule under HEW regulations and practiced in New Jersey, is that the home, when notified of a deficiency, replies by sending a letter of intent to correct. This letter is almost always accepted and nothing more is done to assure compliance. Consequently, the deficiency may remain for months and months. I propose that if patient care areas are deficient, then the home should have days and certainly not more than weeks to correct. If the problem is not corrected, then patients should be removed. Obviously, the best solution would be legislation that would prevent admission unless the

mandated and prescribed services are available in the first place. Also employees of the State and counties, as well as hospital social services, should be held accountable for placement in a substandard facility. No longer can we allow the excuse that, "I had to place the patient and there is no other place."

Another area that has concerned me is the area of substantial compliance. Simply stated, this Medicare term means that if a facility provides a service but isn't fully staffed, or if most but not all services are available, or if then patients require a service but only seven are receiving it, the home is in substantial compliance. I say this concept should be thrown out and forgotten. Full compliance is what we need. If ten patients require special diets or bowel and bladder training, then all ten should receive the service. In my opinion, this area is abusive to good patient care.

Personnel. Personnel in many facilities are not skilled, trained or inclined to provide service. The turnover rate is phenomenal. The ranks of employees are too often filled by part-time students, transients who jump from job to job, or those who do not service the patients. This condition exists in government facilities as well as private. No wonder we often hear the complaint that if you don't tip the help, you don't get service. The few facilities that allow tipping as a condition of providing patient service should lose their license. Further, you may wish to consider legislation prohibiting the acceptance of a "tip" for providing a health or medical service for which payment has been made by a third party payor.

Patient's Property. Besides the services area, there are abuses in the use of patient's property. The most obvious area is in the handling of patients' monies. As you probably know, the greatest majority of nursing home

patients are receiving approximately $25 a month, commonly referred to as personal incidental money. Usually this money is handled by and through the facility. Too often this money is co-mingled with the facilities', not appropriately accounted for, or misused. In addition, personal clothing is in many cases stolen, misused and otherwise denied the patient. I propose that the facilities be held accountable by law to replace lost or stolen property from the facilities' funds, and that the cost of this not be reimbursed by a third party or private payor.

Bureaucracy. Bureaucrats commit abuses by allowing abuses. They also create untoward situations by a lack of firm, clearly-defined and uniform procedures. Permit me to list only a few.

Inspection teams usually announce their visit. Consequently, we have heard that facilities "spruce up" in expectation of the visit. You know it and they know it. Recently, it was suggested to change the law to allow unannounced inspections. We had been informed by health officials and federal representatives that announced visits were required. The simple fact of the matter is that the law says, "If you announce a visit, you cannot give more than 48 hours notice." Note the word "if." The intent of the language was to assure that a facility not be given too much time in advance. In Medicaid, we took the position that we could go in at any time, and we did. However, if this question continues to be interpreted to favor announced visits by inspection teams, I would strongly suggest you clarify the polemic through legislation. Further, I would also recommend that the legislation require night and weekend inspections for obvious reasons.

Life Safety Enforcement. Public Law 92-603 required the use of the Life Safety Code of 1967 as the standard for Medicare and Medicaid participation. The implementation

of that code has caused considerable confusion and expense. There are no agreements among parties on what the code means. To my knowledge, no instruction, interpretations, case histories, etc. have been published by the appropriate authorities, so that uniformity can be discerned. The result can best be described by relating an example of the confusion and resultant abuse caused by the bureaucrats. One very fine non-profit home was ordered to replace their doors with a special door and attachments to meet the code. This they did at a cost of over $20,000. The next inspectors then ordered these doors to be removed and replaced with what? The same doors they had just removed. You can query facilities to determine the extent of this type of "abuse." You may be surprised.

Second, if the 1967 code is the code New Jersey will use for all health facilities, then it should be used as a replacement to the New Jersey Code. We can no longer say,if you build a hotel,you must meet the New Jersey Code; but, if you convert the hotel into a nursing home, you must meet the 1967 code.

Last on this point, how in the world can we tolerate selective enforcement? By this I mean, why shouldn't hospitals, state and other government facilities and institutions. including jails, meet the same requirements? This is an area of concern that should be reviewed by your Commission.

Some families and relative contribute abuses in the nursing home program. There are instances when a member will collect the patient's Social Security checks and use the money for their own purposes; or they will refuse to turn over these monies which are rightfully due the facility. In some instances, the personal incidental money is picked up by a relative for their use even though the patient may need a personal item.

I often think of a situation related to me wherein an individual drove up to a nursing facility in a chauffeur-driven Cadillac. She was visiting her poor mother who was on Medicaid. The purpose of the visit was to tell her mother not to worry if she didn't hear from her for 6 months. The daughter was going on a world-wide cruise.

Neither Medicaid nor any facility can shoulder all the problems. We cannot substitute for families or society as a whole. Medicaid has been abused by some families. By these remarks, I don't intend to insinuate that most people don't care. Unfortunately, however, there are sufficient situations where children or even agencies will place patients just to rid themselves of any responsibility.

If this Commission desires to review listings of individual and specific complaints, I would refer you to the Medicaid Division where complaints are recorded and surveillance records available. This information, coupled with the Health Department records, should provide you with a mosaic of information for your consideration.

Mr. Chairman, I do have some recommendations that I would like to read with your permission.

SENATOR FAY: Of course.

MR. JONES: In addition to those recommendations I included in the body of my statement, I would recommend the following:

1. Consolidation into one agency of all responsibility for regulation, enforcement and policy for all classes of patients in long term care facilities.

2. Adopt a patient ombudsman program, based on the Medicaid Model whereby Professional staff review the level of care needed and provided.

3. Enact a patient abuse law whereby alleged abuses may be reported by employees, families, friends or others, without fear of reprisal. Incorporate a right to sue by the patient, patients' family or the State on behalf of patients without family or unable to act on their own for acts of malpractice including failure to provide prescribed services.

4. Establish by law a uniform life safety code to cover all public and private facilities.

5. Require that all long term care facilities have adequate physician coverage and that reimbursement for same is provided by third party payors.

6. Require that Sheltered Boarding Homes be included in regulations developed for long term care and appropriate reimbursement be provided for patients placed by State agencies or other agencies financially supported with State monies.

7. Consider the creation of a Rate Setting Authority with the responsibility of establishing reimbursement and coordination of said rates with standards imposed by regulatory agencies. Included in their responsibilities would be the role of arbitrator for health care complaints against facilities and/or regulatory agencies.

8. Establish a task force within the Attorney Generals' Office, including auditing capability, for the purpose of expeditiously resolving complaints of a criminal nature.

However, one last word is in order. Too often, when we discuss what is wrong in our system, we tend to paint a bleak picture. We point out the thorns. I would be remiss if I didn't tell you that there are more roses than thorns. In ending, I must repeat that the majority of providers are good, honest, professional people, and we shouldn't paint them all with the same brush.

New Jersey can and should be proud of our accomplishments in Medicaid, health facilities, and, recently, our State institutions. We have a long way to go, but in my opinion, we are far ahead of other states.

Mr. Chairman, this concludes my remarks. I will be pleased to answer any questions you might ask.

(Complete written statement submitted by Mr. Jones can be found beginning on page 15x in the Appendix.)

SENATOR FAY: Senator Dumont.

SENATOR DUMONT: You mentioned over here on page 9 that you don't like particularly the way the certificate of need requirement works out. What do you offer by way of an alternative?

MR. JONES: I would say, Senator, that one of the major problems with the certificate of need is that it is not truly representative of need, number one. If you look in various counties -- for example, up in Hudson County we are told we only need 13 beds and yet we can't move patients out.

The fact you don't take into consideration the usage of facilities, rather the census vis-a-vis formula bed need, is a hole in the program.

I think it perhaps needs some areas of change in the administration. Then there is the question of ownership of nursing homes which by virtue of this act would prevent the resale and the phenomenon that we see in New York if it were properly applied. I don't think basically I would recommend much change in the component of the law, except perhaps talk about rate-setting authorities outside the domain of the regulatory agency.

SENATOR DUMONT: Then going to your rate-setting recommendation on page 13, you would set this up entirely outside, if I understand it rightly, the Department of Insurance and the Department of Health?

MR. JONES: Yes, sir, I would.

SENATOR DUMONT: It would be a separate agency of the State?

MR. JONES: Yes, sir.

SENATOR DUMONT: Would you include it in any department?

MR. JONES: You can, Senator, set it up in any housekeeping way you choose. I think the problem that I am trying to relate is that regulatory agencies,

particularly those who don't have the reimbursement authority,tend to make regulations for which there is no reimbursement and vice versa. I personally feel that the establishment of rates by Medicaid, for example, should be outside of Medicaid. I think the establishment of rates for Medicare should be established by law. We have, I think, too many pieces to have a coordinated approach to reimbursement.

SENATOR DUMONT: That is all I have.

SENATOR FAY: Assemblyman Garrubbo.

ASSEMBLYMAN GARRUBBO: Mr. Jones, you made a statement that I think I understood accurately. You indicated that there was no relationship in your opinion between the per diem rate paid and the quality of health care received by patients. Was that your statement?

MR. JONES: That was a quotation from that report that I have recommended you obtain; yes, sir.

ASSEMBLYMAN GARRUBBO: And you accept that proposition?

MR. JONES: I think that is a very interesting kind of a statement to be made. If you were to look at the matrix of reimbursements, the government institutions are the highest cost. The for-profit and non-profit are pretty much neck and neck. The report does refer to the fact because you are paying more money, you are not getting more services. And in that report, once again, you will find that the highest paid, the government, are on the lower end of the scale. Most of them are in the poor category that we referred to before, sir.

ASSEMBLYMAN GARRUBBO: What you are saying is, by pumping more money into nursing homes doesn't necessarily result in a better quality product.

MR. JONES: That's correct.

ASSEMBLYMAN GARRUBBO: There is a relationship, however, that we have learned in a negative sense, in that

with a fixed per diem in terms of a reimbursement formula, very often the inability to deal properly within that structure causes a loss of health care services. In your experience in your position with Medicaid, did you find that there was that problem?

MR. JONES: Well, if I understand you correctly, sir, there is a problem in reimbursement. The logic of the Medicaid reimbursement was to attract 75 to 80 percent of the available providers. It was not our intention ever to pay every facility, irrespective of cost. That is one of the reasons why that Cranford facility referred to this morning was not a Medicaid provider. We were not likely to pay $40. When the program was first started, there was a better distribution of Medicaid patients than there is now. At present, a home operating with the great majority of Medicaid patients, in my opinion, is in serious trouble financially.

ASSEMBLYMAN GARRUBBO: And, because of that, the only place to skimp is in the health care facilities provided if they are going to remain profit-making organizations?

MR. JONES: The Medicaid patient in the State of New Jersey is probably better protected than any other type patient, including Medicare. Mr. Reilly made reference this morning to the fact that our patients are seen by nursing, physician and other professional staffs. Our staff is in the home every day of the week. The services are prior authorized; they are controlled. So it would be very difficult for a facility to continually cut back on Medicaid services, very difficult, sir. As a result, I don't deny that perhaps they cut back in other areas, private or Medicare.

ASSEMBLYMAN GARRUBBO: We have found from the reports of the New York experience and the investigation of the Cost of Living Council Committee in New York,

Assemblyman Stein's committee, that much of the problem in curtailing health services resulted from the legal structure that was established for compensation. In other words, there was not sufficient room for adequate profit, thereby causing the profit-maker to find his profit elsewhere.

MR. JONES: Well, it is a very profound statement covering a lot of areas, Assemblyman. As you know, New York chose to go the route of reimbursing on the basis of reasonable cost, which meant they reimbursed nursing homes on the same basis as hospitals. And the New York situation did create administratively an opportunity for the people who wanted to go in and wheel and deal, particularly in the real estate, to do it.

As far as the profit is concerned, you know, what is a fair profit? If you build in 7, 8 or 10 percent, that's a fair profit. There are anomalies in reimbursement.

ASSEMBLYMAN GARRUBBO: I think, in order to get into it more fully, we would have to touch the SCI report, and I don't think that is our purpose today. I think I should abandon that line of questioning at this time because, without getting into the content of that report, many of my questions might not be set in the proper context.

You referred in your comments to the fact that you find a distinction in New Jersey with regard to the complaint of overtranquilization, over-medicating patients. What was the basis of that conclusion?

MR. JONES: The methodology is in my report. But the basis of that is that our staff, the nurses, went out, saw patients, interviewed patients, checked the charts for the prescriptions, came back with all that information and presented it to the medical staff who made a judgment as to whether or not the drug was in

accordance with the diagnosis and was within professional parameters of care. And this was an actual review of patients and records, sir.

ASSEMBLYMAN GARRUBBO: The HEW interim report was based upon a very similar type of approach and analysis, and it came to the conclusion that there was broad evidence of over-drugging. I concede that that is on a national investigative approach.

MR. JONES: Yes, sir. One of the problems you have when you talk about national pictures is that you tend to distort for better or for worse the picture in New Jersey. Our concern, quite frankly, is New Jersey. When Senator Moss did come out with some of these statements, we felt we had to take a look at it.

ASSEMBLYMAN GARRUBBO: Mr. Jones, are you saying that in New Jersey you have, after investigation, never found any evidence of over-drugging in any facility of any patient?

MR. JONES: We didn't say that, sir. We said we took a sampling of all the counties within the State, with the exception of two counties. We randomly sampled - I forget the number - about 1400 or 1500 patients. In the random sampling, it was not found. Obviously, no one can say that there aren't patients who are overtranquilized.

I can tell you - I have been Superintendent of Meadowview now for about two months - in my opinion in looking at the records there, we do have patients who are overtranquilized at Meadowview.

ASSEMBLYMAN GARRUBBO: Is that a non-profit institution?

MR. JONES: Yes, it is a county government facility.

ASSEMBLYMAN GARRUBBO: I hope you are one of the executives making more than the Governor of the State of New Jersey.

MR. JONES: No, sir, I am not, unfortunately.

ASSEMBLYMAN GARRUBBO: With regard to the handling of patients' money, I questioned Commissioner Klein earlier about her knowledge of the practice of some of the private nursing homes requiring the assignment or transfer of all of the assets of a patient as a condition for residence. Are you aware that that practice does exist?

MR. JONES: I think you may be talking about life contracts, which was the method that had really been used in past years whereby, if an individual had assets - stocks, bonds, bank accounts - he would turn over all his assets in return for this facility providing for him for the rest of his or her life.

ASSEMBLYMAN GARRUBBO: Does that practice exist at the present time?

MR. JONES: That practice has disappeared, quite frankly, with the advent of Medicare, etc. Since 1966, when Medicare came in and Medicaid also came in at the same time, but was the sleeping giant, the whole ball game for reimbursement to facilities changed. The bonanza was created in 1966 by the Medicare Act. So the need for lifetime contracts was greatly reduced. I don't think today in New Jersey or any other state, you will find any life-time contracts. If there are some, they are obviously very lucrative patients.

ASSEMBLYMAN GARRUBBO: I think there is no doubt about the fact that the charge of a private patient as opposed to a Medicaid patient is certainly higher; in the case of a private patient, the per diem charge is higher, is it not?

MR. JONES: In not all situations. That is another anomaly that we have to look out for. For example, in many county institutions where they have charged somebody $14 a day and the Medicaid rate for that place is $18 a day, and the Medicaid rule says that they would not pay more than a private-pay patient, in many instances the private-pay had to be brought up to $18 a day to meet the

cost. So it is a two-edged sword.

ASSEMBLYMAN GARRUBBO: Would you agree that that is probably the minority rather than the greater number? Let me put it differently. Wouldn't you agree ---

MR. JONES: Yes, sir, I would agree that in all medical facilities, whether it is a nursing home or a hospital, the private-pay patient, out-of-pocket payer, pays more than he should for the service he is receiving.

ASSEMBLYMAN GARRUBBO: So in the case of those hospitals or nursing homes, it would be to the advantage of the administration of those homes to have private patients rather than Medicaid patients, would it not?

MR. JONES: It would be to their advantage to have private patients over any type patient, whether it be Medicare or Medicaid, because Medicare is a very limited program, as you know.

ASSEMBLYMAN GARRUBBO: We are told out of approximately 25,000 residents of nursing homes in the State, approximately 16,000 or 17,000 are Medicaid patients.

MR. JONES: I listened with great interest to the statistics being given to you this morning.

ASSEMBLYMAN GARRUBBO: Do you agree with that?

MR. JONES: I don't agree with the numbers; no, sir.

ASSEMBLYMAN GARRUBBO: What is your estimate?

MR. JONES: My estimate is that in nursing homes outside of State institutions, there are some 14,000 Medicaid patients; the other 3,000 are in State institutions. There are approximately 23,000 long-term beds in the State of New Jersey; 17,700 are available to Medicaid - that is,in facilities that have agreed to participate in the Medicaid program.

ASSEMBLYMAN GARRUBBO: Seventeen thousand out of 23,000?

MR. JONES: Yes, sir. The balance of the beds are

for facilities that will not take Medicare nor Medicaid; they just want private patients. They have a very Cadillac type of service, if you will, and they will not get involved in some of these programs.

Some of the other facilities, I might point out to you, are facilities that don't meet the standards for Medicare and Medicaid, but do meet State standards and continue to service patients.

ASSEMBLYMAN GARRUBBO: Is it your testimony and your opinion that in the balance of those cases where there are private patients, the life-type contract is no longer employed?

MR. JONES: I can't answer the question one way or the other. My own feeling is that it would be a rather small percentage because you have to bear in mind, Assemblyman, what is happening; and, that is, with the Title 16 Program where we no longer require zero assets, where children aren't responsible to contribute anything to the cost, where you can own your own home and have $1500 cash and a car and still be eligible for Medicaid, we are going to go the route that California has gone, that the greatest majority, if not the totality, of patients in nursing homes are going to be Medicaid patients.

ASSEMBLYMAN GARRUBBO: Well, that is the case in New Jersey.

MR. JONES: It's the case in New Jersey and it's a result of the federal law that created this situation.

ASSEMBLYMAN GARRUBBO: But with regard to non-Medicaid patients, my question to you is: In the ordinary case of non-Medicaid patients, are these people resident pursuant to a contract of some kind, a written contract?

MR. JONES: Are you talking about the life contracts?

ASSEMBLYMAN GARRUBBO: Any kind of written contract.

MR. JONES: Between the individual and the

facility, I would suspect that there might be some life contracts. I personally no of none.

ASSEMBLYMAN GARRUBBO: How about non-life written contracts for private patients?

MR. JONES: Every time you go into a medical facility, a hospital or what have you - you know you see the cartoons on television - you sign a contract that you are going to pay.

ASSEMBLYMAN GARRUBBO: You don't employ them in your institution, do you?

MR. JONES: No, sir.

ASSEMBLYMAN GARRUBBO: Have you ever seen any of these written contracts that institutions require patients to sign?

MR. JONES: I have seen some, yes, sir.

ASSEMBLYMAN GARRUBBO: And do these contracts provide a standard or measure of care that the patient will receive?

MR. JONES: Not usually. What you will find, for example, if you were a Medicare patient going into a home today, is that the practice generally is to say that you have to put up a deposit because "we don't know how much Medicare will pay." And some of them also have an agreement that says when Medicare runs out, you must pay privately. To my knowledge,there is nothing in that contract that describes the services you are going to receive in detail.

ASSEMBLYMAN GARRUBBO: In connection with that type of contract, I assume that a per diem rate is specified and the obligations of the resident are detailed.

MR. JONES: Yes, sir. You know, it is commonly not recognized, but it is a fact, that all medical facilities are competitive business facilities, whether you are in a general hospital or in a nursing home. So the answer, quite frankly, is yes. Everyone does sit down

and say, "Put up the money." I don't know if I am being responsive to your question.

ASSEMBLYMAN GARRUBBO: Let me put it to you this way: Is it possible for you to supply to this Commission copies of any contracts utilized by nursing homes with private patients?

MR. JONES: I personally don't have any available to me, Assemblyman.

ASSEMBLYMAN GARRUBBO: I think this Commission would like to examine some of those contracts.

MR. JONES: I would think that they could be made available to you. I would think in the Medicaid Division, they can get copies of their contracts and I think they could also provide you with the contracts between Medicaid and the facilities.

ASSEMBLYMAN GARRUBBO: I would like to get to the question finally of announcements of inspections. I have proposed some legislation that would require unannounced inspections. As a result of research, I have been advised, and Dr. Finley confirmed, that at least one annual inspection by reason of federal regulation must be an announced inspection. You seem to dispute the need for that announced inspection.

MR. JONES: I do for several reasons. First, if you look at the language and the philosophy at the congressional committee meetings as to their intent, their intent was not to say you had to announce, but primarily to say, if you were going to announce, you don't give them too much time.

Secondly, in the Medicare regulations, which is the basis upon which the decision was given to you, sir, there is another clause in there that says,"wherever the State imposes higher standards, then the Medicare and Medicaid programs must go along." So, if you were to enact a law that provides for unannounced visits, I think you would

prevail, sir.

ASSEMBLYMAN GARRUBBO: Well, I would be pleased if your evaluation of the law were the accurate one, because the concept of required announced inspection makes no sense to me.

MR. JONES: I can tell you, sir, that in the Medicaid program, we did not announce, we went in, and we had providers who took us into hearings and, I believe, into the Appellate Court where our position was upheld.

ASSEMBLYMAN GARRUBBO: One final point, you were present during the testimony of Mrs. Mendelson when she related the corporate intricacies and non-arms' length dealing of different business enterprises of ownership and operation and drug supply, etc.

MR. JONES:L Yes, sir.

ASSEMBLYMAN GARRUBBO: During your administration as Director of Medicaid Medical Assistance, did you find any such circumstances in New Jersey?

MR. JONES: We found circumstances that caused us serious concern, Assemblyman.

ASSEMBLYMAN GARRUBBO: Such as?

MR. JONES: Well, the question of financing homes, we heard someone mention this morning - I believe, Mrs. Mendelson mentioned - that FHA would not talk to her, etc. I want to point out that I think Mrs. Mendelson was talking about prior to Medicaid in New Jersey. Some of the financing ---

ASSEMBLYMAN GARRUBBO: She had a single experience and that was in 1970. She did not indicate that that was a continuing practice of State agencies.

MR. JONES: Yes. But Medicaid became effective January 1, 1970, and the organization she was referring to, I believe, was the Bureau of Community Institutions, which got massaged out of I and A by the Certificate of Need legislation and transferred to Health.

I think her point on the ownership is a very valid one. I, personally, have spoken on many occasions to the licensing people, stating, "You license people and nobody knows with whom we are dealing." And we had problems in Medicaid because of licensing and not knowing with whom we were dealing. We find more and more in the State of New Jersey, in my opinion, the practice of medicine is being taken over by lay corporations where a lay corporation will establish either a nursing home or some other kind of a facility or a community health project. And it is a lay corporation who contracts in a non-profit way with other people that provide services.

I, personally -- and I can tell you the agency has referred this question for legal interpretation to the AG's office because the very phenomenon you are talking about in my opinion is occurring. The Medicaid rules say, as you understand I am sure, that in order for Medicaid to contract with a provider, they have to be licensed by the licensing authority in the state. Medicaid in this jurisdiction and in no other jurisdiction has been involved in investigating the people with whom they work. That is a function of the licensing authority. It is an area, as I said before, that demands serious review.

ASSEMBLYMAN GARRUBBO: You heard there was an instance or two in Mrs. Mendelson's experience - and certainly we read in the Stein reports that there were many instances in New York where there were inflated leases and there were non-operated ownerships, but yet related through business entities. Do you think that the under-handed dealing in that fashion, if I can term it such, has had an effect in New Jersey upon the cost of operation and the quality of care sufficiently to warrant legislative action to compel disclosure, for example?

MR. JONES: From my personal experience, Assemblyman, there are situations where the very example is pointed out

in investigation. I don't know if the answer is in disclosure as to with whom you do business on every business transaction. I would suspect that the way to handle that kind of a situation may be a review by area of the component costs. For example, in the study I referred to before, there was a breakdown of costs - meals - and if you see a facility that is spending $4.25 a day on meals compared to an average of $1.55 or $1.85, you know that facility is not properly handling their operation.

I really haven't given much thought as to whether or not legislation would be recommended in that area. I think there might be administrative controls that would be more effective.

ASSEMBLYMAN GARRUBBO: Well, the suggestion has been made to us by witnesses this morning that better control over disclosure might have a direct effect upon reducing the incidences of such intricate corporate relationships.

MR. JONES: The only concern I would have is if you directed that legislation to one industry or one component of the health delivery field. For example, in other medical institutions, members of the board are the people who sell the insurance to the institution - the hospitals, for example. I think you would have to give serious thought as to just how far your legislation would go. If it were directed just to nursing homes, I think there would be a built-in inequity there.

ASSEMBLYMAN GARRUBBO: I guess we have to deal with one problem at a time.

I did forget to ask you one thing on the contracts. Despite the fact that there is no expressed statement in the contract that a nursing home signs with a patient relative to the standard of care he is going to receive, you would agree, I suppose, that inherent or implied in

those contracts is that the patient will receive reasonable care and certainly a reasonably habitable environment.

MR. JONES: I would say, sir, irrespective of any contract, their license demands that they meet the standard of care. It is inherent in any agreement ---

ASSEMBLYMAN GARRUBBO: What standard of care? reasonable?

MR. JONES: Reasonable - to meet the standards that are dictated by the State for your license, as a very minimum.

ASSEMBLYMAN GARRUBBO: There are also regulations dictated by Medicare and Medicaid specifying what constitutes reasonable care and habitable environment, aren't there?

MR. JONES: Yes, sir. I tried to point out before, sir, in licensing - I don't know if they have changed it recently - but it was that if a facility did not want to participate in Medicare and Medicaid, they had to meet the State fire safety codes, but they didn't have to meet the standards for Medicare and Medicaid; and, therefore, theoretically, it was possible for a private patient in that home to receive less care than a Medicaid patient because they didn't have to meet the standards.

ASSEMBLYMAN GARRUBBO: I don't know whether it is too simplistic to ask the question, but I think it is important to establish that inherent in the operation or in the license of such an institution, inherent in the contract and implied by their relationship is this warrant or warranty, if you will, that the facility will provide reasonable care and a habitable environment.

MR. JONES: I agree with you and that is why I recommended consideration of legislation that would give a right to sue on a malpractice basis if they did not provide that.

ASSEMBLYMAN GARRUBBO: Maybe the Legislature has already given that to the Public Advocate. I don't know.

MR. JONES: I can't answer that.

ASSEMBLYMAN GARRUBBO: Thank you.

SENATOR FAY: Mr. Jones, as to your statement on the profit versus non-profit facilities, do you feel that we should not try to encourage more non-profit facilities. From what I know of the Middlesex County operation first-hand, and the few nurses I have met with, who work in the Essex County operation - they seem to be highly-rated, highly-respected operations.

MR. JONES: Well, the problem I have, Senator, is, looking at the field of medicine today, I would question where there is not profit. The physician is for profit. The salaries are profit. I would not just accept a blanket recommendation that "for profit" facilities should not be supported and non-profit should.

I repeat what I said before, government institutions are non-profit and, in testing, they are not as effective and they are certainly higher costing. I think "for profit" organizations have a place in the medical society. But I do think that controls over the income and the public monies should be expanded.

SENATOR FAY: You mentioned in the profit area that the nursing homes in our State were making between 7 and 10 percent profit.

MR. JONES: It depends upon the mix of the patients, Senator. That is why I say you have to be careful. If you are talking about a home - for example, the home that was mentioned by our friend the authoress, Mrs. Mendelson, up in Cranford -- that was a non-profit home, charging, I believe, in the neighborhood of $45 or $48 a day. One of the principals was a man she testified had been high up in HEW. He was on their Advisory Committee. He was in charge of education in nursing homes. There had been a book published by him and other co-authors. In fact, I remember in 1969 going to Washington and taking a course by this gentleman. And it

turned out that he had a PhD that he got from a mail order house in England and everybody went away with egg on his face. Fortunately, this was before Medicare started to my recollection.

The point I am trying to make is that organization was taken over by a "for profit" organization. They only have five Medicaid patients in that facility. That is all they will take - five - because they can't provide the high quality of services, they allege, on Medicaid reimbursement. So that facility with 5 out of 125 patients has a different financial and profit picture than a home that is primarily all Medicaid. The home that is all Medicaid, in my opinion and on the advice of staff in many studies, is in serious financial trouble. The minute a home becomes majority Medicaid, they are in trouble.

SENATOR FAY: Did you have the same problem as Mr. Reilly in arriving at just how much profit was being made by each home in the audit year? When you say they were in financial difficulty, were there any declaring bankruptcy?

MR. JONES: Yes, sir. There were serious problems in homes that were primarily Medicaid.

SENATOR FAY: You say from your experience that the average profit level of a home in New Jersey is 7 to 10 percent?

MR. JONES: In my opinion, Senator, if you were a good, efficient administrator and you ran a home that was 100 percent Medicaid, you could make about 7 percent profit.

SENATOR FAY: And if it were half private?

MR. JONES: If it were half private, 10, 12 percent or more.

SENATOR FAY: So you would figure the maximum profit for a home in this area wouldn't be more than 12 percent?

MR. JONES: I can only give you a gut reaction. I would think the maximum would be about 15 or 16 percent.

I might point out to you, Senator, that the Medicaid program has tons of information: the cost findings on every facility; the audits on every facility; where it is Medicare-Medicaid, you have the Medicaid audits on those facilities. Those figures are available to you or should be available to you.

SENATOR FAY: We had difficulty arriving at cost and arriving at profit figures in our first meeting.

In the study that was made, you found 56 percent of the homes in the State "good" or "excellent," and 30 percent "average," and 13 percent were "poor." Would you say that most of the deficiencies were in the nursing services category in the ranking, compared to what?

MR. JONES: In the ranking, the most glaring was the lack of nursing staff.

SENATOR FAY: Lack of nursing staff?

MR. JONES: Yes. The number of staff to meet the standards.

SENATOR FAY: How would you recommend this be corrected, by a change in the ratio?

MR. JONES: Well, here again, Senator, the regulations and standards are quite clear. The law says you must have a certain number to provide a service. So, if you don't have the number of staff, you are breaking the law, you are breaking your license contract and everything else.

SENATOR FAY: But there are some who are meeting the minimum standards, but still are being rated after inspections as poor? They aren't breaking the law, but they are falling into a poor category?

MR. JONES: Number one, when it comes to personnel, it is quite clear, as I said before, how many people

you need per level of care. For skilled nursing care in the State of New Jersey today, the regulations require 2.75 hours of nursing staff care per day per patient.

SENATOR FAY: Is that adequate?

MR. JONES: It is -- well, once again that depends. If you ran a nursing home of 50 beds for 50 quadriplegics, obviously 2.75 is not adequate. But with the mixture of patients and the level of care requirements, it is the accepted figure as being adequate.

I might add that Medicare doesn't even require that. Medicare doesn't have any numbers on it. One of the reasons New Jersey, I think, is out in front is that we do specify how many people you need to service the patients.

SENATOR FAY: Mr. Jones, this is a comprehensive report, particularly your recommendations. When we start wading through this bureaucratic maze with which we are confronted, I would hope to see many of these immediately enacted by the departments concerned. Some legislation has already been drafted. I believe that many of your recommendations fall right in line with what we are looking for.

MR. JONES: I hope so, Senator.

SENATOR FAY: Thank you very much.

SENATOR DUMONT: Mr. Jones, you worked in the Department of Institutions and Agencies for several years. What is your estimate of the number of nursing homes in New Jersey?

MR. JONES: There are approximately 320 facilities, of which about 214 participate in Medicare and Medicaid. The total bed capacity is around 23,000; and, as I said before, 17,700 are available to Medicaid.

SENATOR DUMONT: Of the 320, how many are proprietary and how many are non-profit?

MR. JONES: I don't have those figures in my head. But I am surprised that this information isn't

available because there is a booklet put out listing the facilities by type of ownership. My recollection is that the voluntary non-profits probably number around 90.

SENATOR DUMONT: Ninety?

MR. JONES: Ninety. And there are probably 50 or 55 that participate in Medicaid.

SENATOR DUMONT: I don't know whether you were here this morning when the two Commissioners testified, but their figures did not agree. I just wanted to get an estimate from you. Your figure doesn't agree with either of theirs.

MR. JONES: One way to find out, sir, would be to get a listing of facilities that are broken down by category and the polemic would be resolved.

SENATOR DUMONT: Thank you.

ASSEMBLYMAN GARRUBBO: Mr. Chairman, I have some figures compiled by Legislative Services Agency which indicate that the licensed capacity of nursing homes in New Jersey is 216.

MR. JONES: The licensed capacity?

ASSEMBLYMAN GARRUBBO: The total nursing homes in the State of New Jersey at the time of this report, which was April of '75, was 216. That does not include boarding homes, by the way.

MR. JONES: I don't know what document you are referring to. As I say, the easiest way to resolve it is to take the licensed facilities, sort it by government, voluntary, non-profit and proprietary. And there is a document within the State of New Jersey, sir, that does list that.

SENATOR FAY: We have all four of them. This is the fourth figure we have received today.

MR. JONES: Well, the figures you got this morning - I think most people in this room would agree they left quite a few people out.

SENATOR FAY: Okay. Thank you.

Mr. James Cunningham, Executive Director of the New Jersey Association of Health Care Facilities.

MR. LEONARD COYLE: Mr. Chairman, for the record, my name is Leonard Coyle. I appear today as counsel for the Association. Mr. Cunningham is the Executive Director. He is to my left. He will give a statement and deliver direct testimony by way of a statement to the Commission.

With your permission, I will ask Mr. Cunningham to proceed.

J A M E S E. C U N N I N G H A M:

My name is James E. Cunningham and I am executive director of the New Jersey Association of Health Care Facilities, formerly known as the New Jersey Nursing Home Association. We represent some 170 long-term care facilities, with approximately 15,000 beds, all of which provide nursing care under the direction of licensed professional personnel 24 hours a day, 7 days a week. Although our members include non-profit and governmental, as well as proprietary--privately owned--facilities, largely. our members fall in the latter category.

I appear with very mixed feelings. We welcome this opportunity at this meeting and, perhaps, at subsequent sessions to review in detail what we consider to be the most advanced and best regulated system of long-term care of any state in this nation.

On the other hand, although the resolution creating this committee was a legislative perennial, having been introduced for five years with little or no effort ever made to move it, our Association--through its legislative representative--suddenly found itself accused of blocking the investigation. Our only action over those five years was to request that the wording of the preamble be changed so as not to begin with an indictment, but with an objective inquiry. Indeed, the wording was so changed this year without "watering down" your mandate.

Last year, nursing homes had become perhaps the most fruitful source of media notice in the nation A New York legislative commission, after casting about in a number of areas, tapped a rich lode of publicity--some of it, perhaps, justified--in alleged deficiencies of nursing homes in the nation's largest city and center of communications.

Where there was smoke and, perhaps, fire in New York, certainly there must be at least some smoke in neighboring New Jersey, appeared to be the reasoning.

New Jersey nursing homes--as a class--became the target of a barrage of abuse.

Our members--all of them--and their employees, among other things, have been accused as perpetrators of "obscenities" and "inhumanities." The families of our patients meanwhile must live with the guilt of having placed their loved ones with such monsters as we are alleged to be on the basis of headlines, not evidence.

I am sure that the members of this committee will understand our feelings when I compare it to the familiar, unjustified and super-cynical statement that "all politicians are crooks."

You must live with your children and we must live with ours. We had thought that such statements had gone out of style with a former United States Senator from Wisconsin.

Now let us examine the facts.

Even before the Medicare and Medicaid programs provided the impetus for the tremendous expansion of long-term care in New Jersey and in the nation in the last ten years, our State had the highest requirements of any for nursing care. And New Jersey--originally in the Department of Institutions & Agencies and now in the Department of Health--has enforced those requirements.

Indeed, it is nursing care that is the foundation of a long-term health facility. Bricks and mortar are important. Geography is helpful. But nursing care--in its professional and human aspects--is the fundamental criterion on which the judgment of a nursing home must be made.

The requirements for nursing care are established at three levels--Skilled Nursing Facilities (SNF), and Intermediate Care (ICF-A and -B). There are mandated ratios of registered nurses, licensed practical nurses and nurses' aides. All of this personnel must provide nursing care. This cannot and does not include dietary service, maintenance or any of the other chores performed by others on the nursing home staff. All patients must be admitted with the approval of a physician, must remain under a doctor's care and no drug can be administered except as directed by the physician.

Generally, such care is provided over a long term, largely to the elderly who cannot be maintained in their own or in relatives' homes and whose ailments or debilities are not of the kind best handled in hospitals which are designed to treat acute illness.

While many patients need only a minimal amount of professional nursing care and thus can be serviced at the ICF-B level, can be involved in recreational, vocational and other therapy, many others--indeed, a majority of cases--are much less pleasant. The stroke victim or amputee who must be lifted from bed to wheelchair, the bedridden terminal cancer case, the aged victimized by the various manifestations of senility and so many others for whom the nursing home is the only answer.

Certainly, reality does not always reflect euphemisms such as "golden years" or "senior citizens."

But New Jersey's nursing homes do meet these problems and meet them well. They provide the services at fair cost, to the taxpayer under Medicare and Medicaid, to the families of the private patient and to that small minority who do have some protection under other insurance programs.

Nursing home care is provided at an average daily cost ranging downward from one-fourth of current hospital rates. It also should be noted that the State does not establish nursing personnel requirements for hospitals comparable to those in our facilities.

As I noted, governmental programs have provided the major impetus for the expansion of long-term care. The largest such program is, of course, Medicaid. At present, there are 16,172 Medicaid patients in long-term care facilities in New Jersey, verified from department figures only yesterday. They occupy 59% of the 27,173 licensed beds. Of the licensed beds, 21,325 are in proprietary facilities with various levels of care; 3,094 in governmental (county) units, and 2,754 in non-profit facilities. These figures were verified also with the Department of Health records only yesterday. There are 98 non-profit governmental facilities in New Jersey, not 10, as was originally alluded to this morning.

In many sections of the State, there is a severe shortage of available Medicaid beds. This situation can be traced to financial limits instituted by the Division of Medical Assistance & Health Services. Chief among these controls are "administrative ceilings," which limit reimbursement to long-term care providers. No such limits are applied to hospitals. Nursing homes which are able to operate below those ceilings are reimbursed in general relation to costs.

Because of the ceilings, however, Medicaid beds are increasingly limited to older, lower-cost facilities. A newer nursing home, because of the tremendous rise in construction costs in recent years, cannot render service at even the highest Medicaid rate without sustaining severe financial losses. Consequently, the newer facilities must seek patients who have private means. This denies the

original promise of Medicaid in 1965 that the poor shall have access to the same health care as the rich.

It should be noted that the federally financed Medicare program--which is designed for much shorter terms of care and for a more sharply defined category of patient--pays audited cost without the ceiling. Medicare patients occupy some 10% of the long-term care beds.

Through maximum Medicaid allowances on rentals, through the "certificate of need" power of the Commissioner of Health over ownership transfers and through a variety of other devides, including a financial feasibility study, New Jersey agencies have an arsenal of weapons to protect the taxpayer against financial abuse.

Earlier this month, the operation of the Medicaid program in nursing homes was considered in an interim report issued by the State Commission of Investigation. Naturally, that report received wide publicity, particularly its claim of "savings" of $1 million a year by changing the "imputed rental" concept dealing with reimbursement for value of real estate. What did not receive much publicity was the fact that this $1 million was less than 1% of total Medicaid expenditures. Even this figure was rendered meaningless by an almost unbelievable arithmetical omission.

Consequently, we called for a discussion of the SCI report at today's hearing. While the SCI denied its mistake, we suggest that you check the figures with Medicaid.

Presumably, the SCI report was intended to serve as one of the bases of your inquiry. If its mathematics are meaningless, all of the current investigations of nursing homes in New Jersey could be seriously misdirected.

But there are other and perhaps more relevant reports regarding both the operation of nursing homes in the Medicaid program and the Medicaid Program itself.

At this time I want to raise the question as to whether this commission has obtained a copy of what we understand is a definitive report of abuses within the Medicaid program that was prepared by former Director William J. Jones and submitted to higher authorities, including--we understand--the Office of the Governor. Some reference has been made to the existence of this "secret" report by a major New Jersey newspaper. We would hope that the Jones report--if it is not already in the possession of this committee--could be obtained by you and be made available to us and to the public.

It is our further understanding that it covers a wide variety of abuse, and it was that study that impelled Governor Byrne to order the SCI to undertake its review of Medicaid. We are most interested in the relationship of alleged abuse in the area of nursing home services in comparison with the services of other providers under the $442 million Medicaid program. We think the context of charges involving our nursing homes should be established--not on the basis of headlines out of New York City--but on the basis of existing facts in New Jersey.

The other report is the only detailed study of which we know concerning the operation of the nursing homes under Medicaid. Developed by the Division of Medical Assistance and Health Services, it covered New Jersey's first three years of Medicaid, from January 1, 1970 to December 31, 1972. It bears a date of May, 1973.

And it has received little, if any, publicity. Perhaps this is due to the fact that it provided no sensational "exposes."

Not only did this report examine costs, but it looked at the quality of care. It found that the cost of service was substantially higher in governmental facilities than in proprietary and non-profit nursing homes. In one of the three years, the daily rates in non-profit facilities were slightly lower than those in proprietary homes. In the other two years proprietary homes had the lowest costs.

This is in the face of the fact that only proprietary homes are required to pay taxes to the various levels of government.

One might say that this indicates cheaper and, therefore, poorer care in the proprietary facilities. But this was not the finding of the Medicaid study, which concluded (page 19):

> "Apparently, the higher cost is attributable to the inefficiency of governmental institutions. The higher cost, which is largely due to the higher number of employees per patient day, has not resulted in a higher level of care. Health Department inspection reports indicate that generally these facilities render a quality of care that is comparable to their non-governmental counterparts."

The Medicaid study--covering an extraordinarily large sample of 98 nursing homes--was the most comprehensive review in this State of which we know. It utilized 18 criteria:

1. Compliance with State and local laws
2. Administrative management
3. Patient-care policies
4. Physician services
5. Nursing services
6. Dietary services
7. Restorative services
8. Pharmaceutical services
9. Diagnostic services
10. Dental services
11. Social services
12. Patient activities
13. Clinical records
14. Transfer agreement
15. Physical environment
16. Housekeeping services
17. Disaster plan
18. Utilization review

The conclusion of that study was: "The outcome of this evaluation... was generally very favorable. The overall merit rating (performance index) was 91.1%."

On the basis of its point system, 98% was considered excellent, 91.1 to 98% was considered good, 84.2% to 91.1 was average, and less than 84.2% was poor. Of the total, 16.3% were in the excellent category, 39.8% good, 30.6 average, and 13.3% poor.

We do not know of any similar study for the years 1973 and 1974, but it is our belief that the quality of care in those years has continued to improve. Perhaps this Commission will make a definitive determination.

As indicated earlier, financial considerations must play an important part in any study of nursing home care. And this applies whether the facility is private, non-profit or governmental. Salaries must be paid, food must be purchased, and--in the case of proprietary facilities--tax bills must be met.

Thus, we were dismayed to learn that a recommendation by the Department of Institutions and Agencies for a 9.8% rate increase in the 1975-76 Medicaid budget has been reduced to 5%. That increase, only partially designed to meet inflation-caused rises in operating costs, already was inadequate. Almost halving it works directly contrary to the professed concern of this committee and governmental officials at all levels for the welfare of the elderly Medicaid patients entrusted to nursing homes. More and more nursing homes will be forced to reduce or eliminate Medicaid beds and turn to private patients or to cut corners and create the conditions all of us are determined to avoid.

Inadequate reimbursement, while already cancelling out the most modern physical plants, now threatens participation of the older facility. Generally, these are smaller nursing homes and many patients, private as well as those under governmental programs, find them preferable because of the personalized nature of their care in an environment that necessarily is more homelike. No nursing home--whether it be proprietary or non-profit--can remain in operation if expenditures

exceed revenues. And the extent of charitable subsidies for non-profit facilities is very limited in these days of economic recession.

These older facilities, however, often are threatened by arbitrary interpretations of safety codes. For example, a fine nursing home in Summit last year invested $40,000 in a sprinkler system and other improvements, obtained State approval and--after all this--this was eliminated from the Medicaid Program, and from business, by a Federal ruling.

Long-term care is a real financial burden for most families of average means. Hence, a few years ago the Blue Cross law was liberalized, ostensibly to permit that program to write long-term care into its programs. Unfortunately, Blue Cross has not seen fit to follow through on any meaningful scale.

Not only our Association, but authorities on health economics in general, feel that significant economies could be realized in Blue Cross if more people could be transferred from expensive hospitals to long-term care facilities that are better provided with specialized nursing service.

Not only should such service be utilized for the elderly but, it has been demonstrated, nursing homes could be a beneficial and economical resource for many younger classifications of patients--convalescents, orthopedic patients requiring extensive nursing attention, the chronically disabled and others.

Some of our members have pioneered in this area of service to younger patients. Others are waiting for the necessary insurance--private, governmental or both--programs to facilitate this use of available nursing expertise. We hope that your committee will take a long hard look at the tremendous potential available for the development of long-term care facilities in these areas.

In your investigation, you will find another interesting fact. There is a substantial number -- we don't know the total, but I think Mr. Jones gave it to you earlier -- of New York Medicaid patients who have been placed in New Jersey nursing homes because they can obtain better care here at lower cost. Yet, we are being visited with the sins of the allegedly high costs in New York. This does not seem fair.

Much has been written and much has been said about full disclosure. Present law requires comprehensive information on the operators of nursing homes. We support expansion of this concept to cover the ownership of nursing home real estate.

Anyone who thinks, however, that this information can be used to prevent out-of-staters from doing business in New Jersey had better take another look at the U. S. Constitution.

And while your commission is looking into nursing home reforms, won't you please take a good hard look at what is our principal operating problem today--our inability to persuade physicians to tend to our patients. Not only is it extremely difficult throughout the State to obtain a doctor for the required regular examination of each nursing home patient, even though that patient may be his charge, but it is most difficult to persuade the doctor to make the personal review of the patient and then to countersign prescriptions he has made over the telephone.

The Division of Medical Assistance and Health Services has presented federal authorities with a program designed to improve the financial incentive to physicians for nursing home service. This is the program Mr. Jones referred to in his statement. The nursing homes would act as the go-between with a modest allowance only for administration.

We're willing to cooperate but, despite the assistance of Senator Harrison A. Williams from his important post as Chairman of the Labor and Public Welfare Committee, much bureaucratic red tape yet remains to be cut in Washington.

We, of course, have not covered the whole range of your interests but - despite the reservations expressed earlier - we look forward to working in a constructive manner with your Commission, whose work product could have such a beneficial impact on many of our least fortunate citizens.

Thank you, and we are open to any questions you might want to ask.

SENATOR DUMONT: Mr. Cunningham, what is your estimate of the number of nursing homes in New Jersey?

MR. CUNNINGHAM: I can give you the actual number that we got from the actual lists right from the Department of Health and from the actual number received from Medicaid of the patients. You will find that there are 318 such animals in the State; 212 plus 18 when you add people who are strictly in intermediate care in the proprietary section. No,10 of those are non-profit, as Commissioner Finley alluded to. Then there are 74 on a list called "non-profit homes for the aging," which includes nursing units. There are 14 governmental units. So in the State you have 98 governmental or voluntary, non-profit facilities, and you would have 220 proprietary facilities.

I think the problem this morning was that they were dealing with only one of three lists. There is a list called, "licensed nursing homes in New Jersey," which includes 10 non-profits and 202 proprietaries. There is a list called, "non-profit homes for the aging" - they have nursing units - which are nursing homes. There is a list called, "governmental facilities," which contains 14. There is a list that contains 18 facilities that are strictly intermediate-care facilities and not a mixed

facility like you find on the licensed nursing home facility list. You have to deal with all of those lists.

SENATOR DUMONT: In a release that you put out yesterday you take issue with this imputed rental concept, or may be it is the way it is set forth rather than the concept itself. I take it then that you don't agree with what Mr. Jones said in his statement, that "it appears that all agree that the imputed rental was desirous for the purpose of keeping the smaller homes in the Medicaid programs." Do you agree with that or don't you?

MR. CUNNINGHAM: Only in part. What it basically was designed to do was pay a fair value over property to somebody who was fortunate enough to care for the people in this state who are up in the years who have their mortgage paid. It was designed for that, and I think that was basically the reason that Medicaid adopted it and also hopefully as a guard against sale and lease problems that you see developed in New York, to protect against just that happening in New Jersey.

SENATOR DUMONT: And you disagree in that release very materially with the so-called savings. The SCI points out, "as contrasted with the actual savings which you indicate for five different nursing homes." Is that correct?

MR. CUNNINGHAM: Yes, we do. In our statement, we say that those figures ought to be available for Medicaid.

SENATOR DUMONT: This report you talk about on page six, in the second half of that page, you say it was developed by the Division of Medical Assistance and Health Services. Was this a report that Mr. Jones put out while he was the Director of that Division?

MR. CUNNINGHAM: Yes. The one that I spoke about ---

SENATOR DUMONT: You mentioned one earlier; is that correct?

MR. CUNNINGHAM: Yes. We have no knowledge of that, and we have not been able to see that.

SENATOR DUMONT: But you understand that was also prepared by him?

MR. CUNNINGHAM: Right. The other report we do have.

SENATOR DUMONT: So if you are right, there were then two reports prepared by him; is that correct?

MR. CUNNINGHAM: Right.

SENATOR DUMONT: Thank you.

ASSEMBLYMAN GARRUBBO: Mr. Cunningham, you have indicated that the nursing home operations have in recent times had substantial economic problems; am I correct? Was that the substance of your comments?

MR. CUNNINGHAM: The newer type of facility -- what I indicated was that it would be impossible for them to participate in any great degree in Medicare or Medicaid without suffering severe financial difficulties, yes.

ASSEMBLYMAN GARRUBBO: I saw as an alternative on page eight of your report, "or in the alternative cut corners." That is what you said; am I correct?

MR. CUNNINGHAM: Right.

ASSEMBLYMAN GARRUBBO: And I suppose that gets back to the point that receiving a certain amount of money will mean either you lose money or find a way of running profitably at the expense of quality care. Do I interpret "cut corners" correctly?

MR. COYLE: Mr. Garrubbo, may I take objection to your question? I think it leads you to a conclusion that cutting corners necessarily means a diminution in the nature of care that is given. I think what the witness has stated in his statement was that if there is insufficient financial income to the facility to meet their cost, then, of course, the facility would have to go to various areas to reduce its costs. It may ultimately have an impact somewhere in the area of patient care, but not necessarily so.

MR. CUNNINGHAM: And possibly a bankruptcy.

ASSEMBLYMAN GARRUBBO: Have there been any bankruptcies of nursing homes in recent times?

MR. CUNNINGHAM: Yes.

ASSEMBLYMAN GARRUBBO: Where and when?

MR. CUNNINGHAM: In my early times with the Association I never saw bankruptcies.

ASSEMBLYMAN GARRUBBO: When was that?

MR. CUNNINGHAM: About eight years ago. I have seen some areas of bankruptcy since.

ASSEMBLYMAN GARRUBBO: Well, how many have you seen in your eight years with the Association?

MR. CUNNINGHAM: Well, I would say the ones I know of personally, about five or six.

ASSEMBLYMAN GARRUBBO: Out of how many nursing home operations?

MR. CUNNINGHAM: Are we talking about the total number now, or are we dealing with only the one list?

ASSEMBLYMAN GARRUBBO: No, I would like to deal with the total number that you know of.

MR. CUNNINGHAM: The total number that I know of would be -- it wasn't 318 at that time. In my early days, you would be lucky if it was half that amount.

ASSEMBLYMAN GARRUBBO: Well, I am not only talking about member facilities, I am talking about the total number of facilities that operated in the State in the eight years that you have been associated with this business. From your calculations you know of five to eight bankruptcies; is that correct?

MR. CUNNINGHAM: I would say five or six, somewhere in that range.

ASSEMBLYMAN GARRUBBO: Can you identify them?

MR. CUNNINGHAM: If I can remember them all. You have Arnold Walter Nursing Home in Monmouth County; there is one in Tenafly in Bergen County. Without sitting down and figuring it out, I don't recall the others.

MR. COYLE: Mr. Garrubbo, I think we can supply that information to your Commission at a later date. We can check our records.

ASSEMBLYMAN GARRUBBO: Fine. The point of my question is that you suggested that these bankruptcies are occurring in newer facilities, and I just don't think that is a fact. The fact of the matter is that the facilities that may have gone bankrupt in the last eight to ten years in New Jersey probably preceded the Medicaid Program; isn't that a fact?

MR. CUNNINGHAM: No.

ASSEMBLYMAN GARRUBBO: All right, you will supply those dates and places to us; is that right.

MR. COYLE: We will supply the information to you on facilities that we have knowledge of that did go into bankruptcy proceedings. I might add, Mr. Garrubbo, that there were, I believe, other facilities that closed involuntarily without going through a bankruptcy proceeding, but they did close.

ASSEMBLYMAN GARRUBBO: I am concerned with those operations that ceased by reason of bankruptcy.

MR. COYLE: You are referring to a Chapter 11 proceeding, bankruptcy ---

ASSEMBLYMAN GARRUBBO: I'm referring to whatever Mr. Cunningham referred to when he said that they went out of business pursuant to bankruptcy.

MR. CUNNINGHAM: Some of them are still in operation under referees.

ASSEMPLYMAN GARRUBBO: Fine. Now, I'd like to ask you about those homes that deal with private patients as well as Medicaid patients. With regard to private patients, I asked Mr. Jones, and I would like to ask you about the business of contracting for residence. Do the members of your association employ a written contract with private residents for their care?

MR. CUNNINGHAM: Yes, and we can supply samples of those to the Committee. If you are talking about an admissions agreement and not a lifetime contract like some of the discussions centered around earlier, our people have never been involved in that kind of contractual arrangement. You will usually find that in a religiously oriented facility, where someone will turn over their assets with the agreement that the facility will take care of them for the rest of their life.

ASSEMBLYMAN GARRUBBO: How many types of contracts are employed by your organization members?

MR. CUNNINGHAM: I couldn't say. Many of the contracts are in printed form.

ASSEMBLYMAN GARRUBBO: When you say printed form, you mean each house or each facility has its own contract?

MR. CUNNINGHAM: Right.

ASSEMBLYMAN GARRUBBO: Does your association propose a form contract?

MR. CUNNINGHAM: No.

ASSEMBLYMAN GARRUBBO: Has it ever?

MR. CUNNINGHAM: Not to my knowledge, in my time.

ASSEMBLYMAN GARRUBBO: Does any member of your association utilize a lifetime contract?

MR. CUNNINGHAM: I would say no. I have never run into that in my time. I had heard of it somewhat, as I said, in the non-profit, religious type of sector. My latest information on that was that it was pretty much being done away with.

ASSEMBLYMAN GARRUBBO: You mean even in that sector?

MR. CUNNINGHAM: Right.

ASSEMBLYMAN GARRUBBO: But your testimony is that it is not used in your association members' practices?

MR. CUNNINGHAM: No, and I don't know that it ever would have been.

MR. COYLE: Mr. Garrubbo, in further reply to your

question, during the eighteen years in which I have personal knowledge, I believe I have come across two situations during that period of time involving life care contracts, and they were both executed some prior years before, and they were still enforced. The patient's assets were depleted, and an issue came up as to what could be done because the facility -- I think in one instance it was a non-profit facility and the other was a proprietary facility. They were both trying to find a way to get out of the contract, because it had become very onerous over the years. Those were the only two instances that I know of where there were life care contracts during the past eighteen years, as I mentioned, and they were contracts that had been entered into many years before.

ASSEMBLYMAN GARRUBBO: To what extent are the lifetime care contracts being used in non-profit type homes?

MR. COYLE: I don't know, Assemblyman, what the extent of the practice may be in that area. I have not run into it.

ASSEMBLYMAN GARRUBBO: Will you supply us, Mr. Cunningham, or Mr. Coyle, with sample copies of the contracts that your member homes utilize with private patients?

MR. COYLE: Yes.

ASSEMBLYMAN GARRUBBO: To your knowledge, do these contracts contain a statement or a recitation of the standards of care to which the member homes will provide care?

MR. COYLE: I would say that they don't go into any great detail, but they have some specifics in the charges involved, and in addition, as you know, Assemblyman, or maybe you are not aware of this, but every facility dealing in government patients must present any patient coming in with a copy of the patient bill of rights now required under Federal regulations. All of the facilities are complying with that regulation, so they not only get the agreement signed, but provide them with the patient bill of rights which outlines the rights of that patient.

ASSEMBLYMAN GARRUBBO: Is that for non-Medicaid patients as well?

MR. CUNNINGHAM: No, it is Medicaid and Medicare. We recommend it to all our people too.

ASSEMBLYMAN GARRUBBO: But there is no Federal regulation given with regard to a private contractual arrangement for private patients?

MR. CUNNINGHAM: No, there is not.

ASSEMBLYMAN GARRUBBO: My question deals with your contract with that private patient. Does that contract -- obviously it calls for or describes the obligation of the patient with regard to the payment of sums of money for whatever the purpose may be, does it not?

MR. CUNNINGHAM: Usually it would outline services, especially services for an added charge, and it would show what that charge would be if it was necessary.

ASSEMBLYMAN GARRUBBO: Do they specify the services to be rendered by the agency or by the home for that particular fee?

MR. CUNNINGHAM: I can't swear to it. I would say the basics, and not in great detail.

MR. COYLE: Mr. Garrubbo, it seems that the policy throughout the State is to have every facility develop its own admission agreement. We have a standard uniform agreement throughout the State that has been adopted or approved by any government agency or by any organization including our organization. The agreements do vary depending upon the types of local counsel, and I assume that most of these agreements have been submitted to their own house counsel and put into effect on that type of legal advice.

ASSEMBLYMAN GARRUBBO: Mr. Coyle, for example, do any one of the contracts expressly state that reasonable care or habitable environment will be provided by the ---

MR. COYLE: I think you will find the general wording, Mr. Garrubbo, to that effect. But the criteria for admission is, first of all, to establish who the responsible relatives are and the sponsors, the identification of the patient, the rate that will be paid, the nature of the care, the attending physician. That is general information. Now, as far as the itemization of services is concerned, I think you will find that it varies from one institution to another. We would be very happy to supply you with blank samples of the types of agreements that our members utilize.

ASSEMBLYMAN GARRUBBO: Well, the Medicare and Medicaid regulations do specify that reasonable care and habitable environment be provided; is that correct?

MR. COYLE: I think that's inherent in every agreement on the admission policy, Mr. Garrubbo.

ASSEMBLYMAN GARRUBBO: Do you think that is implied in any one of your contracts?

MR. COYLE: Yes, it is, and certainly in the adherence to the standards promulgated by the State in order to insure minimum care.

ASSEMBLYMAN GARRUBBO: Mr. Cunningham, you referred earlier to a sale and lease-back type of arrangement that was employed in some uncovered relationships in New York State.

MR. CUNNINGHAM: Right.

ASSEMBLYMAN GARRUBBO: To your knowledge, have you learned of any such arrangements in nursing home facilities in the State of New Jersey that presently exist? Let's start there.

MR. CUNNINGHAM: Not to my knowledge, not a sale and lease-back. I know of leases that have happened in New Jersey. I am not aware of sale and lease-back arrangements by the same parties.

ASSEMBLYMAN GARRUBBO: The Medicaid formula for reimbursement in specifying non-arms'-length-type transactions does contemplate that there will be lease arrangements that are made

perhaps between parties who are principles in related business associations. To what extent does that type of arrangement exist in your membership?

MR. CUNNINGHAM: You are saying at non-arm's-length as compared to arm's length?

ASSEMBLYMAN GARRUBBO: Yes.

MR. CUNNINGHAM: I couldn't even give you, you know, a percentage type of thing. Our members, upon joining -- it is the operation and facility that joins, but they wouldn't give us their corporate changes or structures as they have happened, so we have no knowledge of that.

ASSEMBLYMAN GARRUBBO: That leads me to the next question, and that is, to what degree does your association police the corporate relationships between the owner-operator-mortgagor-mortgagee, if at all?

MR. CUNNINGHAM: The corporate structure ---

ASSEMBLYMAN GARRUBBO: Let me clarify something, Mr. Cunningham, and for you also, Mr. Coyle. Speaking for myself personally, and I think I can speak also for this committee, we are not engaged in a "witch" hunt here. I do not think that you should interpret our action as being one seeking negative information only. If it is there, we want to know about it. Your statement to me seemed quite defensive, and unnecessarily aggressive. I think that much more could be accomplished in a positive fashion, and I don't want you to interpret from my comment or my use of the word "police" that there is nefarious activity going on, but if there is, I would like to know about it. I'm not suggesting that your association is hiding anything. We are here to get information.

MR. COYLE: Assemblyman Garrubbo, I think we should point out that we are not a policing organization. We are ---

ASSEMBLYMAN GARRUBBO: What are you?

MR. COYLE: We are a voluntary, non-profit organization.

ASSEMBLYMAN GARRUBBO: Well, what is your association?

MR. COYLE: The New Jersey Association of Health Care Facilities.

ASSEMBLYMAN GARRUBBO: What is that?

MR. COYLE: That is an association which is a non-profit corporation which has members who own and operate health care facilities in New Jersey. We do not ---

ASSEMBLYMAN GARRUBBO: What is the function of the organization?

MR. COYLE: It is a voluntary organization and its purpose is to assist the owners and administrators of facilities in the management of this type of health facility and also to improve patient care. I think that's generally the wording you will find in its charter.

ASSEMBLYMAN GARRUBBO: So, you don't involve yourselves in knowing or discovering the corporate relationships that exist insofar as your members are concerned?

MR. CUNNINGHAM: We have a membership application, naturally, as all do. Although, in that application we would not get the background corporate structure, as the Department does not get that now. We would get, though, the operational owner, if in effect they own real estate and/or the operation. We would get references from them. We do discuss the facility with both Departments, Health and I&A, to investigate whether there were any problems with the facility and just what their viewpoint is on the facility.

We discussed it somewhat with the references given on the application or with our people in the area. If we feel that there is any area of concern at all, we would send our Peer Review people along with staff into the facility to take a look prior to a recommendation going to our board, as to whether we accept or reject.

ASSEMBLYMAN GARRUBBO: Well, you are not really in a position as an association to tell us that your members do or do not

engage in the type of activities that were related by Mrs. Mendelson or that were revealed by the Stein Committee, namely, in some cases, highly inflated leases, excessive mortgages, inflated costs, and things of that sort, are you?

MR. CUNNINGHAM: No. But I would say, though, that with the controls that you do have in Medicaid and with the maximums in this State, that if that facility was engaging in the type of lease that you are talking about -- it would be a newer facility. That's the way they have been coming up. With the economic costs, and the Medicaid maximums, I would say predominantly - and probably if not 100%, 99% - that facility is over the maximum, and as a result not recovering all its cost from Medicaid, and as a result of that controlling all its Medicaid admissions in order to financially survive.

ASSEMBLYMAN GARRUBBO: Well, I think that our approach to reimbursement and in-cost analysis, and I don't want to get into this very deeply, is one that comes basically from the New York approach. And even in New York, based upon this same approach, they have found many, many abuses that resulted in poor quality of care and cutting of corners in health facilities. I think you will agree to that.

MR. CUNNINGHAM: Not necessarily in the care in this State. We by and large feel that the care in this State is good. I think you will find, also, that there were comments some weeks ago made by the Deputy Commissioner of the Department of Health to that effect, that by and large the care in New Jersey is good. We don't feel that you are going to find a problem area to any great degree.

ASSEMBLYMAN GARRUBBO: Well, your qualification of "by and large" is of little comfort, I suppose to the small minority of people who are not receiving that quality of care.

MR. CUNNINGHAM: We would be as willing to cooperate with you in finding that and being sure that that situation would be

corrected as the Committee is itself.

ASSEMBLYMAN GARRUBBO: But your association, yet, does nothing to uncover those things.

MR. CUNNINGHAM: Right. We don't have an inspection arm, you might say. We have Peer Review, which, up to this point has been doing mostly complaint investigations or new member inspections when a new member comes in. We hope to expand it to inspect every one of our facilities, and we hope to give them our Peer Review stamp of approval. We are limited somewhat the same as the State, as far as financial resources, and we are not staffed at this time to send a team out to inspect every one of our people who have membership for some time.

ASSEMBLYMAN GARRUBBO: Is the Cranford institution that was referred to by Mrs. Mendelson a member of your association?

MR. CUNNINGHAM: It was not at that time.

ASSEMBLYMAN GARRUBBO: Is it now?

MR. CUNNINGHAM: Yes, it is.

ASSEMBLYMAN GARRUBBO: Was the Wayne facility that was referred to by her a member of your association.

MR. CUNNINGHAM: Yes, it is.

ASSEMBLYMAN GARRUBBO: Was it at the time of its imputed involvement in numerous abuses?

MR. CUNNINGHAM: I don't know which facility you are referring to in Wayne, because the name she used for the facility in Wayne has been and still is one of the better facilities in the State. I don't think you will find abuses. I think you are referring to the wrong facility.

ASSEMBLYMAN GARRUBBO: I think the name that was used was Lake View.

MR. CUNNINGHAM: Absolutely. I would invite this Commission to visit this facility at any time any day, and you are not going to find abuses.

ASSEMBLYMAN GARRUBBO: How long have they been a member of your association?

MR. CUNNINGHAM: Well, I would say five or six years.

ASSEMBLYMAN GARRUBBO: What would be the position of your association on the question of unannounced inspections?

MR. CUNNINGHAM: We see no problem with unannounced inspections, and actually some of the information that has come out earlier today, where it said that they must give warning that they are coming, that is only in the case of a Medicare certified facility. You will find only about 100 or 1/3 of the facilities are in that ball game. All of the others have been receiving unannounced visits all along.

ASSEMBLYMAN GARRUBBO: Then, I assume, you would support legislation that would provide for mandatory unannounced inspection of nursing home facilities in this state.

MR. CUNNINGHAM: We see no problem. I think you will find that it has already been proposed Federally.

MR. COYLE: May I qualify that statement, Mr. Garrubbo. We may have some reservations about the specific type of legislation that would be drafted in this area. We have had some previous experience in New Jersey some years ago with unannounced inspections, and while we do not object to unannounced inspections, we have run into a problem with unannounced evening inspections, late-hour inspections. Patients have been disturbed, and there has been a problem involving the giving of patient care, and I would not want to see, personally, an unrestrained right to make unannounced inspections 24 hours a day.

ASSEMBLYMAN GARRUBBO: That would be your only reservation.

MR. COYLE: Yes, sir.

ASSEMBLYMAN GARRUBBO: And would you put a time frame on it if you were to recommend that proposal?

MR. COYLE: I think it is very difficult, sir, to conduct a proper inspection, particularly during the evening hours, between the hours of 12 and 7 in the morning.

ASSEMBLYMAN GARRUBBO: But that might be an appropriate time for an inspection.

MR. COYLE: Well, for a very limited purpose, perhaps, to check staffing, but that would be about all. Other than that, I think it would be disruptive and would tend to disturb the patient care.

ASSEMBLYMAN GARRUBBO: I have no further questions. Thank you.

SENATOR FAY: Mr. Cunningham, I would just like to ask a few questions about your Association, to follow up on Assemblyman Garrubbo's questions. Is your position as Executive Director a full-time position?

MR. CUNNINGHAM: Yes, it is.

SENATOR FAY: And you don't own, operate or administer a nursing home?

MR. CUNNINGHAM: No.

SENATOR FAY: Do you have any background in the field?

MR. CUNNINGHAM: Not prior to coming to the Association 8 years ago.

SENATOR FAY: Eight years ago, you were an administrator or an owner?

MR. CUNNINGHAM: No. I had no experience with the nursing home field prior to that.

SENATOR FAY: You had no nursing home experience at all?

MR. CUNNINGHAM: I had never worked in a facility or administered or owned one.

SENATOR FAY: Is the New Jersey Association of Health Care Facilities the official lobbyist for the 170 members?

MR. CUNNINGHAM: Yes, it is.

SENATOR FAY: The 170 members have approximately 15,000 beds and those somewhat shakey statistics we received this morning said there were 19,000 beds in the State. For all intents and purposes, you do represent practically all of the ---

MR. CUNNINGHAM: In that one category. I think on that non-profit list that we talked about, we only represent a couple of them, and the same in the governmental area. On that one list, we would, yes.

SENATOR FAY: This says, "Although our members include non-profit and governmental, as well as proprietary,

largely our members fall in the latter category." What percentage is that "largely"?

MR. CUNNINGHAM: I would say 95 to 97 percent.

SENATOR FAY: Ninety-five to 97 percent. One of the two reports -- I am only familiar with one report from Mr. Jones that the Attorney General has and presented to me. The only reason that has not been released as of now is that Deputy Attorney General Boylan more or less ordered me not to release the report because there were some names in there and they said the Attorney General might be coming through with some indictments. So I was asked not to release the report because, if some of the names did come out, it could jeopardize the case. That is the only reason it hasn't been released, as far as I am concerned. It was a direct order from Deputy Attorney General Boylan.

MR. COYLE: Do I understand then, Mr. Chairman, that that report will be released and made public?

SENATOR FAY: As soon as the Attorney General takes that onus off of me, that I would not be jeopardizing a court case, yes.

MR. COYLE: I understand your position, Mr. Chairman.

SENATOR FAY: Mr. Cunningham, the only one fault I find with your report is that as an Association representing 95 to 97 percent of the facilities you seemed to display a lack of urgency in going to the weak sisters, going to those who are causing the problem, the 13 percent, if it is Mr. Jones' report we are going to accept. I find nothing in your report regarding any self-policing operation. Most professional organizations do have a code of ethics, a standard of performance, to expose people who are making unconscionable profits when the rest are not. This is documented by Mr. Jones, not by anything else I have right now. This is an area for your organization to move into. Mr. Jones has told us half of the deficiencies were in the nursing service category; the sanitary conditions

were the most serious deficiency found in the area of dietary services; patients' medications were not always properly labelled and stored; and insects and rodents were found in facilities.

MR. COYLE: Senator, we made no admission that that 13 percent represents any part of the members of our Association.

SENATOR FAY: I don't either.

MR. COYLE: And, if they are not, we have no right to make an inquiry into people with whom we have no privy.

SENATOR FAY: No what?

MR. COYLE: No privity. We have no privity with them; we have no right to go in and make an inspection.

SENATOR FAY: I am saying, as an Association, why don't you have a right?

MR. COYLE: In that 13 percent, because we don't have the statutory right, Mr. Fay.

SENATOR FAY: What would stop your organization, your Association, just like any other association, from policing yourself and saying, "To be a member of our Association, there are certain standards we are going to meet. There is a code of ethics"?

MR. COYLE: We do that for our own members. You are asking us to police the 13 percent?

SENATOR FAY: No. I am asking you to police your own members.

MR. CUNNINGHAM: That I pointed out before, our peer review and to what point it is now. We would like to get to a point where we could inspect just like the State does. Possibly the Commission could help us find grant money somewhere to be able to do this. Right now, our peer review, as I said, will investigate any complaints. We will go into a new member trying to come in and do a review there, and we hope to expand that further. We also have gone into a program called "cool line," which I am

sure you saw in the Moss Report, which puts posters in all of the facilities. This encourages any patient or sponsor or anybody reading that in the facility - and it would be in two or three areas in the facility - to first talk with the administration in that facility and, if they do not receive satisfaction, to call "cool line," and the number given is our Association number and the address given is ours. We have done that, but we are not to the point yet staffwise or financially to go out and inspect all our facilities.

SENATOR FAY: Mr. Cunningham, I don't want to be argumentative, but still in your report you didn't strike at the abuses in the field that every report mentions. I don't care whether it is as low as one or as high as thirty. The abuses are serious. Just let me read a few of Mr. Jones' recommendations for you to take back to your membership: "At present, the rule under HEW regulations and practice in New Jersey is that the home, when notified of a deficiency, replies by sending a letter of intent to correct. This letter is almost always accepted and nothing more is done to assure compliance. Consequently, the deficiency may remain for months and months." Mr. Jones proposes that if the patient-care area is deficient, then the home should have days and certainly not more than weeks to correct.

MR. CUNNINGHAM: That is already in the regulations, Senator.

SENATOR FAY: Mr. Jones is saying it takes ---

MR. CUNNINGHAM: It wasn't in his time, but it currently has been published in the register and is final. Any patient-care deficiency must be corrected within 30 days, subject to revocation of the license if it is not complied with.

MR. COYLE: I might add, Mr. Fay, that is in our present statute under licensing in Chapter 136.

SENATOR FAY: But is it enforced?

MR. COYLE: Well, if it is not enforced, Mr. Fay, I don't think you would expect my clients to be the police force when they don't have the statutory power to do anything about it. That power reposes now in the Department of Health and the Department of Institutions and Agencies. And I think the responsibility for the enforcement of standards lies with the agency in whom the Legislature has reposed that responsibility; that is, the Department of Health.

SENATOR FAY: You are saying you have no responsibility then?

MR. COYLE: We may have a moral responsibility, Mr. Fay. If that is what you are referring to, we will talk about a moral responsibility. But I am talking about a legal responsibility.

SENATOR FAY: What about the moral responsibility?

MR. COYLE: We have as much moral responsibility, Mr. Fay, as anyone else to achieve the very best for the patients in our facilities. When you talk about the legal end and the legal responsibility, that is presently in the Commissioner of Health to enforce regulations.

SENATOR FAY: I am quoting Mr. Jones and I don't want to get Mr. Coyle in a state of shock. These are Mr. Jones' words.

MR. CUNNINGHAM: Let me interject here some comments from a meeting we held with Deputy Commissioner David Wagner of the Department of Health about a month or a month and a half ago. It dealt with a similar type area where we were a little unhappy with press releases being put out on facilities, being closed or provisional licenses, etc., prior to the facility even knowing or getting a letter to that effect. We were concerned about conditions in the facilities. Some of the results of

our discussion were to the effect that the Department would give us a copy of deficiency reports of a serious nature, and we would go in and attempt to help that management straighten out the situation. To this date, we have received nothing. We can't help solve a situation that we are not made aware of. They have to give it to us. We have to be made aware of it because we don't have the staff to go out every day looking in every facility to see if there is something there. We would be perfectly willing to help in that kind of a situation if it is presented to us.

SENATOR FAY: Are you talking about situations where they closed a nursing home? Is that what you are talking about?

MR. CUNNINGHAM: Closed or provisional licenses or any area where you have a number of deficiencies where it appears that management is not operating properly.

SENATOR FAY: What kind of a warning were they given before they got the provisional license?

MR. CUNNINGHAM: Provisional or ten days to give notice why the license shouldn't be ---

SENATOR FAY: Yes. What kind of a notice were they given? What kind of a warning were they given?

MR. CUNNINGHAM: By mail - 10 days to show cause why your license shouldn't be revoked or you have a provisional license for the next 90 days. We weren't objecting to the fact that these were legitimate deficiencies. Fine - but tell the facilities you are doing it; don't give it to the press before you tell them. If the facility finds out from reporters, it gets quite a shock.

SENATOR FAY: I thought they were told. As I understand it, they were given a letter that if they didn't do what they were supposed to, they would be closed.

MR. CUNNINGHAM: They were, but after it was in the papers. I must say in defense of the Deputy Commissioner

that he indicated that they did realize that was happening and, in the future, they will hold the press release 48 hours after mailing the letter, so the letter gets to the facility prior to the release getting to the papers. Now we would be perfectly willing to help in that type of problem, but we have to know about it before we can help.

SENATOR FAY: Another suggestion of Mr. Jones is in the area of substantial compliance. Do you have any suggestions or recommendations in relation to that?

MR. CUNNINGHAM: When he talks "substantial" as compared to "full" compliance, we definitely do not agree with the term "full compliance." As you know, the federal government was also talking in that frame and there was major objection around the country to that, as to what really is "full compliance" in the subjective judgments of varying interpretations of inspectors. We still feel it should remain "substantial compliance." But when they really deal with "substantial compliance" in the frame they use it, that doesn't mean you can be doing some bad thing and still comply. There are various factors to the different standards that determine whether you are in substantial compliance or not, and nothing that can be hazardous to the health and safety of the patients.

SENATOR FAY: How about his suggested legislation prohibiting tipping?

MR. CUNNINGHAM: I never heard of tipping in a facility.

SENATOR FAY: In his report he says that too often -- and I have been told this by families -- in some homes they are told that they had better tip the orderly or the aide or the nurse on duty or they won't get treatment at night.

MR. CUNNINGHAM: That is a policy that I was not aware of and never heard of, and, definitely, is not

any policy of any facility.

SENATOR FAY: You never heard of that before?

MR. CUNNINGHAM: No. That is why I sort of laughed lightly when you mentioned it.

SENATOR FAY: The last recommendation had to do with the patient's property, the man or woman losing his or her watch, losing personal property, the family having to bring clothing down two or three times because the personal property keeps disappearing on the patient.

MR. CUNNINGHAM: We have had instances of that and I am sure it has happened in many places. One of the problems is that the family will bring clothes in and not mark them properly. You know, if you have 100 or 200 patients in that place and everything goes to the laundry and the marking that was put on it against the regulations of the facility, which is that the facility wants to be allowed to mark it so it won't come off, washes off --- It is down in the laundry if the family wants to go and look.

SENATOR FAY: How about his suggestion with regard to the accounting for that $25 a month?

MR. CUNNINGHAM: We don't see a problem with that, Senator. In this State, some months ago, Medicaid discussed that and we notified all facilities at that time that that $25 personel incidental fund must be kept in a separate trust account, separate from all other monies in the facility, and be administered separately only with the approval of the patient, if they are not too senile, or the sponsor. The problem that Mr. Jones alluded to where in some instances the family will take it does appear at times. But if that facility is responsible for it, it is in a separate trust fund. And, if that ever exceeds $100, the balance must be sent back to Medicaid. A facility can never hold more than $100 in that P and I fund for that person. It must be returned to Medicaid.

SENATOR FAY: The last point I want to make is in regard to your criticism of the SCI Report. At our next public meeting in two weeks, the SCI will be here to enlarge upon their report. Of course, both you and Mr. Coyle are invited to be here to rebut and to answer the SCI Report.

MR. COYLE: What's the date?

SENATOR DUMONT: Friday, May 2nd.

ASSEMBLYMAN GARRUBBO: I want to make one further comment. You can respond if you want.

Mr. Coyle, it really astonishes me that you would suggest that you are not policing your Association because your sole responsibility may be a moral one and not a legal one,in view of the fact that you have come here as a representative of that Association to tell us of the quality of health care that the Association's members are delivering. Yet, by the same token, you have no machinery whatsoever that would assure that there is quality health care or that you would eliminate abuses that exist. There seems to be something inconsistent in what you are saying.

I am not at all in a position, legally, morally or in any other way, to tell you how to operate your Association. But inasmuch as you have come to this Commission as a representative of a great number of homes, it would seem to me that before you represent that they are substantially without abuse, you should provide machinery to guarantee that.

MR. COYLE: Mr. Garrubbo, we have not made any guarantee as to what may or may not take place in any one facility throughout this State. The Association, my clients, are concerned with the development of standards on a statewide basis. They are concerned with the methodologies that are evolved in delivering health-care services. We are involved with the administrative agencies relating to mutual problems of reimbursement. But we do not have the

authority, Mr. Assemblyman, to police the industry for a number of reasons. We don't have the legal authority to do it; and, secondly, we are not informed of any deficiencies where they may exist. That information is related to the Health Department from the provider and is kept in the Health Department, and the policing is done from that department.

MR. CUNNINGHAM: Let me make a couple of comments here, Assemblyman, about some of the things that we do in an attempt to improve patient care and the conditions in the facilities.

First though, one comment to Senator Fay. He related the fact that we represent 98 percent of the facilities. I wish we did because then I could afford to do peer review in total function. We only represent 70 percent. But we conduct many sessions of a continuing education nature for the administrators, for the key supervisory personnel, to upgrade the care in the facilities and to be sure that the staff is up to date in handling the problems that they face in their work. So we are looking to better and improve patient care. We do not condone poor facilities and would work with the Commission, if they find any, in straightening out that type of a situation.

Our statement seemed a little offensive or defensive, whichever part of the road you are on, in its earlier phases, but I assure you that we look forward to working with the Commission. We don't appreciate the attacks that we have been under and would work with you on behalf of all of the residents in the facilities and all the residents in the State.

SENATOR FAY: Thank you.

SENATOR DUMONT: Alps Manor in Wayne Township in Passaic County - is that a member of your Association?

MR. CUNNINGHAM: No, it is not.

SENATOR DUMONT: Has it ever been?

MR. CUNNINGHAM: At one time about seven years or so ago, it was.

SENATOR DUMONT: It hasn't been since?

MR. CUNNINGHAM: No.

SENATOR DUMONT: Thank you.

SENATOR FAY: Dr. Solomon Geld, New Jersey Association of Non-Profit Homes for the Aging.

Mr. Cunningham and Mr. Coyle, we can expect you at the May 2nd meeting?

MR. CUNNINGHAM: Yes.

D R. S O L O M O N G E L D: Mr. Chairman and members of the Commission: Before I read my seven-page statement --I see the hour is late and I have been sitting here since 10:30 this morning because of a lack of communication - I wasn't given the time schedule when I was supposed to be here -- there are a few preliminary observations I have to make.

My name is Solomon Geld. For the past 36 years, I have been an administrator of a multiple-function center for aging, which includes programs geared to a population whose functional capacity ranges from subtotal self-sufficiency to total dependency. The name of the place is Daughters of Miriam. It is highly visible when you ride the Garden State Parkway on Exit 155. It includes an apartment project for senior citizens with very limited services and all levels of nursing care, ranging from ICS (A) and (B), to skilled nursing care, to Medicare. We also operate a sheltered workshop. We have an affiliation with Fairleigh Dickinson University to send their nurses for geriatric training and with the Bergen County Community College; the New York School of Social Work sends their students to be trained in the problems of the aged, and the rabbinical students from Yeshiva University. We are right now negotiating with the New Jersey College

of Medicine for training of internes for audio and speech therapy. We have a very diversified program, with a total over-all budget of some three and a half million dollars. Our total bed capacity during the 36 years that I have been the administrator of this institution rose from 50 to approximately 400, of which 243 beds and soon 267 beds will be approved for various levels of nursing care.

I come here because I was delegated by the New Jersey Association of Non-Profit Homes for the Aging. All kinds of numbers have been bandied around here. Our membership is 69, of which some 55 facilities are Medicaid approved. Altogether, I am told -- we don't know exactly because some homes for the aging don't have the kinds of visibility and they live in the tarnished splendor of isolation, so we don't know much about them. But our membership is 69, of which some 55 are Medicaid-approved facilities.

Let me say something about the word "non-profit" because Mrs. Mendelson has made a point that non-profit can hide profit. Actually non-profit can be in terms of social welfare entirely irrelevant. Somebody organizes a country club. It is a non-profit organization. So what? The proper name for our type of facility - and we speak for the non-profit facilities, although the New Jersey Association of Health Care Facilities may have a few non-profit, governmental agencies, but we are the major spokesman of church-related, civic-group related, synagogue-related, community-related facilities -- and the proper name should be not non-profit, but philanthropic facility - charitable facility - because what we represent is a partnership of government input and private citizen and community input.

In the last six years at my own place, we have gone through a major upgrading and renovation of our facilities to the tune of six million dollars. We have

another four million dollars to get to give the facility what our community, never mind the State Department, the regulatory agency - what our community wants for our aged.

With this philanthropic character where there is a tremendous investment of capital funds, I couldn't keep my head above water if I didn't have year after year a subsidy from various fund-raising efforts, auxiliaries, bazaars - you name it - where the input for the operating costs is something between $200 and $250 thousand to have the kind of program for our aging people that we have.

So the whole business of profit -- certainly, profit is the hallmark of American life. I would be the last person to deny it. That is what has made this country what it is. But there is a very small demarcation line between profit and profiteering. One is kosher; the other one is not. There is a thin line between avoiding and evading. But this is not my problem; this is the problem for certain people to dig and "ye shall find." Keep on digging and maybe you will find more.

I certainly agree with the statement made here by Mr. Jones that unfortunately because of some scoundrels, of some rascality in the field, the general impression is created that "nursing home" has become a dirty word, with tremendous guilt feelings on the part of families who for one reason or another have to place their loved ones in a nursing home.

The philanthropic character has another impact. In other words, I cannot make any comment about imputed rental and about all the kinds of things that you have asked the proprietary people and representatives of government. We are classified as 501C3, which means that contributions to this organization are tax deductible. The primary consequence of this situation is that we have enormous visibility. We live like fish in a fishbowl. What

happens in our establishment is not the business between us and the Department of Health and the Department of Institutions and Agencies and their inspecting authorities. Our accountability is to the community. If there is bad food or if there is excessive pilferage - pilferage occurs everywhere - if there is abuse of patients, if the patients appear unshaved or their fingernails are not cut, if they look completely forlorn without any program, without any motivation or purpose for living, then you would certainly hear from the community. In fact, those homes which cccupy the low totem on the scale of value in the community have disappeared. But, by and large, we are still doing God's work on earth and we will continue to do this.

Another consequence of the non-profit in community accountability is that we are amenable to change. When I came to Daughers of Miriam in 1939, it was a home for well aged and also an orphanage. Mind you - this was 1939. The first White House Conference on Children was held in 1911 and, at that time, the Conference proclaimed for every child a home of his own; and, if not a home of his own, a foster home. Yet, many organizations continued merrily along and Lady Bountifuls came and handed out candy to the children in the orphanages. Orphanages, fortunately, disappeared.

On the other hand, we, who originally started - and this applies to many philanthropic homes - a home for the well aged, for residential care, expanded our program to nursing care. Right now, we have an application, to which, I believe Mr. Jones referred, to have a day-care program for nursing care to prevent premature institutionalization.

We don't live like the worm that crawls into an apple and thinks that the apple is the whole world. If I may speak for myself, I have been a delegate to the

White House Conference on Aging both in 1961 and 1970. I served as the Chairman of the New Jersey Advisory Council on Nutrition. I am the Vice Chairman of the New Jersey Commission on Aging. I teach a course in Social Gerontology at Rutgers University, a required course for any licensed administrator, and my successor,because I am on the way to retirement, teaches a course on Nursing Home Administration. So we are really responsive not only to our own bailiwick, not only to our own center, but we participate on a broad base in the community.

Now, having said that, I would like to devote the rest of my time to an analysis - and this is a statement I have prepared - concerning the person as a patient. I have listened patiently all day long. Who is the person who comes to us? What are his social, psychological, physical and emotional needs?

In preparation of this, let me tell you I have a colleague in San Francisco who distinguishes among the aged. To say an aged person is anybody of 65 and over is nonsense. You cannot take that kind of conglomeration. There are several categories. He has a funny bone. He says there are the go-go aged, the person from 65 to 75 or thereabouts, who probably doesn't require any administration of any social service agency unless he falls below the poverty line.

Then there are the slow-go aged, people from 75 to 80; the slow-slow aged; and the no-go aged. The person who comes to us falls in the last category. I entitled my seven-page paper concerning the person and the patient. Here I go.

What is the difference between a person and a patient?

Of course, all aged patients are persons and all aged persons are sometimes patients. There is, however, a functional difference between them in relation to the

length, character, and intensity of a pathology and the restorative potential.

There is also a difference between person and patient in the dimension of living, in life's cycle and life's satisfaction.

The question about a patient and his needs versus a person and his needs is one of changing focus. The rights and obligations of a person stand in reverse proportion to the intesity of a struggle for physical survival. The more dangerously ill a person is, the more attention he requires as a patient, during which time his needs as a person are held in abeyance. By example, nobody asks a patient on the operating table about his food preferences. On the other hand, with the passing of danger and assurance of survival, a gradual shift of emphasis occurs. The medical needs,which during the period of acute illness were in the focus, move to the periphery. Personal and social needs, which were in the periphery during the acute illness stage, move to the center.

Every occupant of a post-hospital care facility, of a long-term care facility, whatever name you call it, is, strictly speaking, a patient for a short time and a recuperating person with growing personal and social needs for a longer time. This is so in any age group, but especially in the higher age brackets where a post-hospital situation of the discharged patient calls for an increased amount of social and personal care in proportion to his advancing age, disability and impaired psychological health equilibrium.

Having defined the changed functional relationship between patient and person, we have also spelled the functional difference between a hospital and a nursing home and the rationale for the latter.

Nursing homes, proprietary and nonprofit alike, came into being, at least partly, in response to a quest for meeting the vital personal, social, and medical needs of an individual who could not or would not have these needs met in his own home. Why this is so is another story, and I could go into the history of the development of nursing homes in the past 40 years. Whether it should be so is still another story. One thing is sure: Instead of projecting a world of saints, instead of projecting that there is going to be intergenerational family living of an extensive nature, we should understand that placing an aged person in a nursing home is not the worst of the sins of western civilization.

I emphasize that the recuperating person, depending on his functional deficit, has personal and social needs. Meeting these needs is an integral part of the therapeutic process and of restoration of personal and social functions. It is not a superfluous appendix.

At this point, permit me to introduce a synonym of personal needs, one which is very much in use; namely, ADL - activities of daily living. These range from getting in and out of bed, grooming, bathing, dressing, eating, various degrees of walking, and so forth, toward more advanced activities, such as reading, writing, communicating, participating and being motivated for purposeful living.

Think of these and similar ADL's and think at the same time of the population of the majority of good nursing homes, and you will realize that the bulk of their direct services to the individuals within their walls revolve around the above-named functions. Think of the nursing time required, two and one-half hours a day in a skilled nursing-care facility or in an ECF facility, 2.75 hours per day. The question: What happens to them the rest of the time? They constitute, as a rule, an individual's greatest need and hope at the point of intake into a

nursing home. The improvement of a person's ADL capacity rather than the skilled nursing and medical services, is the part of the nursing home's program that consumes the bulk of the service time.

This is why good nursing homes are multicare facilities, geared to the different functional capacities of the clientele, with much space, staff and time allotment for promoting ADL and much less time, space and personnel for medical service and skilled nursing.

Good nursing homes aim to prepare some of their clients for return to their own social setting, whenever possible. When that is not possible, we must try to create an environment within the nursing home that will approximate the former home environment of the client.

What do we mean by social needs? Permit me to quote from the Bible and don't hold it against me because I am a graduate rabbi, especially when you read the recent articles about New York. I am not ashamed and I am not saying I am a non-practicing rabbi. I am a practicing rabbi, except that my practice is not from the pulpit; it is at the bedside of an old man.

The Bible teaches us that it was not good for Adam to be alone. The modern existentialist philosopher, Heidegger, said that "to be" means to be here and now and it also means to be with. Both quotations represent an insight that the term "human being" is an abstraction, that in reality we know a Mr. Jones or a Mrs. Smith and their particular environments.

By way of comparison, we may say that while we isolate individual words in a dictionary, a live language is characterized by a relationship of words. A mere string of words is gibberish, not language. The mere presence of many unrelated individuals in physical proximity is not society.

What syntax is to language, social interaction is

to society. It is in social relationships, beginning with the family members and growing with the development of individual capabilities, that the person finds his social fulfillment, irrespective of whether this relationship unfolds through the actual physical presence of others or whether it exists in the person's mind. Therein lies the difference between the loneliness, which we know can occur in a crowd, and solitude, which can embrace thousands in a meaningful, imaginary relationship in a mind's eye.

The fundamental social unit is the family. The family is the primary answer to a person's social needs. Where that primary answer is not possible because the person has no family or where the family deviated seriously from the norm of wholesome and beneficial relationship, or the condition of the person would adversely affect that norm, we create social substitutes.

In terms of social needs, the institution for the aged in advanced years or the chronically ill is that social substitute. Therefore, its social task is to utilize, as much as is feasible and desirable, the existing symbiosis of the person with his family and/or friends and, over and above that, to transform a crowd of people living in an institutional setting next - I emphasize "next" - to each other into a community of people living with each other.

Community means that its members have something in common or create something in common. The more common denominators, the more cohesive is the community. That such a community can have a therapeutic effect has been amply demonstrated by Maxwell Jones who created this kind of a community to deal with World War II veterans suffering from industrial neurosis.

The therapeutic community in a nursing home of which a person becomes either temporarily or permanently

a member, is a structure in which sizable personal and social needs interlock with peripheral medical and nursing needs. This principle governs long-term hospitals, skilled nursing care facilities, extended care facilities, intermediate care facilities - in short - all post-acute hospital congregate, social and health-care settings.

Therefore, in all of them, we must learn to strike a balance between care and self-care, to divide the time in consideration of a person's need to be alone and to be with others; to establish a harmony between freedom and authority, between reliable dependence and opportunity for independence; and to balance the distribution of space in consideration of the old person's perception of space - private, semiprivate, and public - with an opportunity for both privacy and socialization with small and large groups.

Most of what I am saying --- You see, I testified before Senator Moss way back in 1960 and twice before Senator Williams and what I submitted to him was much more elaborate. Some of it was reprinted in the reports of Senator Williams.

We just cannot square the philosophy, the tradition and the moral mandate of continuity of care -- when I say "we," I mean the philanthropic, church-based, community-based home-- of the total person and meeting his fluctuating needs with growing fragmentation of care and fragmentation of reimbursement.

Both fragmentations are, regrettably, imitations of the hospital establishment and its patient orientation. They don't take into account the distinction between a short-term hospital and a long-term posthospital setting. Whereas in a short-term hospital, the patient, as a rule, comes in for a specific diagnosis and therapy in a specific department, in a long-term setting the same aged person moves from a status of ECF case, skilled nursing case, ICF case and shades in between, and this happens in frequent intervals, which no one can ever

chart in advance with any degree of accuracy.

Nothing but a multiple-function,post-hospital congregate social and health-care facility with an established range of services geared to the needs of the aged person, who is sometimes a patient, having a range of health deficits from subtotal sufficiency to total dependency - nothing but an over-all reimbursement cost based on the accounting of total expenditures for all, each according to his needs, will do justice to our concept of the dignity of the aged person and how to maintain it.

I am equally convinced that government would save money by doing away with fragmentation of care and fragmentation of reimbursement. And the aged may - I don't know now, but at the time I wrote it I thought they may get better service at less cost.

I realize that the present structure cannot be changed in short order, but I am suggesting that what I have formulated deserves serious experimentation. Since philanthropic long-term health-care facilities, under civic and church sponsorship, represent only nationally a small percent - I am told 15 percent of the total bed capacity - of the country's total nursing home bed - 23,000 nursing homes, I am told,in the United States - and of this bed capacity only some are multiple-function health-care centers, they lend themselves ideally to such experimentation without disturbing the present structure for the great majority of our nursing-care beds.

I would invite the Commission to ponder one consideration. This is an interpolation I am putting in. It is a sad situation that whereas the majority of the country's hospitals are community-based hospitals, the 70,000 hospitals, the overwhelming majority of nursing homes are in proprietary hands.

Our traditional concern with and performance for the aged - our Association alone is 40 years old and we have some homes for the aging which have developed into multi-care facilities - our lack of profit motivation, our personal and material participation in public welfare, makes our moral stance and interest equal to that of government, including investigatory bodies, including the writers of reports like Mendelson and Nader.

In the light of what I have said, we can assess a measure of progress and failure of the country's concern and action with and for those aged whose functional status fluctuates between patient and person.

This I believe: With Medicare and Medicaid, we have reduced the dimension of physical suffering. We have not increased the dimension of living and we have a long way to go.

Government and society pay much more attention to the aged patient than to the aged person. Rejection of an elder is compatible even with good medical care. It is incompatible with appreciation of dignity of the aged person.

We have mitigated the punishment of old age; we have yet to increase its rewards. We have relieved the precipitous decline, a very doubtful favor. Years ago, double pneumonia solved the problem because greater longevity doesn't necessarily mean more years in which to live; it may mean more years in which to die, to die by inches. I say we have relieved the precipitous decline, the bitter fate of the aged patient; but we have not enhanced the yearned-for fulfillment of the aged person.

Whether there is hope in this direction will depend upon the moral stance of society and its priority decision in relation to the aged. We of the philanthropic feel that the best is just good enough for them. I have said this to Senator Williams, and I will repeat it, that somehow we talk as if they were "they." What are we talking about? We are talking about ourselves. The bell of time tolls for

everyone of us. What we want for our aged is something that we should want for ourselves if and when, God forbid, we should belong to the 4 percent that have to be placed in this type of environment.

Such a moral stance was expressed by the famous Rabbi Heschel - bless his memory - at the first White House Conference - it was the only report of the first White House Conference that was fully reprinted in the proceedings - when he reminded the audience that, according to the Talmud, one is permitted to pawn the holy scrolls of the Biblical Scriptures for the sake of an old person.

If you will adopt that kind of a stance and strengthen the hands of those who for years labored to improve the fate and fulfillment of the aged person, then there is perhaps some hope. Thank you.

ASSEMBLYMAN GARRUBBO: Thank you, Doctor. I think that the function of this Commission, along with its other functions, is to hopefully accomplish the kind of care that you are concerned with and express in your statement.

One of the problems, of course, is to detect the deficiencies in the legal structure that we deal with. As a non-profit nursing home facility, you are dealing with the same legal structure that controls profit operations. And I am sure that despite all of the philanthropic purposes behind non-profit facilities, there are still some deficiencies in compliance in certain institutions. We don't suppose that you are representing that every single institution complies 100 percent in either non-profit or profit institutions.

What we are trying to determine is whether or not there are abuses, what those abuses are, and how can we as a Legislature improve the structure to diminish the possibility of those abuses to a minimum.

DR. GELD: As I tried to point out in my testimony, visibility of the home has a great deal to do with that.

ASSEMBLYMAN GARRUBBO: Do you include in that disclosure of ownership?

DR. GELD: Of course.

ASSEMBLYMAN GARRUBBO: I would assume so.

DR. GELD: In fact, in our Association of Non-Profit Homes, we know exactly who owns.

ASSEMBLYMAN GARRUBBO: There are no private enterprises.

DR. GELD: If I were to go around and ask my colleagues in the philanthropic field what is the imputed rental, I can assure you 90 percent wouldn't know what it is. It just doesn't exist. This is something that is usually formed by a Methodist Church, by the Presbyterians, by the Lutherans, by the Jewish community, by the Masonic Order - a home for retired teachers, a home for actors. There the ownership is part of the charter. We could not possibly qualify for 501C3 tax-exempt status and be entitled to tax-exempt contributions if those things weren't disclosed.

ASSEMBLYMAN GARRUBBO: How else do you perceive that we might improve the structure to minimize the potential for abuse?

DR. GELD: Well, upgrading the quality of staff is one of them. There are certain places where there are substandard wages. But good wages don't automatically guarantee good care. But as long as we are going to depend on the bedside care to be done by a person who doesn't have an elective affinity to the aged person, the picture is going to look dim. Look at the people who are on the front line of duty. Do you see usually marginal people, etc.?

We are paying a living wage. So, comparatively speaking, we have little staff turnover. We have instituted very intensive inpatient training and we are trying to work with the lower-echelon people, making them feel

important. They are there really doing God's work. For example, I don't know whether you have heard of the reality orientation program. A reality orientation program is geared for the senile patient, to take him out of the world of fantasy into the world of reality, with such simple things as "What's my name? What's your name? What day is it? What is this?" - realities. Obviously we don't have trained psychologists to go around and do this work, but we have trained nurses' aides to do it, which means that they are not just the bedpan carriers, but they are participating actively in the program.

This is an uphill struggle and it is going to take time.

As far as financial abuse is concerned, I can only tell you what I know. You see, we are not guilty. There are no financial abuses. Take, for example, spending money. Every time, not only, you see, do we turn the money over to the patient and his family, but demand from the family a receipt of the clothing that they have bought and have given to the patient. And this is kept in a separate file available to the patient at his request.

Certainly life-time contracts exist among some of our organizations, but not the ones that have Medicaid contracts. This goes back to the time when some of the philanthropic homes for the aged were primarily residential-care facilities, the old type home for the aged. There a person came in years ago with an amount like $1500 or $2000 and the church undertakes to give life care. Now you know how far you could go with this kind of money. The type of abuses we hear today, that the person has to sign over his entire material wealth -- we have had life-time contracts abolished 30 years ago. Since I was at that time employed by Daughters of Miriam, I can tell you the assets that a person had amounted to something like $1500 to $2000. But we abolished it and

we went on a pay-as-you-go basis and it has nothing to do with a person's assets.

ASSEMBLYMAN GARRUBBO: Thank you.

SENATOR FAY: Doctor, I want to particularly thank you for being here. I think you summed it up beautifully. I think that besides being realistic, we do have to be philosophical about this, and realize this is a matter of conscience, no matter if you are a legislator or an employee or just a member of the general public. I think maybe we are trying to rush too fast, but I would rather we do this than ignoring it or going too slow.

I think we have tried to stress from the very beginning that we are dealing with long-range plans. We are not here particularly to point fingers and call names as much as we are to get suggestions and recommendations, such as yours, to tell us what could be done and what should be done. We must remember we are talking about our fathers and mothers, we are talking about our grandfathers and grandmothers, and, eventually, the bell is going to toll for us -- in around two years, I think, the way I feel right now.

But I do want to thank you for coming and look forward to some kind of movement among the non-profit organizations, the religious and otherwise, to prompt them to get into sheltered care, into long-range care, and not just to be standing on the sideline watching you and others in this field.

DR. GELD: The basic thing is to be amenable to change. In other words, you see sometimes a certain facility may be obsolete because it is totally unrelated to the community. It should go out; in other words, it should be expanded. For example, I am looking forward to having a day-care nursing care program. We just made application for this. Imagine 50 people receiving day nursing care without total institutionalization. It will

accomplish two things.

ASSEMBLYMAN GARRUBBO: Did you hear Commissioner Klein?

DR. GELD: That's right. I am one of the two that have applied, which means less cost.

SENATOR FAY: Doctor, if you would permit us, we would like to come up and visit with you.

DR. GELD: Any time, unannounced, any time of the day. We don't have visiting hours. We live like fish in a fishbowl. So you can come up unannounced any time. You are certainly welcome.

May I ask you a question? You referred to the May 2nd session. How is this going to be structured? It is important because ---

ASSEMBLYMAN GARRUBBO: There is going to be continuing testimony from other witnesses.

DR. GELD: Oh, I see.

SENATOR FAY: At the next session on May 2nd, we will hear from the SCI and from the Nursing Home Association.

DR. GELD: In rebuttal to the SCI?

SENATOR FAY: Both groups will have their innings, and we will also hear from a few other witnesses that day.

DR. GELD: Thank you.

SENATOR FAY: Thank you, Doctor.

Mr. Alan Kenter, who has been very patient.

A L A N K E N T E R: Mr. Chairman, because of the late hour, I will just summarize brief portions of my presentation.

I would like to point out at the outset, there is a Manual of Standards for boarding homes for sheltered care, which I tried to obtain copies of for the Commission, but they were unavailable at the Department of Health. We consider this an integral part of our report.

SENATOR FAY: We will see that copies are obtained for all Commission members and for the record.

MR. KENTER: Thank you.

A sheltered care facility serves as a substitute for the resident's own home, furnishing facilities and comforts normally found in a home, but providing, in addition, such services, equipment and safety features required for safe and adequate care of residents at all times. A resident is an adult person who is ambulant, who is reasonably oriented mentally and who has been certified by a licensed physician to be free from communicable disease.

We must provide three meals daily, supervision of medication, clean linens, laundry service, 24-hour supervision, provide assistance in bathing and feeding, if necessary, ensure the well-being of the individual and provide a facility that meets all the requirements of the Department of Health and the State Fire Marshall's Office.

This Association represents approximately 90 facilities out of 200 licensed facilities in the State. Approximately 80 to 85 percent of the licensed beds are occupied by former patients from state mental hospitals. We are talking about the care of approximately 4,000 people with varying mental disorders.

It must be mentioned that we do not operate boarding houses, rest homes, senior citizen hotels, rooming houses, etc. We own and operate a proprietary long-term health care facility geared to the reorientation of an individual to living and participating in the community.

Sheltered care facilities, since its inception, was probably the only health care facility created with the sole purpose of being community oriented. The idea was to take people from state institutions, place them in sheltered care facilities so that they can become accustomed to community living. Then,hopefully, they will become self-sufficient so that they can live on their own and

become an asset to society.

Being that 80 to 85 percent of all residents in sheltered care facilities are former patients from state institutions, it must be emphasized that we do provide a health care service - mental health care. With the emphasis today to depopulate the state institutions, the patients from the state hospitals cannot be turned out en masse with no place to go. They must be placed in a facility that will help them to readjust from long periods of institutionalization. Documentation can be provided, if requested, that we have taken these people who have been institutionalized for long periods of time and are now out in society as productive individuals.

I will just briefly cover some of the areas we are active in. The work we have done with these people is a start, but our basic problems of operations are great.

Prior to January 1974, we were receiving $4.93 per guest per day to meet all the requirements in the Manual. With the inception of the Supplemental Security Income Program, the rate was increased to $5.60 per day. Prior to this, we had not received an increase for five years.

In March 1973, we made a plea in front of the Joint Appropriation Committee for an increase in the per diem rate. They were, at that time, willing to grant us an increase of $1.50 per day. However, a representative from the Department of Institutions and Agencies claimed that the increase would create a "ripple effect"; that is, all other segments of the health care industry would also have to be increased by the same amount, thus costing the State millions of additional dollars. But, this was not and is not the case. During the last five years, all other segments of the health care industry received many increases and we received nothing. The end result of that hearing

was SR 2015 which was a compliation of worthless material.

SENATOR FAY: Who put that resolution in?

MR. KENTER: I am not sure, Senator.

In March 1974, we presented a report to the representatives of the Department of Institutions and Agencies, prepared by our accountants, that showed, using the State's own figures, a copy of which is attached, we should be receiving $17.04 per guest per day. At that time we received nothing but sympathy and apathy from representatives until September of 1974 when we decided that if the State cannot afford to pay us for maintaining and operating a facility according to their standards, then, instead of being put out of business because of increasing regulations and operating costs, we would return the people to the institutions from which they came. In other words, we could no longer afford to subsidize the State in the care of their indigent people. This letter, copy of which is attached, showed that even if the State gave us a per diem rate of $17.04, over returning approximately 4000 people to the State institutions at an average cost of $36.04 per person per day, the savings to the State would be approximately $34.7 million.

After the letter was issued, a long series of meetings were held with State officials, during which not one person could justify moving a person from a $36 per day setting into a $5.60 per day setting and expect better care and living conditions than what is found at the State mental hospitals.

In January of 1975, our rate was increased to $7.30 per day and in July it is to go to $9.00 per day. We accepted this as a temporary increase and are struggling to stay in business even though our rate is still inadequate.

I would like to mention at this time that the rate in New York State is $375 a month; in Illinois, it is $395 per month; and in California, it is close to $400

a month for providing the same care for which we are now receiving $218 a month.

Senate Bill 3025 has been introduced that would define us as a long-term health care facility, change our name to residential health care facilities and set up a mechanism for annual negotiation of rates. Senator Maressa has the undivided support of the Association for this important bill.

It is also understood that the Department of Institutions and Agencies is preparing legislation that would remove us from the Department of Health and place us under their jurisdiction. It is presently the Department of Health who regulates us, while the Department of Institutions and Agencies sets the rates.

Passage of Department of Institutions and Agencies' proposed legislation would only duplicate those regulations and controls already in effect, that is, Health Care Facilities Planning Act, 1971, Chapters 136 and 138. We operate health care facilities that provide a much needed health care service. To take us out of the Department of Health would only be a step backwards.

I will skip over the representation. It is really not that important at this time.

To date we have attempted, through the courts, to force the State to take two actions that the Association felt would be beneficial to our industry and to the people who reside in our facilities.

The first case was aimed at preventing county and local welfare boards from placing people discharged from State institutions into unlicensed homes; that is, those residences not licensed by the State Department of Health. It is common knowledge and practice that the parties responsible for placing people from State institutions into the community make no differentiation between licensed and unlicensed homes; that is, the first bed that

is available for the person ---

SENATOR FAY: Is that covered in Senator Maressa's bill?

MR. KENTER: I am not familiar with that piece of legislation. I would hope so.

SENATOR FAY: If it isn't, my first suggestion to you would be, as long as you have a bill in, that you might as well touch all the bases. Anything that you consider that important, that has a high priority, it would be very simple for Senator Maressa to amend the bill now while it is in Committee.

MR. KENTER: I think Assemblyman Codey said he was going to introduce legislation, covering different areas. I am not sure.

SENATOR FAY: Again, this is going to be your responsibility. It is only my suggestion to you that it might be self-defeating if you start running two or three different bills in different houses. If you could cover the subject completely in one or two bills at the very most, have Assemblyman Codey put both bills in over here or have Senator Maressa put both bills in the other House, then work together on them with your Association, it might be better.

MR. KENTER: Thank you.

I will skip some of this. A study was made that indicated that of all the readmissions to State institutions, only 2 percent were from licensed sheltered care facilities; the remainder came from unlicensed homes, family situations, etc.

The second case involved the issue of whether or not the Department of Health could implement new rules and regulations requiring tremendous expenditures without increasing the per diem rate to cover additional operating costs. I would like to state at this time that this Association does not and will not object to the implementation of rules and regulations that benefit the residents

who a r e in our facilities and improve their care. But there must be some mechanism for increasing the rates to cover increased costs.

The next section is just a review of the budget recommendations and the capital needs statement by the Department of Institutions and Agencies. It shows two conflicting aims within those two statements. I will skip that.

SENATOR FAY: Mr. Kenter, do you represent most of the people in this field?

MR. KENTER: We represent 90 homes. We represent about 45 percent of the licensed facilities in the State.

SENATOR FAY: Do you operate a facility yourself?

MR. KENTER: Yes, I do.

SENATOR FAY: Where is that?

MR. KENTER: That is located in Plainfield.

ASSEMBLYMAN GARRUBBO: What is the name of it?

MR. KENTER: The name of the facility is the Older Americans. It is in Plainfield.

SENATOR FAY: I would like to say this, Mr. Kenter: Obviously at a first hearing like this, we never have a time schedule and we never, never know how long it is going to go on, as you found out. But I would like to have you come back, if you would, some other day, not necessarily at one of our public hearings, but one of our other meetings, to go into this in more detail, when we start putting the whole picture together, so you will have even more of a major input than you are having right now.

It is a very important part of this problem and we would like to have you come back again some other day.

ASSEMBLYMAN GARRUBBO: It is an often over-looked area of the nursing home problem.

MR. KENTER: First of all, it would be my pleasure to come back and give the Commission whatever assistance we could. But it is just a feeling, through newspaper releases, that we have no guidelines, that we have no rules and regulations, that we are not inspected, and that we have just "warehouses for people." This is just not the case. Admittedly, as in every segment of every industry, there are a few bad ones that do damage to the whole. But we feel that we are doing a job and should be recognized for what we are doing, and the public and especially this Commission should ---

SENATOR FAY: It is an overlooked area and we do have it as a high priority. From your report, one can see how badly it has been overlooked, just looking at the figures alone.

MR. KENTER: Right.

SENATOR FAY: There is a need for clarification. And, obviously, there is a need to get rid of those warehouses, which affect your image. It is our responsibility to move in and do this and clean the others up.

MR. KENTER: We agree completely.

May I just read my recommendations for the record?

SENATOR FAY: Certainly.

MR. KENTER: This Association feels that the following recommendations will benefit the health care industry, the State in the savings of dollars, and, most important, result in better treatment and care of the individual:

A. Passage of S 3025.

B. Ultimately sheltered care facilities should operate on a "cost plus" system of reimbursement rather than a flat rate. This way regulatory agencies will be able to monitor the actual operating costs more closely and the facility will be insured of a reasonable profit.

Thus, there will be no excuse for not complying with the Manual; in other words, full implementation of the Health Care Facilities Planning Act.

C. A statewide system of uniform after care and services provided by county and local welfare agencies. Programs in effect now range from excellent to non-existent and the quality of services available varies widely.

D. Put an end to the discriminatory practices that affect the residents in our facilities. For example, on May 1, 1975, a "co-payment program" goes into effect where people who are eligible for Medicaid will have to contribute 50 cents for each prescription that has to be filled. If a person has four prescriptions per month to be filled, this additional expense represents about 10 percent of his disposable income. But if this person resided in a nursing home, there would be no additional monies required from his disposable income to pay for his prescriptions. Residents in sheltered care facilities should be entitled to the same benefits as those people in other health care facilities.

E. Persons sent to us directly from State mental hospitals should be sent to our facilities with a brief case history so that we may be aware of his problems. For example, there was a ---

ASSEMBLYMAN GARRUBBO: You don't get that?

MR. KENTER: No, sir. Some institutions do and some don't. That was the cause of that fire down in South Jersey about two years ago where people were killed. Afterwards, it was found out this man had been in and out of institutions for a period of time with a case history of pyromania and he was sent to the shelter care home without any backup papers whatsoever.

SENATOR FAY: That is almost indictable.

MR. KENTER: F. The practice of placing people in unlicensed homes should be ended.

As I have done in the past, I am offering the expertise that this Association and its members have in planning for the future. We freely admit that there is a need for change, but being on the receiving end of all decisions, we must be able to work with various agencies and legislators.

In conclusion, we, as an industry, are the first to admit that we need upgrading and more professionalism instilled in our operations. We operate in daily violation of the law with the low compensation we are receiving for operating our facilities. We have to make cuts somewhere to stay in business. We operate proprietary facilities that for years have been subsidizing the State in the care of its indigent people.

Again, as previously mentioned, we, as an Association, plead for the opportunity to work with various agencies to implement changes that will create a more viable atmosphere for a person to live in and for an operator to manage. We do not want to operate good facilities - we want to operate the best. And we are willing to work with any interested agency at any time to achieve this goal.

(Prepared statement of Alan Kenter begins on page 29x in the Appendix.)

SENATOR FAY: Thank you very much.

Just one announcement for the record, the next public hearing will be May 2nd. At this point, the scheduled witnesses are: the SCI people, Public Advocate Stanley Van Ness will testify and representatives of the New Jersey Nursing Home Association.

I am assigning to a subcommittee on alternate care Senator Anne Martindell and Assemblyman Clifford Snedeker.

The hearing is adjourned.

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Statement

on

Long-Term Health Care Services & Facilities

Presented

to

New Jersey Nursing Home Investigation Commission

By

Joanne E. Finley, M.D., M.P.H.
State Commissioner of Health

April 16, 1975

I. INTRODUCTION: Meeting the Long-Term Care Needs of New Jersey's Citizens

II. The Role of the New Jersey Department of Health in assuring Safe and Effective Long-Term Care

A. Setting Standards, Licensing and Inspections

B. The issue of unannounced inspections

C. Problems found in Long-Term Care Facilities and Programs

D. Enforcement Policies

E. Staffing Problems

III. Roles and Relationships with other Departments of State Government

IV. Summary and Some Questions On the Outcomes of Commissions and Investigations

I. Introduction

I wish to congratulate this Commission. I am particularly impressed that the resolution by which you were established cites your responsibilities as going beyond nursing homes as bricks and mortar per/se, and includes a review of "the adequacy of such facilities to the social needs of the State."

I say this particularly because I feel that the real issue is: are we meeting the long term care needs of New Jersey's citizens?

Some would say that nursing homes have become the whipping boy for a dimly perceived realization that something is amiss, that we have lost our sense of direction and that we have failed to involve the elderly, the chronically ill and their families in planning for what best meets their needs. Yet it was well intentioned social policy, backed by the financial expressions of Medicare and Medicaid that spurred the over emphasis in this society on the physical plants we call nursing homes. For a time they became the great panacea particularly in the care of the aged.

As so often, when one thing and one thing only is seized upon by Americans as the "ultimate solution," the public fervor and especially the public money inevitably brings abuses. Abuses bring regulation and it often becomes the lot of State agencies to implement these regulations. And we become so busy correcting abuses and punishing abusers, while social policy may have encouraged them in the first place, that we lose our perspective. We forget to look beneath the surface and ask, "What is the better way--What should we have done instead?"

I will attempt to spell out in considerable detail the role of the Health Department as a regulator of long term care facilities, and the problems we find. But I would like to keep constantly before us as my theme the fact that your Commission, and the responsible Executive Departments of the State should have the courage to start all over again as developers of the programs our older citizens, and our chronically ill really need and want in their communities.

There are many alternatives to Nursing Homes and institutional care that would probably be less costly to the public purse and more rehabilitative in their functions. There is a real need in New Jersey to develop coordinated home care services. There are many cities particularly in which fascinating complexes have been built which include housing for the elderly with recreation, socialization, nearby acute care, and "well-elderly" facilities for health maintenance; meals-on-wheels, friendly visitors, homemaker and available home nursing services are woven in so that older persons, even with some handicaps, can be kept in the mainstream.

I for one, much prefer the role of a developer and planner to that of policewoman over a system that may, at least in part, be uncorrectable.

II. The Role Of The New Jersey Department of Health In Assuring Safe And Effective Long-Term Care

Long-term care is provided in a variety of health facilities. Aside from the nursing home per se, there are long-term care units in Special Hospitals, General Hospitals, Intermediate Care Facilitie Homes for the Aged, etc. Strictly speaking, there are 212 Nursing Homes in the State, of which 202 are proprietary. To arrive at a better understanding of the total picture of institutional long-term care the subject of "participation" must be introduced.

Many health facilities have entered into agreements to participate in Federal (Medicare) and Federal/State (Medicaid) cost reimbursement programs. Some facilities participate in Medicare (Title 18) only; some participate in Medicaid (Title 19) only; some participare in both, and some do not participate at all. As a condition of participation the facility must agree to comply with all applicable Federal and State regulations and standards. In the administration of these programs a designated State agency, in conjunction with the Federal government, evaluates the performance of participating facilities which results in a "certification" decision as to whether the facility is in compliance. The designate State agency for the Medicare Program is the Department of Health and for the Medicaid Program it is the Department of Institutions and Agencies. The interaction and coordination between the two Departments will be discussed later.

Noting that participation status affects our inspection and licensing procedures for health facilities, the following chart categorizes the various types of facilities in which long-term care services are provided and also specifies the number of those facilities that participate in government-sponsored reimbursement programs.

Facility	Title 18	Title 19	Title 18 & 19	Non-Participating	Total
Nursing Home (SNF)	5	62	98	47	212
ICF	-	10	-	7	17
Home for the Aged (SNF)	-	17	10	19	46
Gov't. Med. Inst.	-	12	1	-	13
Special Hospital	1	1	6	-	8
General Hospital	3	-	3	8	14
Mental Retardation	-	6	-	-	6
Totals	9	108	118	81	316

When discussing nursing homes in the generic sense, only the first three categories of facilities are usually considered. The Intermediate Care Facility (ICF) is, in actuality, a nursing home in all respects except that, the required intensity of nursing care (measured in terms of nursing hours per patient per day) is less than that in a nursing home. In nursing homes, which are called Skilled Nursing Facilities (SNF), the requirement is 2.75 nursing hours per patient per day. In ICF's the patients are evaluated as requiring either Level "A" care (2.5 hours) or Level "B" care (1.25 hours). Based upon a recent pilot study the Health Department now permits facilities to house and mix patients with differing nursing care needs. No longer are separate facilities, or identifiable units within facilities, necessary in order to segregate patients requiring disparate levels of care. This policy, promulgated as a regulation, is thus in conformity with health planning concepts and procedures which combines the community need for SNF and ICF patient beds and establishes a composite need for long-term care beds.

Homes for the Aged are "combination" facilities which are usually sponsored by religious or fraternal groups. One section of the Home will house residential beds for the elderly and these beds are classified as Sheltered Care Boarding Home beds. There is also an infirmary section in the Home which provides skilled nursing care and this section is classified as a SNF.

A. Setting Standards, Licensing and Inspection

Under the authority of the "Health Care Facilities Planning Act" of 1971, the Department of Health is responsible for the inspection and licensure of all health care facilities in the State. A State license is valid for one year and the minimum surveillance requirement is an annual inspection. However, in the case of those facilities which participate in Title 18 and Title 19 (or both) a follow-up inspection visit is mandatory if the annual inspection reveals any deficiency whatsoever. Although such follow-up visits are not required for non-participating facilities at least one follow-up visit will normally be made depending upon the severity and extent of the deficiencies to be corrected.

For all facilities, regardless of their participation status, the inspection teams from the Health Department may conduct several additional on-site visits if the cited deficiencies are serious enough to warrant extensive monitoring of the corrective actions. A facility will also be visited in response to a written complaint filed with the Department. Although such complaints were investigated in the past by one or more members of a nursing home inspection team this function has recently been assigned to a special surveillance team which may make an unannounced investigation visit at any time of the day or night and on any day of the week. This team devotes all of its time to both complaint visits and to spot checks on "problem" facilities.

As can be seen from the foregoing, the total number of facility inspections will vary from year to year. During 1974 approximately 700 inspection visits to nursing care facilities were conducted.

B. The Issue of Unannounced Inspections

As shown previously, most of the long-term care facilities in New Jersey participate in the Medicaid and Medicare Programs. Therefore, the Health Department's inspection protocol is partly based on Federal requirements and guidelines. A Federal regulation states that "regular scheduled surveys should not be conducted without advance notice to the facility." To insure equitable and fair treatment of all health care facilities, the announced visit policy has been applied by the Health Department to all facilities, whether or not they are participants in government-sponsored reimbursement programs. However, as implemented by the Department, the announcement policy applies only to the annual inspection visit to a facility. All other re-visits, for follow-up monitoring purposes, and all spot checks are made on an unannounced basis.

The Federal position on announced visits is that "advance notice enables the facility's administrative personnel to be present at the survey and to assemble materials the surveyor will ask to see." My personal philosophy is that, in most respects, an unannounced visit is more desirable and more indicative of the facility's operations. There are some portions of an inspection (the physical plant evaluation, for instance) which are not affected by an advance notice. Some facilities employ part-time consulting pharmacists who may not be on the premises for an unannounced visit.

Thus, although we probably cannot implement a total and universal policy of unannounced inspections we are presently moving toward a sharp decrease in the time of advance notice. We are also conferring with the Federal government to develop a modified version of the announced visit which will satisfy the legitimate concerns of HEW and preserve the benefits of an unannounced inspection as well.

(NOTE: Since giving this testimony, the federal government has dropped its requirement for announcing inspections, and the Department is now making all inspections on an unannounced basis.)

C. Problems Found in Long-Term Care Facilities and Programs

During the course of an inspection visit a facility is evaluated against the regulations specified in a manual of standards. The areas of evaluation include: nursing coverage; medical records; handling of drugs; the physical structure; housekeeping; patient diets; etc.

While not all nursing care facilities are cited for the same deficiencies (violations) there are several types of deficiencies which commonly occur. Among those deficiencies which are listed below there are some (check-marked) which are considered most serious and warrant the special attention of the facility for rapid corrective action. Depending upon the severity and duration of the deficiencies, however, the Department of Health may also levy a punitive fine, reduce the license to a provisional (probationary) status, or proceed with a license revocation order against the facility.

There are also some deficiencies associated with the Life Safety Code which are, essentially, non-correctable and if waivers cannot be granted in recognition of an "equivalent" fire protective status the facility will lose its license.

a) Nursing Services

- ✓ - insufficient nursing coverage for patient care
- inadequate records of treatments and administration of medications
- nursing care plans (lack of short and long term goals)

b) Pharmacy

- ✓ - "stop order" policies for continuance (discontinuance or modification) of medications not observed by attending physician
- inadequate pharmacist review and documentation of drug regimens and monthly report to Administrator

c) Dietary and Housekeeping

- menu planning records inadequate
- amount of food portions and nutritional content inadequate
- ✓ - patient special diets not observed

- lack of general cleanliness and sterilization (kitchens, equipment)

d) Physician Services

- lack of countersigning of treatment and medication orders
- non-specific physical therapy orders and therapist progress notes not kept current
- ✓ - physician visits to patients not occurring within required time limit
- patient physical exam not done by physician within required time limit

e) Physical Plant & Life Safety Code

- ✓ - inadequate fire resistivity of the building structure
- lack of sprinkler system throughout entire facility
- ✓ - inadequate fire alarm system
- inadequate emergency power system
- inadequately fire-protected means of egress from facility
- ✓ - inadequate smoke barrier compartmentation of facility
- insufficient room size to accommodate patient beds
- ✓ - lack of nurse call system
- lack of isolation room with proper toilet and lavatory facilities

Examples of Recent Enforcement Actions

Over the past two months the Department of Health has taken action against several nursing homes and boarding homes which were found to have serious deficiencies as reported by the inspection teams.

During this time period:

1. Five (5) nursing homes and one (1) boarding home were ordered to show cause why their facilities should not have their license revoked.

2. Three (3) nursing homes and one (1) home for the aged had their licenses reduced to a provisional status for a 90 day probationary period during which time corrective actions must be taken to prevent a revocation order.

3. One (1) nursing home was assessed a penalty of $1000 for willful falsification of records to conceal inadequate nursing coverage.

4. One (1) nursing home and two (2) boarding homes were ordered to cease admitting new residents and arrange for the orderly transfer of present residents to other health facilities.

Some of the reasons for taking these actions are:

a) no policies in the facility for the control of communicable diseases

b) a serious shortage of nursing care hours

c) the food service did not have the full-time supervision of a qualified dietitian and had numerous deficiencies in sanitation

d) medications were not given as ordered

e) structural deficiencies prevented compliance with the Life Safety Code

The Department of Health has issued press releases to publicize its enforcement actions and copies of these releases specifying the affected facilities and their deficiencies are attached to this document.

Also attached is a brief description, based upon State law, of the procedures by which the Department of Health:

a) issues a temporary permit for the intial operation of a health care facility, and may then proceed to the issuance of a full license

b) reduces a full license to the provisional (probationary) status and may then proceed to restoring the license to its original status or seek a revocation order.

D. Enforcement Policies

The administration of licensure enforcement procedures can be viewed in terms of previous, current and future development of policy. Prior to my appointment as State Commissioner of Health the enforcement policy could be characterized as lenient and haphazard. Although some nursing facilities were induced to cease operations due to serious deficiencies, some poorly-run homes were not closely monitored at all, while other facilities were habitually entreated to upgrade their operations rather than being forced to close. Ostensibly, the basic rationale for this policy was a sincere concern for the patients who would have had to be transferred to alternate nursing homes and suffer the trauma of such transfer. However, by merely promoting the improvement of facilities the Department's posture was perceived as being lax in demanding compliance with licensure regulations. Only when a serious deficiency was revealed or shown to be long-standing, was a concerted effort made to insist on corrective action with the alternative being license revocation. In this context, then, the Department gave the appearance of being both inconsistent and irresolute in its enforcement of regulations.

The current enforcement policy of the Department is certainly cognizant of patient needs and at the same time more vigorous, firm and consistent in dealing with licensure violations. The nursing facilities are being made aware that deficient and inadequate service to the patients will not be tolerated. The Department believes that its recent enforcement efforts including, punitive fines, reductions in licensure status and proceedings to revoke licenses, are resulting in improved patient care and an increased willingness on the part of facilities to "come around" and correct deficiencies more rapidly than in the past. Parenthetically, it has not taken any new legislation or regulation to institute this policy. Rather, by using the tools (regulations) at hand, significant progress is being made.

Further improvements in the enforcement area to be achieved in the future will be based upon an improved administrative control of the inspection and licensing functions. The need for organizational and procedural changes in these key areas was strongly endorsed in an internal management study report released in mid-winter. Based upon the report's recommendations, the ongoing reorganization of the (former) Division of Health Facilities has resulted in an increased managerial strength and a clear chain of command to carry forward the Department's enforcement policy. Currently under consideration and development is the concept of grading

the various types of deficiencies according to a scale of severity. According to such a grading system a facility can be evaluated and a rational and consistent decision can be made as to what corrective action (including license revocation) the Department will pursue. Also to be considered is the concept of keying the facility's reimbursement rate to its inspection and licensure status.

E. Staffing Problems

In order for the Department of Health to improve its capability of performing the inspection/licensing functions three types of conditions, all inherited from the previous administration, must be overcome.

The first concerns the sheer numbers of available professional staff. In my judgement, to obtain a more rapid and thorough compliance with licensure regulations requires an increased surveillance effort, with more elaborate follow-up, and an emphasis on the policy of unannounced visits. Due to the already existing work-load the size of the present staff hinders the Department from achieving these objectives.

Secondly, there is an inherent reluctance on the part of the inspection process to take a forceful "hard-line" with violators. Unfortunately, this attitude has been impressed upon the professional staff over the many past years of lenient administration and policy enforcement. The staff is not to be faulted as they are extremely competent and conscientious in the performance of their duties. Through the guidance of the newly established managerial leadership this obstacle to firm, fair and consistent enforcement will be easily rectified.

The third difficulty to be overcome is the insufficiency of staff time that can be applied to the task of upgrading and improving the various regulations and standards upon which the inspection and licensing functions are based. It is my conviction that the Department must, of necessity, continually evaluate and modify its licensure standards in light of the changing modalities, needs and priorities in the provision of long-term health care services for the community.

It is easily recognized, then, that the continued severity of budgetary constraints will hamper the Department's efforts to enhance the quality and proficiency of its inspection and licensing activities.

III. Roles and Relationships with Other Departments of State Government

The Department of Health and the Department of Institutions and Agencies must necessarily coordinate their activities since both agencies regulate different aspects of health facility operations. The Health Department, being responsible for licensing all health facilities as required by State law, inspects all long-term care facilities according to Federal and State standards.

For those facilities which participate solely in the Medicaid Program the Health Department forwards the results of the inspection to the Department of I & A. Also included is the Health Department's assessment (certification recommendation) as to whether the facility is satisfactorily in compliance with Federal and State requirements to warrant acceptance (certification) in the Medicaid Program and be eligible for cost reimbursement.

The Department of I & A makes the certification decision based upon the inspection materials supplied by the Health Department. However, the Dept. of I & A does not make the certification decision if the Dept. of Health has requested a waiver of Life Safety Code requirements for a facility. In these instances only the Federal government (HEW) makes the final ruling on Medicaid certification. The Health Dept. is notified of all certification decisions via a copy of the certification letter from the Dept. of I & A to the facility delineating the time period of the Medicaid Program participation agreement, the number of patient beds certified and the levels of care to be provided. In cases where the Dept. of I & A disagrees with the recommendations of the Health Dept. concerning certification an inter-Department meeting is held (for clarification purposes) before a final certification decision is made.

For those facilities which participate in both the Medicaid and Medicare Programs the Health Dept. forwards all inspection results directly to the HEW Regional Office (in New York) together with a certification recommendation. Thereupon, HEW makes the certification decision and notifies the Health Dept. via a copy of a certification letter to the facility specifying the terms of the participation agreement. The Health Dept., in turn, then notifies the Dept. of I & A of certification decision made by HEW.

Some additional coordination between the Department of Health and the Department of I & A is necessary in the area of patient care assessment. The Health Department inspects all facilities in terms of the nursing care program, housekeeping, sanitation, Life Safety Code, etc., while the Department of I & A surveys (evaluates) Medicaid patients in long term care facilities and classifies such patients as to their required level of care (intensity of nursing coverage). The Department of I & A conducts what is known as a

Periodic Medical Review (PMR) which involves numerous re-visits to participating Medicaid facilities to regularly re-evaluate patients as to their proper level of care required. The patient evaluation function, however, seems to involve a patient care assessment and a critique of the facility's nursing care program. In this regard there exists an area of overlap with the inspection function of the Health Department. The two Departments are proceeding to resolve this matter to achieve a more complementary set of activities.

IV. Summary and Some Recommendations to the Commission

General Conclusions:

1) There are some excellent nursing homes in the State of New Jersey, and some that border on the unsafe and unfit.

2) Currently the Department of Health does much of its regulating after-the-fact. The Nursing Homes are here and we have stepped up our vigilance over those that do not really care for patients well, or those which are patently unsafe--particularly from fire hazards. After fair due process, we are closing homes which cannot or will not correct deficiencies. Working closely with the Medicaid program, we have been able to do this without jeopardizing patients' access to better beds or working undue hardships on families.

3) The very small homes often have special problems particularly if they are in violation of Life Safety Code fire resistive standards. Many of them also exhibit problems in staffing with properly qualified nursing care. In trying to chose between the necessary safety and welfare of patients and the obvious desirability of warm and home-like surroundings, I would rather see DCA, I & A and Health work together on new concepts in group housing for the elderly with firm and proper arrangements for access to medical and nursing care, than to try to perpetuate "homes" as nursing facilities. Some of the lovely older homes which do offer tender concern might very well be developed into safe foster homes, providing nearby community hospitals would work out full written arrangements to "be the doctor and the nurse" when needed.

However, such arrangements may have a reimbursement problem with which the State should concern itself.

4) I have stated my firm preference for community based and home related services over institutionalization, wherever possible. New Jersey needs to give much more planning and budgetary consideration to such alternative systems.

5) I have questioned the possibility of administrative wastefulness and overlap when two agencies are both involved in some aspects of Nursing Home inspection.

Recommendations to the Commission:

1) Broaden the scope of your investigations as much as possible. Safety, sanitation, and the best possible conditions of care in those nursing homes that exist must be one focus.

But you should always be asking--what systems really would best meet the needs of the elderly (and the chronically ill)?

2) The costs of long-term care, and the correction of abuses that lead to high costs, must also be one of your concerns. If this leads you to a sense of additional responsibilities for a State agency, such as audits, surveillance of transfers of ownership, rules about depreciation allowances, etc., then the Legislature must permit in the way it funds Departments, budget for qualified staffs to do these things.

3) The elderly and the families of patients in long-term care facilities should be involved in all planning and delineation of need.

4) There should be more attention given, through legislation and appropriations if necessary, to development of special housing for the elderly with health care services built in. Equally, as there is in the coastal areas, there should be legislated prohibitions against private development for these populations with special needs, unless there are assurances of certain services including health care.

5) There should be statutory authority for vigorous crackdowns on the owners and governors of facilities where there is an actual defrauding of the public--whether it be Medicaid, or the private payor who must make extra deposits of his assets, or whose Social Security checks are taken from him.

STATEMENT OF WILLIAM J. JONES

Mr. Chairman, Members of the Commission, my name is William J. Jones. At present I am the Superintendent of Meadowview Hospital in Secaucus, New Jersey. Prior to my present appointment, I was the Director of the Division of Medical Assistance and Health Services, commonly referred to as Medicaid, in the Department of Institutions and Agencies. I held this position from May 1971 to January 1975. From January 1969 to the time of my appointment as Division Director I was the Chief Medical Care Administrator within the Division and served as Acting Director from November 1970 to May 1971 when appointed Director.

I thank you for this opportunity to testify on Medicaid's role and Nursing Homes in New Jersey. Further I hope your Commission's work will result in meaningful change.

I believe it only proper to open my remarks by stating that, in my opinion, the greatest majority of our skilled nursing facilities and intermediate care facilities are doing a commendable job. The few who abuse the patients and the taxpapers through misuse of programs should not be allowed to denigrate the fine work done by the majority. Further, I believe, we in New Jersey can be proud of our Medicaid accomplishments. However, in spite of these accomplishments there are problems and anomalies which have detracted from patient care and yes, there are abuses. These abuses have been committed not only by providers but also by the bureaucrats and families of patients. I will attempt to identify for you some of these areas in my later remarks.

At this point permit me to express a few remarks about my philosophy which I think is germane to the questions before this honorable body. Many of the problems and the dilemma of Medicaid in its stormy history derive from the fact that it too often has been viewed by many as simply an extension of welfare. This view has created an image that Medicaid is simply a conduit to pay taxpayers' monies to providers. As the former Director of the Medicaid Program I reject that concept.

Medicaid with its 400 million plus dollars can and should be a catalyst for improving the quantity and quality of health care in New Jersey. The spin-off values should reflect in concurrent improvements in the private sector.

However, the purchase of service by a public agency from the private sector creates special problems, not the least of which is the assumption that the private sector itself is efficient. Certainly the experience of the New Jersey Medicaid Program gives little ground for optimism that the health care delivery system, including those regulatory agencies responsible for health care, are efficient. It must be recognized that any vendor payment system cannot exist without adequate controls over quality, costs, as well as availability and organization of services. The New Jersey Medicaid Program attempted to accomplish these goals. However, the dilemma we faced was that the responsibilities, the authority and perhaps the will to accomplish the objectives for the public good are dispersed and diffused in this State. The Health Department, the Department of Institutions and Agencies, the Insurance Department, the fire marshall's office, the treasurer's office, the Federal Government, et. al., are busily engaged in making rules and regulations and determining reimbursement without due regard of one to the other. A current example is the Medicaid Program's attempt to install a copayment for prescription drugs for Medicaid recipients. I presume this is an attempt to "save money". On the other hand facilities who are required to maintain comprehensive care and provide the prescribed medications under rules and regulations will be forced to cut service, raise more money or distort the system to stay in business. Another example is a legislative attempt to do away with "exempt physicians" and require only licensed physicians in medical facilities. Sounds like a great idea until one asks where will the physicians be found and equally important, will the paying agencies reimburse or have the ability to reimburse for the additional cost. The answer is, there aren't enough physicians available now and regulatory agencies in New Jersey traditionally have not recognized reimbursement requirements whenever they impose additional standards. Consequently all groups must share the responsiblity for many of the problems in our health care facilities. If anyone questions this premise I need only refer them to a recent discussion revolving around the passage of a bill in the legislature which reportedly would assure patients' rights. The news media reported that some people were concerned that passage of the bill would require the state institutions to meet the life safety code of 1967 and the money is not available. Do we say to a Commissioner, who fervently desires to provide the best care possible, you are responsible to meet all standards but we have no money. Worse yet, do we come back in a year or two and criticize her because she didn't do what we didn't give her the money to do? Do we say we want quality in community facilities but rationalize that we don't have to provide the tools -- the money -- for state facilities. This is one example of my premise.

Medicaid deals with the private and public health sectors, where the other programs themselves are insufficient. Medicare, for example, does not really entitle the aged to comprehensive health care -- it presently covers only about 40% of the health expenditures of the aged, and Medicaid is expected to overcome the deficiency. Similarly, if private health insurance were adequately covering the working population we wouldn't need all the Medicaid coverage we have to provide. Thus Medicaid is a reflection of broader deficiencies in health care and social problems.

Mr. Chairman, you and your Commission have a great opportunity to define, clarify and implement a cohesive, effective system in New Jersey through your work. I said opportunity where I should have said mandate. In my opinion, it's time to stop the headline seeking of some individuals who pursue sensation but cannot offer proof. It's time to weed out the cancer of abuse and restore a healthy system, but most of all it's time to stop the innumerable outbursts that stir controversy, then subside without action or change only to revive at a later date to start the circle again. The public requires action. You, sir, can give it to them.

Since Medicaid and the health and medical systems are very complicated I have thought long and hard about an approach to my statement today which would prevent a long dissertation, yet give you some meaningful points of consideration. It is my considered opinion that I can accomplish this by commenting on several points presented lately in the press and on television. Second, to be specific on points of abuse, quality of care, and recommendations for your consideration. With your permission, Mr. Chairman, I will proceed to follow this agenda.

Political Influence and/or Interference

New York Assemblyman Stein recently stated on public television that the reason abuses continued in New York Nursing Homes was because of political influence or interference. I wish to unequivocally state here and now that during my tenure as Director of the New Jersey Medicaid Program no political interference was attempted nor would it be accepted or tolerated. On three occasions I received telephone calls in regard to contemplated action. One was where a former State Senator telephoned me in reference to a home under investigation. He stated that his only interest was for me to know that he believed the facility to be a good one and of his interest. I replied that I was sure he didn't understand the extent of the investigation, and second I would be pleased to see that his

interest was made known to the investigators and in any hearing forthcoming. I never before nor since have heard from this gentleman. The second was in the case of a large facility operated by an order of nuns who were threatened by an order of the Health Department for decertification due to the fact the building didn't meet life safety, being a wooden structure. Members of the former Governor's staff on several occasions called asking that I do all I could to assist. I saw nothing wrong in this and didn't consider this anything but part of the Governor's office function. In fact members of our Congressional delegation also called asking for and offering assistance in this matter. I shared their concern that the work done by the dedicated nuns would be negated by this order. In fact the good sisters had already raised the money for rebuilding and expected new housing in approximately one year. This situation was saved by arranging for installation of a sprinkler system and smoke detectors at considerable cost to the Order. A hearing was held and a waiver given to the home. I in no way would consider this political interference. In fact I believe an injustice would have been committed had not Medicaid assisted. The last incident occurred during this administration whereby a member of the Governor's staff was allegedly engaged in assisting a home wherein the home had a labor strike and Medicaid was removing patients to other facilities because of reduced staffing. In neither of the last two situations were there any improprieties, coercion, interference or any other term for suggesting an attempt to influence decisions. I cannot speak for other programs but I can say I know of no evidence that suggests they had political influence or interference. But they can speak for themselves.

Profit vs. Non-Profit Facilities

The news media has quoted New York and New Jersey Officials as advocating the liquidation, if you will, of so called profit making facilities. This I consider the height of parvenuism. Consider, if you will, that almost 75% of the facilities providing beds for Medicaid patients are profit homes. How will you organize non-profit organizations to replace them? Second, many non-profit organizations have employees who are paid more than the Governor of this sovereign state, plus automobiles, country club fees, etc. At this rate who wouldn't want to be a so-called non-profit organization. Third, profit making facilities pay taxes, non-profit generally do not. Fourth, government facilities are non-profit. Res ipsa loquitur. Last, some non-profit facilities are also poor. On this point, I refer you to Ms. Jean Nassau, authoress of a recently published book on "How to Choose a Nursing Home", and former New Jersey Nursing Home administrator. She recently announced on a talk show on W.O.R. that "the worst facility

for whom she worked was a non-profit, religiously oriented home while the best was a for profit facility." Jean Nassau is not noted for giving fudge answers and does know of what she speaks.

In my opinion this much publicized approach and suggested solution should be given little consideration.

S.C.I. Interim Report

The S.C.I. interim report, as reported by the press, makes much ado over imputed rental and the fact that New Jersey allegedly copied in toto the New York system. It questions why 10% was added to New York figures to establish a rate for New Jersey; also, the fact that the Nursing Home Association had a committee which discussed Medicaid policy with members of the Division. Sounds very omnious. Omnious indeed. The fact is that New York reimburses nursing homes on a reasonable cost basis. New Jersey does not so we didn't copy verbatim. If we went New York's route we would have spent millions more than we did. The simple fact is that the 10% adjustment was made by using the medical component of the consumer price index to reflect New Jersey's situation. (As an aside, others could argue that we decreased the figures by 10% rather than increased. I guess the interpretation depends on whose ox is being gored.)

It appears that all agree that the imputed rental was desirous for the purpose of keeping the smaller homes in the Medicaid Program. Well, Mr. Chairman, that's exactly the point. New Jersey does not nor did we have anything but a preponderance of smaller homes to care for the Medicaid patient. The larger and newer homes were for private pay and Medicare patients. They catered to New Jerseyites and thousands of New Yorkers who placed their relatives in New Jersey homes because these homes were less expensive and better than New York. Even today it is estimated that there are over 2,000 New York residents in New Jersey homes and over 600 New York City Medicaid patients in New Jersey facilities.

However, the basic question is should ~~computed~~ IMPUTED rental have been allowed in the program in the first instance? In making our decision the following facts were considered: (1) The Regional office of H.E.W. recommended we consider the New York State System of reimbursement, which they claimed at that time was a good one. Remember, New York had been operating a Medicaid Program for four years. (2) Because of increased standards we attempted to provide sufficient reimbursement to the smaller and non-profit homes who were the providers to the majority of Medicaid recipients. (3) We attempted to prevent the sale-resale, lease and re-lease phenomena. This we felt was accomplished by (a) imputed rental, (b) administrative ceiling and (c) the Certificate of Need law which by language prohibited sale of the property unless the application was approved. So the phenomenon of sale-resale, which occurred in New York, was theoretically impossible or of no advantage in New Jersey, provided the Department of Health followed the law. The imputed rental therefore served a valuable purpose in aiding the smaller homes to meet standards and remain viable institutions.

The ceiling imposed on Medicaid reimbursement provided no advantage. Consequently the imputed rental served the smaller and religious homes who were primarily the Medicaid providers.

With reference to meetings with the Nursing Home Association even a cursory review of federal regulations would reveal that the Medicaid Program is required to have a Medical Assistance Committee composed of representatives of providers, recipients and citizens. New Jersey also established technical assistance advisory committees for the expressed purpose of obtaining input and advice on technical matters. The Nursing Home Associations enjoyed no special privilege.

Also, the press reports of the S.C.I. report left me with the impression that the complexity of the Medicaid Program, particularly the federal regulations, are little understood by the S.C.I. For example, the regulations require that reimbursement be such as to enlist the largest number of providers. Our reimbursement rates enlist approximately 75~~85~~%. To cut back will mean someone will have to find other facilities for Medicaid patients.

My opinion of this interim report is that it is selfserving and does not reflect the realities of the Medicaid Program.

Quality of Care

The Division of Medical Assistance, as I stated before, did more than just pay bills. We constantly reviewed and evaluated our program. A substantial effort was directed toward nursing homes. In May of 1973 we published a report on three years of our experience. This report was developed by using sound research principles and scientific methodology. I highly recommend you obtain copies. This report is entitled, "An Examination of Nursing Homes Under the New Jersey Medicaid Program, January 1, 1970 - December 31, 1972".

I would like to synopsize sections of this study. The outcome of this evaluation of the homes was generally very favorable."More than half (56.1%) of the homes were found to be in the "Good" or "Excellent" category. Thirty point six (30.6) percent were classified as "Average". Only 13.3% were found to be "Poor"."

"It is conceded that long term care facilities rated as "Poor" in New Jersey might be termed acceptable elsewhere. Mr. Val Halamandaris, Associate Counsel to the Sub-Committee on Long-Term Care of the Special Committee on Aging of the U.S. Senate, acknowledges that New Jersey is known as one of the most progressive states

in long-term care and that State Standards for nursing homes are among the highest in the nation." Not resting on this 1973 comment the New Jersey Medicaid Program instituted a medical review system based on each individual patient's needs and services. This system rates a facility on patient service rather than a facade of bricks and mortar. Consequently if a similar study were done today I am convinced that the 13.3% homes found to be poor in 1973 would be reduced to less than 5%. I would not be satisfied until the figure is zero.

Another important finding is that..."There is practically no relationship between the per diem rate paid and the quality of care rendered by these institutions."

Deficiencies Found by the Study

"Almost half of the deficiencies were found in the nursing services category..."

"In physician services, cases were observed where patients were not seen by a physician..."

"The sanitary conditions . . . were the most serious deficiency found in the area of dietary services."

"In pharmaceutical services, two major deficiencies were detected. First, not all medications administered to patients were ordered in writing by the patient's physician."

"Second, patient's medications were not always properly labeled and stored in a locked cabinet at the nurses' station."

"Some facilities did not provide sufficient housekeeping and maintenance personnel..." "Insects and rodents were also found in several facilities."

A complete list of the remaining deficiencies can be found in the report.

Tranquilizers and The Quality of Care

One of the most controversial issues associated with long-term care facilities revolves around the haphazard use of tranquilizers. U.S. Senator Frank E. Moss of Utah, Chairman of the Sub-Committee on Long-Term Care, asserts that "patients indiscriminately receive tranquilizers to keep them quiet and make it easier on the staff." Closely related to this statement is the fact that it is less expensive to tranquilize a patient than to provide social, restorative or any of the other services characteristic of

these institutions. Hence, if this allegation was true of New Jersey nursing homes, it could be concluded that tranquilizers were being utilized to circumvent the high quality of care decreed by the State.

Medicaid Tranquilizer Investigation

In order to determine the accuracy of the overtranquilization allegation, the Division of Medical Assistance and Health Services instituted an investigation of Medicaid nursing home patients.

The findings suggest that New Jersey Medicaid nursing home patients were not indiscriminately receiving tranquilizers. Of the 840 patients observed, 563 (67.0%) were not being tranquilized. As prescribed by the attending physician, 277 (33.0%) were receiving tranquilizers for medical reasons. The dosage given to these patients fell well within accepted norms. Whereas Senator Moss' allegation may be valid elsewhere, the evidence does not support overtranquilization in New Jersey nursing homes.

The study addresses other issues as well as those referred to in the above remarks.

Physician Service

There are several additional points I would refer to your attention on the question of quality of care. The most glaring reason for deficiencies, in my opinion, is the lack of physician service in nursing homes. Many of the patients do not have private attending physicians. Many of the homes cannot obtain adequate physician coverage hence the patient is, too often, left to the prescribing of nurses or worse to laymen. Quite frankly, if a patient is ill enough to be in one of these facilities he or she is ill enough to require adequate physician services. However, the blame for this situation extends beyond the facility. It should be shared by Medicare whose ruling to pay a physician for only one visit per month has caused alienation of physicians. It should be shared by regulatory agencies for not insisting on adequate physician coverage in standards and reimbursement.

If you were to ask the Medicare people about this phenomenon they will tell you physicians can be paid for more than one visit per month if medically necessary. But ask physicians. They will tell you no. I, as former Director of Medicaid, will also tell you no. For all the period I was director we couldn't break this problem. If you are interested in this aspect you can request all pertinent documents from the Division.

One last point on quality for your consideration. It has to do with the certificate of need program.

Certificate of Need

While the concept of the certificate of need program has many desirable aspects it has memorialized some poor facilities. This occurs because bed needs are determined by population census and beds in the community. Hence if a poor facility provides a percentage of listed beds, a potentially excellent facility cannot build in the area. Consequently the less desirable facility reigns. This should be changed. Competition should be reinstalled so that the patient and family have a choice.

One last point on the certificate of need. As I stated above, the need is based on New Jersey census figures. Also if you recall, earlier I told you there are estimated to be over 2600 New York residents in New Jersey homes. This represents about 12% of available beds. Yet the planners using New Jersey population figures do not take this into account. As a result many counties in this State must "bus" patients to distant locations because of a lack of beds in their home area. Couple this phenomena with the discharge of institutionalized patients and we have problems in the area of availability of resources.

Abuses

In my earlier remarks I made reference to abuses. Abuses committed by facilities, bureaucrats and patient's families. I will now attempt to describe examples.

Total Services

The most obvious abuse to the patient is the failure of some facilities to provide a full range of competent professional services. This cannot be tolerated and a deficiency in patient care noted by inspectors and adjudicated to be valid must be immediately corrected. At present, the rule under H.E.W. regulations and practiced in New Jersey, is that the home, when notified of a deficiency, replies by sending a letter of intent to correct. This letter is almost always accepted and nothing more is done to assure compliance. Consequently, the deficiency may remain for months and months. I propose that if patient care area are deficient then the home should have days and certainly not more than weeks to correct. If the problem is not corrected then patients should be removed. Obviously the best solution would be legislation that would prevent admission unless the mandated and prescribed services are available in the first place. Also employees of the State and Counties, as well as hospital social services, should be held accountable for placement in a sub-standard facility. No longer

can we allow the excuse that, " I had to place the patient and there is no other place."

Substantial Compliance

Another area that has concerned me is the area of substantial compliance. Simply stated, this Medicare term means that if a facility provides a service but isn't fully staffed, or if most but not all services are available, or if ten patients require a service but only seven are receiving it, the home is in substantial compliance. I say this concept should be thrown out and forgotten. Full compliance is what we need. If ten patients require special diets or bowel and bladder training then all ten should receive the service. This area is abusive to good patient care.

Personnel

Personnel in many facilities are not skilled, trained or inclined to provide service. The turnover rate is phenomenal. The ranks of employees are too often filled by part time students, transients who jump from job to job, or those who do not service the patients. This condition exists in government facilities as well as private. No wonder we often hear the complaint that if you don't tip the help you don't get service. The few facilities that allow tipping as a condition of providing patient service should lose their license. Further, you may wish to consider legislation prohibiting the acceptance of a "tip" for providing a health or medical service for which payment has been made by a third party payor.

Patient's Property

Besides the services area there are abuses in the use of patient's property. The most obvious area is in the handling of patient's monies. As you probably know, the greatest majority of nursing home patients are receiving approximately $25.00 a month, commonly referred to as personal incidental money. Usually this money is handled by and through the facility. Too often this money is comingled with the facilities', not appropriately accounted for or misused. In addition, personal clothing is in many cases stolen, misused and otherwise denied the patient. I propose that the facilities be held accountable by law and to replace lost or stolen property from the facilities' funds. This cost should not be reimbursed by any third party payor nor private patient.

Bureaucracy

Bureaucrats commit abuses by allowing abuses. They also create untoward situations by a lack of firm, clearly defined and uniform procedures. Permit me to list only a few.

Inspection teams usually announce their visit. Consequently we have heard that facilities "spruce up" in expectation of the visit. You know it, they know it. Recently it was suggested to change the law to allow unannounced inspections. We had been informed by health officials and federal representatives that announced visits were required. The simple fact of the matter is that the law says , "If you announce a visit you cannot give more than 48 hours notice." Note the word if. The intent of the language was to assure that a facility not be given too much time in advance. In Medicaid we took the position that we could go in at any time. And we did. However, if this question continues to be interpreted to favor announced visits by inspection teams I would strongly suggest you clarify the polemic through legislation. Further I would also recommend that the legislation require night and week-end inspections, for obvious reasons.

Life Safety Enforcement

P.L.92-603 required the use of the Life Safety Code of 1967 on the standard for Medicare and Medicaid participation. The implementation of that code has caused considerable confusion and expense. There is not agreement among all parties on what the code means. To my knowledge no instructions, interpretations, case histories, etc. have been published by the appropriate authorities, so that uniformity can be discerned. The result can best be described by relating an example of the confusion and resultant abuse caused by bureaucrats. One very fine nonprofit home was ordered to replace their present doors with a special door and attachments to meet the code. This they did at a cost of over $20,000.00. The next inspectors then ordered these doors to be removed and replaced with what? The same doors they had just replaced. You can query facilities to determine the extent of this type of "abuse". You may be surprised. Second, if the 1967 code is the code New Jersey will use for all health facilities then it should be used as a replacement to the New Jersey Code. We can no longer say if you build a hotel you must meet the New Jersey Code but if you convert that hotel into a nursing home you must meet the 1967 code. Last on this point, how in the world can we tolerate selective enforcement? By this I mean why shouldn't hospitals, state and other government

institutions, including jails, meet the same requirements as long term care facilities? This area of concern should be reviewed by your Commission.

Some families and relatives contribute abuses in the nursing home program. There are instances when a member will collect the patient's Social Security checks and use the money for their own purposes. Or they will refuse to turn over these monies which are rightfully due the facility. In some instances the personal incidental money is picked up by a relative for their use even though the patient may need a personal item. I often think of a situation related to me wherein an individual drove up to a nursing facility in a chauffeur driven Cadillac. She was visiting her poor mother who was on Medicaid. The purpose of the visit was to tell her mother not to worry if she didn't hear for six months. The daughter was going on a world wide cruise.

Neither Medicaid nor any facility can shoulder all the problems. We cannot substitute for families nor society as a whole. Medicaid has been abused by some families. By these remarks I don't intend to insinuate that most people don't care. Unfortunately, however, there are sufficient situations where children or even agencies will place patients just to rid themselves of any responsibility.

If this Commission desires to review listings of individual and specific complaints I refer you to the Medicaid Divsion where complaints are recorded and surveillance records available. This information coupled with the Health Department records should provide you with a mosaic of information for your consideration.

Recommendations:

In addition to those recommendations I included in the body of my statement, I would recommend the following:

1. Consolidation into one agency of all responsibility for regulation, enforcement and policy for all classes of patients in long term care facilities.

2. Adopt a patient ombudsman program, based on the Medicaid Model whereby Professional staff review the level of care needed and provided.

3. Enact a patient abuse law whereby alleged abuses may be reported by employees, families, friends or others, without fear of reprisal. Incorporate a right to sue by the patient,,patients' family or the State on behalf of patients without family or unable to act on their own for acts of malpractice including failure to provide prescribed services.

4. Establish by law a uniform life safety code to cover all public and private facilities.

5. Require that all long term care facilities have adequate physician coverage and that reimbursement for same is provided by third party payors.

6. Require that Sheltered Boarding Homes be included in regulations developed for long term care and appropriate reimbursement be provided for patients placed by State agencies or other agencies financially supported with State monies.

7. Consider the creation of a Rate Setting Authority with the responsibility of establishing reimbursement and coordination of said rates with standards imposed by regulatory agencies. Included in their responsibilities would be the role of arbitrator for health care complaints against facilities and/or regulatory agencies.

8. Establish a task force within the Attorney Generals' Office, including auditoring capability, for the purpose of expeditiously resolving complaints of a criminal nature.

Mr. Chairman, this concludes my remarks. However, one last word is in order. Too often when we discuss what is wrong in our system we tend to paint a bleak picture. We point out the thorns. I would be remiss if I didn't tell you that there are more roses than thorns. In ending, I must repeat that the majority of providers are good, honest, professional people and we shouldn't paint all with the same brush.

New Jersey can and should be proud of our accomplishments- in Medicaid, health facilities and recently our State institutions. We have a long way to go, but in my opinon, we are far ahead of other States.

Mr. Chairman, members of the Commission, this concludes my remarks. I will be pleased to answer any questions you may care to ask.

Thank you.

William J. Jones

William J. Jones

THE RESIDENTIAL HEALTH CARE ASSOCIATION
OF NEW JERSEY

April 16, 1975

Report for the

NEW JERSEY NURSING HOME INVESTIGATION COMMISSION

Honorable John J. Fay - Chairman

Respectfully submitted
Residential Health Care
Association of New Jersey

Alan Kenter
President

Note: Manual of Standards for New Boarding Homes for Sheltered Care (Reprinted 1974) by the New Jersey State Department of Health, Trenton, New Jersey is an integral part of this presentation.

INTRODUCTION

A sheltered care facility "serves as a substitute for the resident's own home, furnishing facilities and comforts normally found in a home, but providing, in addition, such services, equipment and safety features required for safe and adequate care of residents at all times. A resident is an adult person who is ambulant, who is reasonably oriented mentally and who has been certified by a licensed physician to be free from communicable disease.[1]

We must provide three meals daily, supervision of medication, clean linens, laundry service, 24-hour supervision, provide assistance in bathing and feeding if necessary, ensure the well-being of the individual and provide a facility that meets all the requirements of the Department of Health and the State Fire Marshall's Office.

This Association represents approximately 90 facilities out of 200 licensed facilities in the State. Approximately 80-85% of the licensed beds are occupied by former patients from state mental hospitals. Thus we are talking about the care of approximately 4000 people with varying mental disorders.

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[1] Manual of Standards for New Boarding Homes for Sheltered Care, New Jersey State Department of Health, Trenton, New Jersey.

Any reference to "Manual" in this report refers to the above-mentioned publication.

It must be mentioned that we do not operate boarding houses, rest homes, senior citizen hotels, rooming houses, etc. We own and operate a proprietary long-term health care facility geared to the reorientation of an individual to living and participating in the community.

A BRIEF HISTORY OF SHELTERED CARE FACILITIES

Sheltered care facilities, since its inception, was probably the only health facility created with the sole purpose of being community oriented. The idea was to take people from state institutions, place them in sheltered care facilities so that they can become accustomed to community living. Then hopefully, they will become self-sufficient so that they can live on their own and become an asset to society.

Being that 80-85% of all residents in sheltered care facilities are former patients from state institutions, it must be emphasized that we do provide a health care service - mental health care. With the emphasis today to depopulate the state institution, the patients from the state hospitals cannot be turned out en masse with no place to go. They must be placed in a facility that will help them to readjust from long periods of institutionalization. Documentation can be provided, if requested, that we have taken these people who have been institutionalized for long periods of time and are now out in society as a productive individual. We have people who are graduating from grammar and high schools, attending vocational training schools, and providing volunteer work for the community. All these services we provide to our guests are over and above the regulations as set forth in the Manual. The work we have done with these people is a start, but our basic problems of operations are great.

REIMBURSEMENT RATES

Prior to January 1974 we were receiving $4.93 per guest per day to meet all the requirements in the Manual. With the inception of the Supplemental Security Income Program (SSI) the rate was increased to $5.60 per day. Prior to this we have not received an increase for five years.

In March 1973, we made a plea in front of the Joint Appropriation Committee for an increase in the per diem rate. They were, at that time, willing to grant us an increase of $1.50 per day. However, a representative from the Department of Institutions and Agencies claimed that the increase would create a "ripple effect". That is, all other segments of the health care industry would also have to be increased by the same amount, thus costing the state millions of additional dollars. But, this was not and is not the case. During the last five years, all other segments of the health care industry received many increases and we received nothing. The end result of that hearing was SR 2015 which was a compilation of worthless material.

In March 1974, we presented a report to representatives of the Department of Institutions and Agencies, prepared by our accountants that showed, using the state's own figures (copy attached) we should be receiving $17.04 per guest per day. At that time we received nothing but sympathy and apathy from representatives until September 1974 when we decided that

if the state cannot afford to pay us for maintaining and operating a facility according to their standards; then, instead of being put out of business because of increasing regulations and operating costs, we would return the people to the institution from which they came. In other words, we could no longer afford to subsidize the state in the care of their indigent people. This letter (copy attached) showed that even if the state gave us a per diem rate of $17.04, over returning approximately 4000 people to the state institutions at an average cost of $36.04 per person per day, the savings to the state would be approximately $34.7 million.

After the letter was issued, a long series of meetings were held with state officials, during which not one person could justify moving a person from a $36 per day setting n to a $5.60 per day setting and expect better care and living conditions than what is found at the state mental hospitals.

In January 1975, our rate was increased to $7.30 per day and in July 1975 it is to go to $9.00 per day. We accepted this as a temporary increase and are struggling to stay in business even though the rate is still inadequate.

I would like to mention at this time that the rate in New York State is $375 per month, Illinois is $395 per month and in California it is close to $400 a month for providing the same care for which we are now receiving $218 per month.

LEGISLATION

Senate Bill 3025 has been introduced that would define us as a long-term health care facility, change our name to residential health care facilities and set up a mechanism for annual negotiation of rates. Senator Marressa has the undivided support of the Association for this important Bill.

It is also understood that the Department of Institutions and Agencies is preparing legislation that would remove us from the Department of Health and place us under their jurisdiction. It is presently the Department of Health who regulates us while the Department of Institutions and Agencies sets the rates.

Passage of Department of Institutions and Agencies proposed legislation would only duplicate those regulations and controls already in effect (Health Care Facilities Planning Act, 1971, Chapters 136 and 138). We operate health care facilities that provide a much needed health care service. To take us out of the Department of Health would only be a step backwards.

REPRESENTATION

We have none.

All of the regulatory and policy making boards and committees have representation from various segments of the health care industry. They have a voice in what regulations are being considered and whether or not the regulation will be adopted. To date, we have no official input to any of these committees. We have been working in this area and hope to have representation soon.

LEGAL ACTIONS

To date we have attempted, through the courts, to force the state to take two actions that the Association felt we be beneficial to our industry and to the people who reside in our facilities.

The first case was aimed at preventing county and local welfare boards from placing people discharged from state institutions into unlicensed homes. (Those residences not licensed by the State Department of Health). It is common knowledge and practice that the parties responsible for placing people people from state institutions into the community make no differentiation between licensed and unlicensed homes. That is, the first bed that is available for the person is the place to which he is sent. These "unlicensed facilities" flourish all over the state and in some cases unofficially approved by county welfare departments. The unlicensed homes have no regulatory agency to make certain that care is being provided for the individual, or that any of the safety mandates imposed on licensed facilities will be enforced.

But placement of an individual in an unlicensed facility is often a hinderance to the progress of the individual. A study that was made, indicated that of all the readmissions to state institutions only 2 per cent were from licensed sheltered care facilities, the remainder came from unlicensed homes, family situations, etc. We must be doing something right.

The second case involved the issue of whether or not the Department of Health could implement new rules and regulations requiring tremendous expenditures without increasing the per diem rate to cover additional operating costs. I would like to state at this time that this Association does not and will not object to the implementation of rules and regulations that benefit the residents who reside in our facilities and improve their care. But there must be some mechanism for increasing the rates to cover increased costs.

REVIEW OF THE CAPITAL NEEDS STATEMENT AND BUDGET RECOMMENDATIONS BY THE DEPARTMENT OF OF INSTITUTIONS AND AGENCIES

"Conditions in our institutions certainly have improved relative to their historical state. Yet, we continue to tolerate situations which are not consistent with minimum humanitarian requirements. We maintain facilities which do not meet fire and life safety standards. We are expected to provide adequate diets to institutional residents for less than a dollar per person per day. We have a stated mission to improve or rehabilitate the residents of our institutions, yet we tolerate situations which almost guarantee that the condition of those residents will not improve and, indeed, may deteriorate. The solution to these problems are varied and are not always a function of additional funding . . .

"At the same time, we are attempting to improve institutional environments, we are also seeking to increase options for meeting individual and societal needs, short of institutionalizatio To the extent that legitimate and viable alternatives are developed, individuals will benefit because they will receive treatment, without being isolated from their families and communities. Society ultimately will benefit as a result of lower treatment costs in the community.[1]

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1 State of New Jersey, Department of Institutions and Agencies, FY 1975-1976 Budget Recommendations, November 20, 1974.

The above recommendations and remarks generally follow the accepted trend in this country to phase out institutions and move the people back to the community where they belong in a supervised setting where follow up treatment will be issued. However, on February 24, 1975, the Department of Institutions and Agencies submitted a report to the Governor's Commission to Evaluate the Capital Needs of New Jersey stated the following.

"To be more specific, our institutions have identified a need of roughly $500 million for facility improvements over the next five years. This may be a good estimate of what is required to bring up to standard every building at every institution which this Department operates. The question which must be asked, however, is whether the shape and configuration of our institutions as they now exist represent the future direction of programs in these areas.

"The capital needs which I have identified for this Department total $133 million over a five-year period."[2]

There seems to be a conflict of directions within the Department of Institutions and Agencies as to which direction to proceed regarding the future of state institutions. On one hand they admit that institutionalization of an individual may retard the correction of his condition, yet, on the other hand, the Department requests $133 million to improve the conditions of the institutions.

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2 Statement by Commissioner Ann Klein, Department of Institutions and Agencies to Governor's Commission to Evaluate the Capital Needs of New Jersey, February 24, 1975.

It is hard to comprehend the reasoning behind the conflicting statements.

We feel that definite plans should be developed as to the future of institutions in this state before any more monies are expended on them.

RECOMMENDATIONS

This Association feels that the following recommendations will benefit this health care industry, the state in the savings of dollars, and most important, result in better treatment and care of the individual.

A. Passage of S 3025

B. Ultimately sheltered care facilities should operate on a "cost plus" system of reimbursement rather than a flat rate. This way regulatory agencies will be able to monitor the actual operating costs more closely and the facility will be insured of a reasonable profit. Thus, there will be no excuse for not fully complying with the Manual. (Full implementation of Health Care Facilities Planning Act, Chapters 136 and 138).

C. A state-wide system of uniform after care ~~mental health care~~ and services provided by county and local welfare agencies. Programs in effect now range from excellent to non-existent and the quality of services available varies widely.

D. Put an end to the discriminatory practices that affect the residents in our facilities. For example, on May 1, 1975, a "co-payment program" goes into effect where people who are eligible for Medicaid will have to contribute 50 cents for each prescription that has to be filled. If a person has to have four prescriptions per month refilled, this additional expense represents about 10 per cent of his disposable income. But if this person resided in a nursing home, there would be no additional monies required from his disposable income to pay for his prescription. Residents who reside in sheltered care facilities should be "entitled" to the same benefits as those people in other health care facilities.

E. Persons sent to us directly from state mental hospitals should be sent to our facilities with a brief case history so that we may be aware of his problems.

F. End the practice of placing people in unlicensed facilities.

G. As I have done so in the past, I am offering the expertise that this Association and its members have in planning for the future. We freely admit there is a need for change, but being on the "receiving end" of all decisions, we must be able to work with various agencies and legislators in bringing changes about that will not be disruptive to the operation of the facility, and most important, to the guest who resides with us.

CONCLUSION

We, as an industry, are the first to admit that we need upgrading and more professionalism instilled in our operations. We operate in daily violation of the law with the low compensation we are receiving for operating our facilities. We have to make cuts somewhere to stay in business. We operate proprietary facilities that for years have been subsidizing the state in the care of its indigent people.

Again, as previously mentioned, we, as an Association plead for the opportunity to work with various agencies to implement changes that will create a more viable atmosphere for a person to live and and for an operator to manage. We do not want to operate good facilities - we want to operate the best. And we are willing to work with any interested agency at any time to achieve this goal.

THE RESIDENTIAL HEALTH CARE ASSOCIATION
OF NEW JERSEY

PRESIDENT
ALAN KENTER

EXECUTIVE DIRECTORS
THOMAS L. ARMOUR
GERALD PLINER
KENNETH I PIERSON

SECRETARY
AGNES B. MATERA

TREASURER
SANDRA R. GILL

602 Central Ave
Plainfield, N. J. 0

September 1, 1974

Ann Klein
Commissioner
Department of Institutions and Agencies
135 West Hanover Street
Trenton, New Jersey 08625

Dear Commissioner Klein:

As you know, we have been trying for the past five years to get an increase in the rates we receive for caring for public guests. To date, we have been unsuccessful and our constant meetings with officials of the State do not give us much hope for the future. Our operating costs have gone up tremendously, with no relief in sight, and our pleas for an increase have fallen on deaf ears.

Our attempt to get an increase has three purposes. One is to receive an increase in our reimbursment rate for public guests- which everyone says we deserve but no one has done anything about. Two, to give those public guests a chance to live in society without the confines of institutional walls surrounding them. We are the biggest 'butlet' for state mental patients and yet we are not recognized for the work that we do. Thirdly, we want to save the taxpayers of New Jersey some money- approximately $ 34 million.

Studies have shown that we should be receiving $17.04 per guest per day. This study was compiled by our accountant using the states own figures. Receiving $5.60 per guest per day indicates that something is drastically wrong with the whole system. We are constantly operating in violation of the law because at $5.60 per guest per day one has to make cuts somewhere to stay in business. Please remember that we operate health care facilities- not welfare homes. We estimate that there are 4,000 former state patients in licensed sheltered care beds in the State. The total cost for this program

(continued)

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TREASURER
SANDRA R. GILL

602 Central Avenue
Plainfield, N. J. 07060

at $17.04 per guest per day would be as follows.

$17.04 per guest per day X 4000 people X 365 days per year
= $ 24,878,400

minus Supplemental Security Income contribution

$140 per month per guest (SSI) X 4000 people X 12 months per year
= $ 6,720,000

Total cost to the State would be $ 18,158,400

If all these people were returned to state institutions the cost would be as follows (using Marlboro Psychiatric Hospital cost per patient day as an average).

$36.24 per patient day (1974 Budget) X 4000 people X 365 days per year
= $ 52,910,400

However, if the State gave us what we so desperately need, the total savings to the State and its taxpayers would be $ 34,752,000.

Therefore, effective October 1, 1974, the per day rate for a public guest will be $17.04 in a licensed sheltered care facility. If this new rate is not met, the relatives and social workers of these guests will be notified to find other places for them within 15 days or return them to the institutions from which they came. If they are not moved within that time, their responsible persons or agencies will be billed for the difference. There will not be any mass public demonstrations with these people because we have compassion for them, but we have to survive also.

(continued)

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GERALD PLINER
KENNETH I. PIERSON

SECRETARY
AGNES B. MATERA

TREASURER
SANDRA R. GILL

602 Central Aven
Plainfield, N. J. 07

This entire association is at your disposal to work out an equitable solution to this problem, and we are available any time to discuss this matter.

Thank you for your consideration.

Sincerely

Alan Kenter

Alan Kenter
President

RESIDENTIAL HEALTH CARE ASSOCIATION OF N. J.

RESIDENTIAL HEALTH CARE ASSOCIATION OF N. J.

I N D E X

HOWARD, LISTANDER & BERKOWER, P.A.

Certified Public Accountants

220 MARKET STREET
PERTH AMBOY, N. J. 08861
RED BANK AREA (201) 741-1155 PERTH AMBOY AREA (201) 442-2211

ARTHUR P. LISTANDER C.P.A.
MORTON M. BERKOWER C.P.A. (RET.)
JEROME GOLDBERG C.P.A. (RET.)
EDWARD S. GARR C.P.A.
LEWIS J. ROSNOCK, C.P.A.

March 7, 1974

Mr. Alan Kenter, President
Residential Health Care
Association of N. J.

602 Central Avenue
Plainfield, N. J. 07060

Dear Sir:

In accordance with your request, we have reviewed the report "An Examination of Nursing Home Care Under The New Jersey Medicaid Program" - January 1, 1970 to December 31, 1972 as it affects Residential Health Care.

The enclosed data shows that the Division of Medical Assistance and Health Services arrived at an Average Cost per Patient Day in 1971 for Nursing Home Care of $18.78. Costs included therein and not applicable to Residential Health Care amounted to $7.03, leaving a net applicable Cost per Guest Day of $11.75 for 1971. Allowing an average of only 7% for Cost of Living Increases each year brings this Cost per Guest Day in 1974 to $14.39.

Additional costs to be considered add substantially to this figure and should result in an effective reimbursement per Guest Day in 1974 of $17.04 as shown in the attached data.

Respectfully submitted,

Howard, Listander & Berkower, P.A.

Certified Public Accountants

ANALYSIS OF COSTS OF OPERATIONS FOR

RESIDENTIAL HEALTH CARE GUESTS

Based on data prepared by the Department of Institutions and Agencies in "An Examination of Nursing Home Care Under the New Jersey Medicaid Program" - January 1, 1970 to December 31, 1972.

The data presented is for the average expenditure per patient day.

For the year 1971, the lowest costs were for Proprietary Homes as compared to Governmental Facilities and Non-Profit Facilities.

The average cost per Patient Day in 1971 for Nursing Homes was:

Administrative and General	$ 3.30	
Dietary	1.40	
Food	1.33	
Laundry	.47	
Housekeeping	.88	
Nursing	6.71	
Medical Supplies	.32	
Recreational Therapy	.08	
Plant Operation	1.15	
Property Expense	2.88	
Other	.26	
Total Expenses		$18.78

Costs not applicable to Residential Health Care Facilities are as follows:

Nursing	$ 6.71	
Medical Supplies	.32	
Total Deducted		7.03
Net Applicable Cost per Guest Day		$11.75

Allowing an increase of 7% in the Cost of Living per year for 3 years, the current Daily Cost for 1974 is $14.39

TABLE VII

ESTIMATED EXPENDITURES PER PATIENT DAY OF LONG-TERM CARE FACILITY, BY TYPE OF OWNERSHIP, CALENDAR YEARS 1970 AND 1971

...IN. & ...ERAL	DIETARY	FOOD	LAUNDRY	HOUSE-KEEPING	TOTAL NURSING COST	MEDICAL SUPPLIES	RECREATIONAL THERAPY	PLANT OPERATION	PROPERTY EXPENSE	TOTAL EXPENSES	GROSS INCOME	PROFIT/ LOSS
$3.72	$1.71	$1.48	$ .60	$1.03	$ 7.91	$ .31	$ .08	$1.55	$2.20	$20.89	$20.05	$ (.84)
3.89	1.64	1.44	.56	1.00	7.37	.32	.08	1.39	2.19	20.15	17.31	(2.84)
5.17	2.45	1.85	1.07	1.36	11.67	.31	.12	2.72	.63	27.80	18.94	(8.85)
4.65	2.31	1.67	.93	1.39	10.24	.30	.13	2.49	.72	25.05	13.27	(11.77)
3.47	1.96	1.57	.53	1.22	7.68	.30	.03	1.56	1.50	20.01	22.67	2.66
3.06	1.77	1.47	.50	1.07	6.73	.28	.03	1.38	1.53	18.12	17.69	(.43)
3.30	1.40	1.33	.47	.88	6.71	.32	.08	1.15	2.88	18.78	19.82	1.04
3.82	1.37	1.34	.44	.84	6.49	.35	.07	.99	2.88	18.88	18.67	(.21)

...EDICAL ASSISTANCE AND HEALTH SERVICES

ADDITIONAL COSTS

1. Prior to November, 1973, homes were encouraged to use residents to help with home activities as therapy for the guests. However, in the case of Souder vs. Peter J. Brennan, U. S. Secretary of Labor in the U. S. District Court for the District of Columbia, the court ordered the enforcement of minimum wage standards for working patients in mental hospitals.

   This ruling has been applied to Residential Health Care Homes.

   The estimated cost of this change is calculated to be $1.50 per Guest Day for 2 additional employees in a 20-bed home.

2. The skyrocketing cost of food and fuel in 1974 will increase 25% or more in 1974 by current newspaper reports.

Food - per Study -	$ 1.33	
1972 @ 7% Increase	.10	
1973 @ 7% Increase	.10	
Total	$ 1.53	
1974 @ 25%	$ .38	
1974 @ 7% as already included	.10	
Additional Estimated Cost	$ .28	per Guest Day
Fuel - in Plant Operation		
1973 Cost	$ .30	
1974 Cost Increase	$ .09	
1974 Cost Increase at 7% as already included	.02	
Additional Estimated Cost per Guest Day	$ .07	

3. Safety requirements changed on January 10, 1974 with the adoption of Subchapter 7 of the Manual of Standards for Boarding Homes for Sheltered Care, effective July 1, 1974.

   Paragraph 8:31-7.1 provides for extensive changes in the Homes including:

   a. Comprehensive automatic sprinkler systems.
   b. All Floors above first to have:
      (1) 2 sections
      (2) Magnetic door hold - open devices connected to
      (3) Smoke detectors
      (4) Direct egress from each subdivision at least 35 feet from the building

ADDITIONAL COSTS

-2-

d. All exposed wood construction in the basement is to be protected with one-hour fire resistant materials
e. Illuminated signs are to be provided at all approved exits.
f. Emergency lighting is to be available at all times

These changes represent an extensive capital outlay and will have to be recovered in the new Daily Rate.

The Estimated Cost per Guest Day would depend on each home's requirements.

To recover a $20,000 cost in a 20-bed home in 10 years would cost $.30 per Guest Day.

4. The cost reimbursement gives no consideration to Return on Investment.

Consideration of this factor is proper and furthermore justified when the report issued by the Division of Medical Assistance and Health Services states on Page 19:

> "The question arises as to why the average cost per patient day of governmental facilities is higher than that of the other two types of facilities. Some might conclude that governmental facilities tend to be inefficient operations, guided neither by the profit motive to minimize costs nor the dedication of the non-profit institutions in providing quality care. Others might conclude that the higher cost per patient day reflects the provision of high quality care. Apparently, the higher cost is attributable to the inefficiency of governmental institutions. The higher cost, which is largely due to the higher number of employees per patient day, has not resulted in a higher level of care. Health Department inspection reports indicate that generally these facilities render a quality of care that is comparable to their non-governmental counterparts."

We ask for a return of only $.50 per Guest Day.

5. On Page 3 of the Report, the position of the Residential Health Care Homes is defined. They represent the most economical form of care that can be provided and must not be allowed to be wiped out by the unconscionably low reimbursement formulas in effect.

ADDITIONAL COSTS

-3-

6. Table VI of the Report shows the Average Medicaid Per Diem Rates for 1970 through 1972 as follows:

TABLE VI
AVERAGE MEDICAID PER DIEM RATES IN LONG-TERM FACILITIES, BY TYPE OF FACILITY
1970 THROUGH 1972

TYPE OF FACILITY	1970	1971	1972
All Facilities	$15.88	$17.87	$18.97
Proprietary	$15.70	$17.58	$18.72
Governmental	$17.24	$19.29	$20.82
Non-Profit	$15.66	$18.38	$18.95

Source: Division of Medical Assistance and Health Services

They have increased the Average Rate $3.09 per day. The Residential Health Care Homes have received

N O T H I N G ! !

7. There are approximately 225 Licensed Boarding Homes in the State caring for approximately 4,000 Public Guests in approximately 6,000 available beds. This is vitally important care to a substantial number of people.

SUMMARY OF COSTS PER GUEST DAY

AVERAGE EXPENDITURE	$14.39
NEW LABOR COST	1.50
NEW FOOD COST	.28
NEW FUEL COST	.07
NEW SAFETY COST	.30
TOTAL COST PER GUEST DAY	$16.54
REQUESTED RETURN ON INVESTMENT	.50
TOTAL REQUESTED REIMBURSEMENT	$17.04