PUBLIC HEARING

before

SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE

on

(Private-Pay Contracts in Nursing
Homes and Nursing Home Bed Shortages)

Held:
March 19, 1984
Room 346, State House Annex
Trenton, New Jersey

MEMBER OF COMMITTEE PRESENT:

Senator Richard J. Codey (Chairman)

ALSO PRESENT:

Eleanor H. Seel, Research Associate
Office of Legislative Services
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SENATOR RICHARD J. CODEY (Chairman): I would like to get started with the hearing, please. Our first witness this morning will be the Commissioner of Human Services, George Albanese. Commissioner, please?

COMMISSIONER GEORGE J. ALBANESE: Good morning, Chairman Codey. I welcome this opportunity to discuss an issue with you that will become even more pressing for both the elderly and for State government: Access to long-term care services in New Jersey.

While I will focus on the immediate question of prohibiting the use of private-pay contracts for Medicaid-eligible patients, I want to do so within the context of a larger issue: Access to long-term care. It is important that we focus on the problems in a comprehensive and systematic way. The overall question is how we can ensure that all elderly and disabled persons have access to quality long-term care in the most appropriate setting, regardless of their financial status.

The Nursing Home Task Force Report, which we submitted to you, represents the first truly comprehensive review of New Jersey's system of institutional long-term care. The report is thorough in its analysis, concise in its presentation, and realistic in its recommendations. It demands the close scrutiny of those who develop and administer the State's programs for the elderly. Much of my testimony today is based on the report and our response to it, which we have recently shared with members of the Task Force.

Probably the most important section of the Task Force Report deals with three interrelated problems: The use of private pay contracts; the preferential admission of private-pay patients; and the illegal transfer of assets in order to gain Medicaid eligibility. As you know, three bills have been introduced by Assemblymen Gallo and Franks, implementing the Task Force's recommendations on these three issues. Bills A-872, A-873, and A-874 have our vigorous support.

In discussing private-pay contracts and discriminating admission practices, it is essential to understand their root causes. These practices are an almost predictable outcome in any seller's market where there are established base prices that can be "bid-up" in the competition for services. Essentially, private-pay contracts are

the result of the laws of supply and demand; they are not necessarily the result of inadequate Medicaid reimbursement.

Proof of this can be seen in the fact that private pay contracts are as prevalent in states where Medicaid rates are up to 50% higher than in New Jersey -- for example, New York -- as they are in states with reimbursement far less generous than ours -- for example, Pennsylvania. The prevalence of private-pay contracts seems to bear no relationship to the relative reimbursement levels.

However, indiscriminate increases in Medicaid rates have the potential of also increasing the per diem rate for private-pay patients. After extensive analysis and considerable debate, the Task Force concluded that the only way to equalize access for the poor is to:

First, prohibit nursing homes from requiring private-pay contracts as a precondition for the admission of Medicaid eligible patients.

Second, restrict the ability of facilities with low Medicaid occupancy rates to grant preferential admission to private-pay patients.

Third, incrementally increase the Medicaid reimbursement rates for those facilities with especially high proportions of Medicaid patients.

Increases in reimbursement for facilities with a high percentatge of Medicaid patients should be based on Medicaid incentives. These incentives should consider the number of Medicaid and non-Medicaid patients in order to strike an appropriate balance in the mix of patients. Since most facilities realize their basic profit from private-pay admissions, which would be curtailed by the prohibition, it is essential that an equitable formula that is fair to both the industry and the State be developed.

However, increases may be necessary for only a limited number of facilities. Since the nature and amount of the increases need to be carefully reviewed, they should not be incorporated as part of the legislation. I suggest that a small work group consisting of the industry and Department staff be convened to design an incentive reimbursement program.

Ensuring equal access to existing nursing home beds is, of course, only part of the answer. We must also make sure that the overall supply of beds is adequate and that a range of community-based alternatives is also available. Recently, tremendous strides have been made in this regard.

As Dr. Goldstein will discuss later, in the last several months we have witnessed a significant increase in the availability of nursing home beds. Moreover, an exceptionally large number of facilities are now under construction or nearing completion. These trends portend a possible end to New Jersey's chronic "bed shortage."

In this regard, we are pleased to note that the Medicaid waiting list has receded below 2,500 for the first time in many years. This decrease of 400 is due largely to the many new beds recently becoming available. We expect that the State's Community Care Program for the Elderly and Disabled will, over the next three years, enable further reductions in the waiting list as we achieve a more balanced system of care.

Because of these improvements in bringing beds on line, we are not recommending implementation of the 1981 Nursing Home Construction Bond Issue. It is not clear that the State any longer needs to stimulate construction through public financing. We believe that a more prudent approach would be to see how these recent developments will affect the future supply of nursing home beds before reactivating the Bond Issue.

The population historically experiencing the greatest difficulty in obtaining nursing home care are geriatric patients awaiting placements from State and county psychiatric hospitals. These individuals often encounter waits of two years or more in our attempts to secure care appropriate to their needs. To immediately correct this inequity, we are authorizing selected nursing homes to add several beds in under-utilized areas. These beds can be retained for up to three years as long as the beds are reserved for this especially needy population.

The Division of Mental Health and Hospitals anticipates placing approximately 200 appropriate geriatric clients into participating nursing homes within the next several months.

I should also note that the statewide Health Coordinating Council has taken additional steps to ensure that a fair proportion of the new nursing home beds being built are available to former psychiatric patients; all new facilities must now reserve seven percent of their beds for this population. This seven percent is included in the overall 35% direct Medicaid admissions required for the last two years.

Finally, I would like to mention a means by which we hope to enhance access to the long-term care services and settings most appropriate and efficient for the needs and conditions of each individual. We are highly supportive of the Task Force's pre-admission screening recommendations. They offer an exciting and innovative approach to restructuring access to the long-term care system. The recommendations would ensure that all potential nursing home patients had access to comprehensive pre-admission screening. Modeled on a successful system in Virginia, the proposals would enable us to intervene prior to institutionalization, alerting clients to our expanded array of community-based services and denying Medicaid reimbursement for inappropriate admissions.

As recommended, we will begin implementing the screening system as we achieve statewide coverage with the Medicaid Community Care Program for the Elderly and Disabled.

One last point: We continue to support the merger of the ICF/A and ICF/B levels into one level of ICF care, subject to funding. This was recommended in a study presented last year to the Legislature.

In conclusion, I want to reaffirm our support for the legislative package on private-pay contracts. The reform of existing discriminatory practices must be a priority and we look forward to working closely with the Legislature and all interested parties to secure passage of these bills. Without them, our comprehensive plan for improving access to appropriate care for the elderly will not succeed.

I would like to take this opportunity to thank you for allowing me to testify today.

SENATOR CODEY: Thank you, Commissioner. Commissioner, as more Medicaid beds become available, what additional cost does that bring to the State?

COMMISSIONER ALBANESE: As we see it, in the context of the private-pay contract prohibition, we are estimating a State cost of approximately $12.5 million -- an annualized figure.

SENATOR CODEY: Is that realistic, Commissioner?

COMMISSIONER ALBANESE: That is pretty much the consensus of all the parties concerned that I have talked to -- $12.5 million on an annual basis.

SENATOR CODEY: Has that been budgeted for 1985?

COMMISSIONER ALBANESE: No. The Budget office took that out of the budget. They indicated to me that if we did put that in our budget, they would wait to see if the legislation was enacted and then there would be a supplemental appropriation. But, we did have that in our request. It was pulled out, based on the timing of the legislation.

SENATOR CODEY: Commissioner, you spoke earlier in your testimony about the illegal transfer of assets. Do you want to clarify exactly what you mean by that?

COMMISSIONER ALBANESE: Well, one of the complaints of many concerned, including the industry, is that people divest themselves of their assets for the purpose of gaining Medicaid eligibility. We, in the State of New Jersey, have tightened that up recently by requiring a twenty-four month period. And, I would suggest to you, Mr. Chairman, that you memorialize that in the form of legislation, because I think that is significant. We must be fair to all sides of the fence. We must have the private-pay prohibition, but, likewise, when people divest themselves of their assets, it is unfair to the Medicaid population. So, we would ask your cooperation in memorializing that in legislation.

SENATOR CODEY: Commissioner, what about situations, such as the legislators who are here today will tell you about? They will tell you about people who come to our offices and say, "I don't have any money." This may involve a couple in their 70's. They may have a

lifetime savings of $20 thousand, and we ask them to just wipe that out over a short period of time because one of them is going to enter a nursing home. What do you say to people like that? Do you understand the situation I am talking about?

COMMISSIONER ALBANESE: No, not really.

SENATOR CODEY: Okay. You know, when you speak about the illegal transfer of assets, maybe they would transfer those assets to a daughter or son. That is really a very sad thing to see happen.

COMMISSIONER ALBANESE: Oh, I can understand that particular concern. But, I think we have to look at it in terms of, what are the priorities? What is government's responsibility in providing care? If we take that position and multiply it out for people who have $1 million, or $500 thousand, the bottom line is the Medicaid program is established to deal with those who are elderly and poor.

We recently had similar concerns in that area when we talked about the Community Care Program, and we talked about the asset limitations required in our petition to Secretary Heckler. We asked him to be more liberal in understanding the spend-down, as well as the assets an individual can retain in the community. So, we are concerned about that.

But, basically, the Medicaid program is for a population that is poor and elderly. We have to take that into consideration.

Given the fact -- I think you asked before if I could project this -- that if we continue the present "norm" of simply building nursing homes, as opposed to a combination of community care, we are projecting in our budget that we have to spend approximately $330 million a year right now for nursing home care in our Medicaid budget. Projections are that by 1990, we are talking about close to $1 billion, based on the "greying" of New Jersey, as well as of America.

SENATOR CODEY: Commissioner, how much will the incentive payments cost the State?

COMMISSIONER ALBANESE: We have not developed a formula for that. We have no idea right now. It is based on a formula.

One of the things we are talking about is, if we are at a statewide average of 65% Medicaid for a private nursing home -- this is

some of the thinking in developing that system -- when that average is exceeded, the incentive program will kick in for those nursing homes that take additional Medicaid beds. So, I really have no facts or figures on that right now.

SENATOR CODEY: You mentioned something before about a pre-admission screening test. Do you want to explain exactly how that would work?

COMMISSIONER ALBANESE: Based on the Virginia model, one of the concerns is-- When you think about it, Middlesex County has a channeling program, which is quite a successful program, in my opinion. It provides for an entrance point into a long-care system, and allows us to provide for people through a continuum of care. Not everyone has to go directly into a nursing home. It has been my experience in the County that many people could have been supported in the community.

One of the advantages of the screening unit is to ensure that the individual knows the options, whether it be a community-care program or eventually getting into a nursing home. It also allows us to control admissions, based on need.

For example -- this is my personal opinion, having run a specialized hospital in the past -- some people say that 25% to 35% of the people in a nursing home do not necessarily have to be there. If there were other options provided in the area of community-care programs, some of those people would have elected, in the past, to stay in their residence and have community care provided to them.

So, the screening process becomes very important as we put people into the long-term care system. We will give them an array of options, afforded to them by government and the private sector, and it will allow us to control access to the long-term care system.

SENATOR CODEY: Can you explain how it works on a day-to-day basis?

COMMISSIONER ALBANESE: The details?

SENATOR CODEY: Yes.

COMMISSIONER ALBANESE: Any individual looking to go into a nursing home would have to be pre-screened by our Medicaid operation.

Those that are Medicaid eligible, and those that plan to convert to Medicaid after they are in the institution, would be screened to determine whether they need the nursing home bed, whether they can appropriately use community care, or, in fact, whether they are really eligible under Medicaid for nursing home reimbursement at this point in time. So, it really becomes an entrance point for evaluation of the individual and the various mechanisms, and it will be operated by our Medicaid operation.

SENATOR CODEY: Okay. So, before they are granted a bed, the screening process takes place?

COMMISSIONER ALBANESE: Yes.

SENATOR CODEY: Commissioner, when do you think we will have enough nursing beds in the State of New Jersey?

COMMISSIONER ALBANESE: As a "guesstimate," at this rate, maybe five years, maybe six years. It depends upon the population projections. It also depends on the mix of community-care programming and nursing home beds.

For example, if we did not have 30%, or 25%, as some people say, inappropriate placements in nursing homes -- if those people were not there -- it would allow us to appropriately fill what is needed in the nursing home area. You can't take people out of nursing homes if they are in there inappropriately and if they have given up their community life. But, if you think about this over time, as we screen and as we review the process, those beds will become available to the type of individual who is in need of nursing home care.

Five years is really a "guesstimate" on my part. I have no idea.

SENATOR CODEY: Commissioner, how did we reach the point where we are now about 3,000 beds short? How did that come about?

COMMISSIONER ALBANESE: From my past experience in Union County, I would say that the problem had an awful lot to do with the economics of constructing nursing homes in the State of New Jersey. We had great hopes in Union County that the private sector would build. There was a $10 million bond issue for this purpose, but it seems that the bottom dropped out, and we did not experience that growth.

I experienced another problem in Union County. There are many county facilities that had a desire to expand. I had a 250-bed proposal for John E. Runnells Hospital in Union County when I was there, but that was stymied, not as a result of capital but as a result of the five-percent "cap." We could not expand beyond the five-percent "cap," and that eliminated the possibility of operating that facility.

So, I think a lot of the county facilities have really been hampered by the five-percent "cap."

SENATOR CODEY: Okay. Thank you very much.

COMMISSIONER ALBANESE: Thank you, Senator.

SENATOR CODEY: Our next witness will be John Fay, Ombudsman for the Institutionalized Elderly.

JOHN J. FAY: First of all, Senator, I would like to thank you for having this public hearing on a subject that has been a constant concern to our office in the five and one-half years of its existence.

My testimony to you and to the Senate and Assembly Health Committees is that we are dealing in New Jersey with a blatant sense of discrimination, and it is an insidious form of discrimination in that it is not aimed at a racial group, or an ethnic group, but it comes down on a growing minority in our State and our nation, and that is the very sick, the very poor, and the very old. It is a kind of national issue as well. It is not limited to New Jersey, by any means. But, we have seen in some states of our Union where they have acted legally and legislatively against this discrimination.

In the last two years, we have seen Maryland, New York, Massachusetts, Minnesota, and the States of Washington and Connecticut address this through a variety of legal measures. I have attached a legal addendum to this report, showing what each state has done in this area. (see page 1X in appendix)

The way these acts of discrimination show up is when a family is told that a hospital can do no more for their parent, or their grandparent -- or they are told this by the family doctor -- and they are told to get a nursing home bed for the patient. I am talking now about those who are eligible for Medicaid to begin with. And, by being Medicaid eligible, they have been documented as being poor, sick, and

in need of a particular type of skilled, or intermediate nursing care. This is when the average family is told by a great number of nursing homes in our State that they have to sign a private-pay contract, and these private-pay contracts run anywhere from six months to three years. The average amount they are asked to pay is $20 thousand a year.

Our office just had a family on the phone last week, and this family was told to be ready to sign a $12 thousand contract for a six-month stay. You know, it goes without saying that we are talking about the average middle-class, working-class family in our State, and a $20 thousand to $60 thousand debt is overwhelming, and in too many cases it is impossible.

But, the most seriously hurt -- and this includes a growing number in our State and in our nation -- are those growing numbers of eighty and ninety-year-olds who, in their most productive days, could not afford $20 thousand a year. Today, the eighty and ninety-year-olds are, in many cases, outliving their families, and, therefore, there is no one available to sign a private-pay contract for them. With most county hospitals having anywhere from a one-year to a two-year waiting list, these people do not ever get a nursing home Medicaid bed.

Our office deals with the reality of this. It is not academic to us. We know the names. We see the men and women who are backed up in the hospitals. And, the hospitals are screaming that they shouldn't have to have them; that they are being burdened. And, they are right. But, we have also seen where the eighty and ninety-year-old is a victim. We have found in the last year -- just to cite a few terrible, cruel cases -- an eighty-year-old woman who was not in a nursing home; she was in a boarding home in New York, and it took a few days to find her family.

Another case involves a ninety-two-year-old man, who, again, was eligible and qualified for a nursing home bed. We found him too. If it weren't for his neighbors, we never would have found him in a boarding home in New York.

Too often we have found people who should be in nursing homes, living in boarding homes where they cannot, and they do not, get

the proper medical help and the medical service they rightfully deserve and need.

We issued a report, a little over a year ago, about the improper placement of our older people. This happens to a great number of our elderly population because there just aren't Medicaid beds available for them.

I want to go on record as concurring with all of the major recommendations of the State Nursing Home Task Force. I think Commissioners Albanese and Rodriguez have shown a very strong expertise in this whole field of long-term care. I think what they are saying to the Governor and to the Legislature is, "Here is a short-term plan, and a long-term plan for the future in our State."

I am also strongly in support of Assembly Bills 872, 873, and 874. I am very happy to see that they have strong bipartisan support, and they could very easily be coming up for a vote in the near future.

I think the Governor is also to be commended for making this a major plank and a major promise in his State of the State address: That this should stop, and it is going to stop in the near future.

But, most of all, Senator, I want to testify and speak for the thousands of people in our State who couldn't possibly be here today. These are the people who are being hurt right now in more ways than just economically.

Again, I would like to commend you for having this kind of a public hearing, bringing this major evil, and this major flaw, to the forefront. Thank you.

SENATOR CODEY: In your dealings with nursing homes, how bad is the practice of, whatever you want to call it -- private-pay, up-front money, etc.?

MR. FAY: It is almost a prevailing practice. It is a rare, rare nursing home in the State that will take a Medicaid person strictly at the Medicaid rate.

SENATOR CODEY: How prevalent is it? Are some nursing homes worse than others?

MR. FAY: Yes, some are worse than others. Some will ask for a two or three-year contract, while the "humanitarians" will ask for a six-month contract.

SENATOR CODEY: The what?

MR. FAY: Those who will accept the six-month contract, instead of the one-year, two-year, or three-year contract.

SENATOR CODEY: How about complaints of discrimination against Medicaid bed patients as opposed to the private patient -- in other words, the level of service given to one as opposed to the other?

MR. FAY: Again, this is usually a subjective kind of judgment. There are obviously those who are "flush." There are obviously cases where the family or the individual is paying $25 thousand or $28 thousand a year, and the food, the service, and everything that goes with it fits the price.

Generally speaking, we look for any distinction in the food, the diet, the type of room, or the type of ward a person is in, and this is not usually a problem. I would say the average nursing home in the State does treat the private-pay person and the Medicaid person equally.

SENATOR CODEY: How about the other states that have outlawed these private-pay contracts? What has been the experience there?

MR. FAY: We have been monitoring them. We have been in close touch with the States of Massachusetts, Connecticut, and New York. We are also in close touch with the Washington office of the National Coalition for Nursing Home Reform. Where they have gone to court, they have been upheld. Where the nursing home industry has taken a few of these states to court -- the few cases that have been challenged -- the courts have upheld the right of these states to bar this discrimination. And, we are still monitoring this. We have found no major problem developing in the states that have outlawed this practice and that have put it on a first-come, first-serve basis, or have put a blanket condemnation on discrimination against a Medicaid patient.

SENATOR CODEY: Okay. And, they are still in business?

MR. FAY: Yes, they are. I have heard of no CARE packages being mailed into Minnesota.

SENATOR CODEY: What about discrimination by nursing homes with regard to taking in rooming-house patients who may have had some psychiatric problems?

MR. FAY: The psychiatric patient has always been a particularly difficult man or woman to place. The Public Advocate, the Department of Human Services, and the nursing home industry seem to have worked out an acceptable and agreeable solution. They were a problem, and sometimes the State wasn't very fair to people who needed particularly strong tranquilizers. They did not send along their medical charts to the nursing home administrator. So, there were such cases, and our office has investigated cases where the nursing home had a right to ask for more backup support and cooperation when they accepted psychiatric patients.

But, the State has, I think, been doing a lot too. Just a few years ago, the State of New Jersey opened Glen Gardner and took in a great number of people from Trenton Psychiatric and, I believe Marlboro. These people shouldn't have been in a psychiatric hospital in the first place; however, there was literally nowhere else to put them.

The State of New Jersey runs three nursing homes, the Veterans' Home in Menlo Park, the Veterans' Home in Vineland, and the Glen Gardner operation. The Glen Gardner operation happens to be a very good one, a very strong one.

Commissioner Albanese also mentioned the role of the county hospitals, and I feel this should be given legislative priority also, because the county hospitals usually take in the very sickest, and the very poorest people.

Assemblyman Long just got a bill out of Committee last week, A-815, which would help do away with the problem Commissioner Albanese mentioned regarding the "cap" being involved in the operation of county hospitals. So, I think the role of the county hospitals, which serve the very sick, the incontinent, the non-ambulatory -- patients that a nursing home is hesitant to take in just because they are so sick and because they are Medicaid eligible and poor -- should be given a high priority also by the Governor's office, the Senate, and the Assembly. That too would be a major step: To give priority and more support, Federal, State, and local, to the county hospitals, which are 98% geriatric today.

SENATOR CODEY: What about the practice by which some nursing homes require so-called "gifts," or whatever? In other words, a patient will be a private-pay patient until he or she uses up "x" amount of dollars. They will then become a Medicaid patient, and the home says: "What about a donation to the "so-and-so fund," or whatever? What is that money? Is that a kickback to get your mother or your father into a nursing home?

MR. FAY: Yes. I know. Again, these are complaints that are brought to us, and this usually happens in nonprofit homes -- usually religious homes. Sometimes one wonders whether it is a demand, or "We are going to give you indulgences if you contribute so much money to the home."

SENATOR CODEY: Let's not just pin it on one particular church.

MR. FAY: No. They will also build you a king-sized statue of Moses if you contribute to another group. But, every Protestant group, every Catholic group, every Jewish group -- every religious group -- requests donations, and if it is a legitimate donation, it is all right.

SENATOR CODEY: But, is it a legalized kickback?

MR. FAY: If they say, "You have to give us money," or, "We are demanding a $5,000 or a $10,000 contribution or you are not going to get a bed," then it is illegal. We would then bring it to the Medicaid Fraud Division, the Attorney General's office, to Bob Popkin in Medicaid Integrity, and it would become an issue. But, we have found that people are very reluctant to sign the charge.

SENATOR CODEY: Does it then get down to a question of semantics, where they bargain?

MR. FAY: Exactly. It is a very difficult point to bring forward. But, we get the complaints. They come to us sometimes after their parent has died, and they tell us, "This was forced on us." If we ask, "Will you sign a deposition attesting to that, and will you allow us to take it to the Attorney General?," in most cases they won't. If they do, it immediately goes to the Medicaid Fraud people.

SENATOR CODEY: Do you find that they will ask for what the market will bear? If you are wealthy they will--?

MR. FAY: Again, I don't claim any expertise in this. My knowledge comes from the few people who have literally come to us with these kinds of charges. It is just like the charge that the family has had to sign over their assets. Again, I think we need a strong system of checking the assets, and the two-year qualifier is badly needed also. The Medicaid Fraud people happen to have a very strong, effective office, if they are given the authority to check these things out.

Again, we get many charges, but we do not get specifics. No one will tell us the names of the people who are involved in possible Medicaid fraud.

SENATOR CODEY: Mr. Fay, when you are talking about turning over assets, are you talking about someone who goes into a nursing home and as a result of being accepted, he or she legally turns over his or her assets?

MR. FAY: A couple of weeks before they go into the nursing home, they will sign over say $100 thousand in assets, and then when they show up before the Medicaid people to be evaluated, they have that $800 and "some" dollar maximum income with no assets in the bank.

SENATOR CODEY: So, in other words, the nursing home runs up charges and takes it out of that $100 thousand?

MR. FAY: No. They do not even claim the $100 thousand. As far as the nursing home is concerned -- which, by the way, would put them on a waiting list -- if they are trying to get Medicaid eligibility, they would claim they have no, or very little, assets, with an income of, maximum, $800 and "some" dollars a month.

But, there are families, and we have records in our office of this, that have gone through $100 thousand or $150 thousand of their income. You know, it doesn't take long at $20 "some" thousand a year to go through $100 thousand.

SENATOR CODEY: But, does a nursing home have a habit of running up charges on those patients?

MR. FAY: Not really. No. The normal charge would be $20 thousand a year.

SENATOR CODEY: So, as far as you know there is no practice of running those charges up quicker?

MR. FAY: Not that we know of, Senator. No. We have never found that to be the case.

SENATOR CODEY: Okay. Thank you very much, Mr. Fay.

Our next witness will be Betty Tierny.

BETTY TIERNY: Good morning, Senator.

SENATOR CODEY: Do you just want to relate for us, if you can, your own experience?

MS. TIERNY: Yes. My mother is now in a nursing home. In June of 1983, she had a stroke and a heart attack. She is also blind from the stroke. She was in Englewood Hospital in Bergen County until January 4, because we could not place her anywhere.

We went to numerous nursing homes and everywhere we went, it was the same story. As soon as they heard she was going to be a Medicaid patient, it was as if we said she had leprosy. There was a year and one-half to a two-year waiting list, unless, of course, you could prepay up to a year. And, of course, we couldn't do that, because the nursing homes varied. They were $68, $77, to $80 a day, and, of course, the better ones were $90 and $100 a day. We could not afford those prices. We come from a middle-income family.

My mother has no assets. She has $1,500 in the bank, and she does not even have any burial insurance. So, this is not a case where there was any money.

Discriminated against? Yes, I felt we were; and, there are many like us. It is a terrible, terrible experience. I have a picture of my mother. It was not as though we were trying to get rid of her. It was a fact that she needed nursing home care. None of us could handle it.

SENATOR CODEY: You were told by the hospital--?

MS. TIERNY: (interrupting) We were told by the doctor that she would have to be placed in a nursing home.

SENATOR CODEY: Did the hospital say to you at any time, "Listen, you have to have her out by a certain day?"

MS. TIERNY: Yes. What happened was, after five months, they did come up with a nursing home. The home was unacceptable to us.

SENATOR CODEY: The hospital came up with the nursing home?

MS. TIERNY: Yes, they did. Because, up until this time, they had been taking Medicare. That was fine for them. But, they knew they had to push her out because they could no longer do anything for her. They wanted her out of the hospital. So, they came up with this nursing home, which was unacceptable, totally. We were not going to put her there. We told them this, and at that point -- that day -- they discontinued her benefits.

So, they started billing my sister. My mother lived with my sister. I have a sister and two brothers. We had a meeting with the hospital administrator, and the problem was that Medicaid never really told us anything. The social worker never told us anything. She had her on a list, so she said. It is her word against ours, of course, but nothing was ever done. We were not advised as to what we should do or what we shouldn't do.

My sister refused the Medicaid bed, and when she did that, everything ended. We realized that after we did it. But, before that, no one told us that if we refused the Medicaid bed, then Medicare would be terminated.

SENATOR CODEY: What was wrong with the nursing home?

MS. TIERNY: When they first mentioned the nursing home, my brother went to the home. He met the administrator, and she was really quite rude to him. Most of the patients were drugged and sitting in wheelchairs. Of course, a lot of them were on medication. That is typical. It was not the kind of place one would want to be in.

When you go to a nursing home -- and I have been to enough of them now -- you can go in to see them, and then you have to ask yourself if you would want to be in this home if it happens to you.

My sister then went to the home to see it after the social worker called. She was allowed to walk onto the floor without anyone stopping her. She said the smell was really terrible. And, of course, we were told by everybody, "You cannot go by that." But, you can, because the nursing home my mother is in now has no odor like that.

SENATOR CODEY: What was the odor, human waste?

MS. TIERNY: Excuse me?

SENATOR CODEY: What was the odor?

MS. TIERNY: Human waste, yes. My sister also met a lady who was feeding her mother, and she told my sister that her mother had been there for a number of years, and if my sister had any other recourse, she should not put my mother in there. It was a terrible place.

The administrator told this lady that she was just a pain in the neck because she was there every day to feed her mother.

SENATOR CODEY: What eventually happened? How did you eventually get your mother in a home?

MS. TIERNY: Because the hospital was so anxious, and because we were pushing so hard, they found the home my mother is now in. We had to prepay four months, which we are not complaining about. We had offered to pay three or four months anywhere, but that wasn't enough. In December, my brother negotiated for three days with a home in Pittstown, New Jersey, and they told us then -- he offered them six months prepay -- that was not enough money because my mother would be too much work and they wouldn't make any money on her.

SENATOR CODEY: In other words, the nursing homes you went to were willing to take your money, money you really didn't have?

MS. TIERNY: Yes. They all want to use prepayment now -- nothing less, really.

SENATOR CODEY: What were they asking for?

MS. TIERNY: They were asking for approximately $30 thousand.

SENATOR CODEY: Thirty thousand dollars?

MS. TIERNY: Between $28 thousand and $30 thousand. That is for one year.

SENATOR CODEY: They would take your mother in as a private patient--

MS. TIERNY: (interrupting) Yes.

SENATOR CODEY: (continuing) --if you were willing to sign a contract that you would pay them $30 thousand?

MS. TIERNY: Yes.

SENATOR CODEY: Were you allowed to pay that over the course of a year?

MS. TIERNY: Yes. Well, in the home my mother is in now, the prepayment is spread over four months. We are billed. In these other

homes they didn't say, because we just walked out. We put her on the Medicaid list, but we couldn't prepay.

SENATOR CODEY: What was the highest amount of money you were asked to pay?

MS. TIERNY: Most of the homes just wanted a year, and that ranged in amount. You know, if you went to a better home, it was something like $77 to $80 a day, and the others were $68 to $70.

SENATOR CODEY: Per day?

MS. TIERNY: Yes, per day.

SENATOR CODEY: Did any of them also tell you that you would have to give a gift in addition to that?

MS. TIERNY: No, they didn't.

SENATOR CODEY: How did you eventually find the home that your mother is presently in?

MS. TIERNY: Through the social worker at the hospital. They said they wanted my mother out. I think it was really the hospital administrator who was putting pressure on the social worker to get our family away from the hospital because everybody was calling. I had United Way calling me. I called the Ombudsman. He was very nice, but he couldn't help either.

It is a terrible thing when you have a situation like this and nobody can help you. If you are the victim of a crime, the law is there to protect you. The law is not there to protect an elderly person. They are not a priority anymore, and that is a terrible thing. It really is.

SENATOR CODEY: How long did it take you from the time the hospital told you they could no longer help your mom, suggesting that she go into a nursing home, until you were finally able to find a home?

MS. TIERNY: She was in the hospital about six or seven weeks when they finally said, "Well, she seems to be stabilizing. You really should start looking for a home." So, okay, we went out and we looked -- you know, it was just one day after another.

My sister and I looked at most of the homes. I guess from August on, we looked. We went the day after Thanksgiving to look at homes. We would go on Saturdays, but a lot of times the administrators

are not there on Saturday, and they don't like you to go through the floors on that day. You have to go during the week.

You can go to look at a home on a Saturday or a Sunday, but there is really nobody there to show you the home on those days. You have to go during the week when everybody is at work.

SENATOR CODEY: So, it took you six months or so to find a nursing home for your mom, and even then you had to pay?

MS. TIERNY: Four months.

SENATOR CODEY: So, in other words, you were never able to find one nursing home in the State of New Jersey that would accept your mother as a Medicaid patient?

MS. TIERNY: That's right. And also, because of the condition my mother is in, she cannot even get Medicare from the nursing home-- I mean, the nursing home can't get Medicare for her because she won't take any therapy. She is going into the fetal position. She is just a total bed-care patient, so we also have to pay the Medicare portion of her stay in the nursing home.

SENATOR CODEY: So, it has really become expensive for you and your family?

MS. TIERNY: Yes, it is going to be about $16 thousand.

SENATOR CODEY: Money that you really can't afford, I guess.

MS. TIERNY: No. But, you have to do it. I mean, she is our mother. We are not going to leave her. She would do it for us, I am sure.

SENATOR CODEY: Ms. Tierny, I just want to thank you for coming here this morning and sharing your story with us. I appreciate it.

MS. TIERNY: Thank you.

SENATOR CODEY: Our next witness will be Assemblyman Dean Gallo. Assemblyman?

ASSEMBLYMAN DEAN A. GALLO: Thank you, Senator. I don't think we need a further description of some of the problems we are facing in the State of New Jersey when we are dealing with nursing homes and Medicaid beds than we heard from the last witness.

What I would like to do is to give you a presentation. It deals with a number of bills that were previously mentioned by both Commissioners Albanese and Fay.

My testimony will not dwell upon the need to prohibit the practice of requiring private-pay contracts of Medicaid-eligible individuals as a precondition for admission to a nursing home. Today, this Committee has heard and will hear testimony which eloquently expresses the need for the prohibition. Most people I have spoken with find the practice pernicious. It should also be noted that Governor Kean, in his State of the State Message, requested legislative action that would protect the Medicaid and Medicaid-eligible individual from this unjust practice. In summary, I believe that ample evidence exists to prompt the Legislature to take up the cause raised by the Governor.

I will concentrate my remarks on the legislative remedy to this problem. Assemblyman Bob Franks and I have introduced a three-bill package which deals comprehensively with the private-pay issue. I will speak to A-872, of which I am the prime sponsor, and Assemblyman Franks will speak to his bill, A-873. The third bill, A-874, of which Assemblyman Franks is also the prime sponsor, appropriates the Federal funds necessary to accommodate the potential increased costs to the Medicaid program resulting from the prohibition.

Let me state from the outset that this package is the product of the extensive and intensive deliberations of individuals who are highly knowledgeable of New Jersey's institutional long-term care system. These deliberations took place under the auspices of the Statewide Nursing Home Task Force. The package that Assemblyman Franks and I are about to present to you represents the findings of the Task Force, and most specifically, the Task Force Committee which studied the private-pay issue.

A-872 contains three important provisions. First and foremost, it prohibits the current practice of many nursing homes in which the home -- as a condition of admission -- requires the Medicaid-eligible individual or his or her family to sign a private-pay contract. If this bill is enacted, a nursing home administrator or operator would not require either the Medicaid-eligible individual

seeking admission or his family to sign a private-pay contract. If the person is admitted, then he must be admitted as a Medicaid client.

The bill also provides for penalties to be imposed on any nursing home administrator or operator found guilty of violating this law. The violator would be guilty of a third degree crime. Moreover, he would be liable to the person or persons illegally forced to sign the contract for: one, the amount of money paid out in compliance with the illegal contract; and, two, interest on that money. The violator would also be liable to the State for any payments the home received not to exceed threefold of the total amount and a penalty of $5 thousand for each valid claim.

The third important provision -- and one which, unfortunately, has not received a great deal of public attention -- deals with what you might call the "flip side of this coin," the illegal transfer of assets. It is sometimes the case that an individual will divest himself or herself of their assets in order to qualify for Medicaid benefits. There exist Federal and State laws against this sort of practice, but these laws fail to take into account one important factor in this sad and unjust practice: The recipient of these divested assets. It is often the case that the elderly people are taken advantage of by some unscrupulous members of their families. These family members manage to get their elderly relatives to divest themselves of their assets. Once this action has taken place, it is not feasible -- or, in a sense, even fair -- to seek redress from the elderly individual. What the law must do is hold the recipients of the assets accountable for their actions. Currently, laws governing the transfer of assets do not do this. My bill addresses this oversight by allowing the State to take legal action against the recipient of the transferred assets. Incidentally, it is my understanding that if this law is enacted, then New Jersey would be the first State to have such capabilities.

The bill also appropriates from the General Fund $595 thousand to pay for any potential increase in State Medicaid costs resulting from the prohibition. This appropriation, along with the Federal appropriation found in A-874, should cover the estimated increased costs from April 1 to the end of the fiscal year.

The picture I have begun painting is not complete until Assemblyman Franks gives his testimony, but let me conclude, Mr. Chairman, by stating that my bill does what we all want to see done, and that is to prohibit the use of private-pay contracts as defined during this hearing. It protects the economically-disadvantaged senior citizen from being treated unjustly. It also protects the taxpayers from individuals who try to obtain public financial assistance when they do not really deserve such assistance.

Given the importance of this legislative package, I hope it receives prompt consideration from the Assembly. When this Senate Committee reviews the package, I would be pleased to come back and offer any further testimony that you might desire. Thank you.

SENATOR CODEY: Thank you Assemblyman. What has been the response to your bills from the industry itself, sir?

ASSEMBLYMAN GALLO: Well, I think the industry has not been overly-enthused with the bill, to say the least. There have been attempts -- not directly with me, but with staff people -- to make some modifications and suggested amendments. At the present time, we are reviewing some of those, but the initial reaction from the industry was one that I would expect.

SENATOR CODEY: Thank you very much.

Our next witness will be Assemblyman Robert Franks

ASSEMBLYMAN ROBERT FRANKS: Mr. Chairman, thank you very much for allowing us to testify on these bills of substantial public importance. I believe by virtue of the fact that this public hearing is being held, Mr. Chairman, you are doing all of us a great favor, most notably all of the tens of thousands of New Jersey families who have elderly members in the family and who are contemplating their need for nursing home care in the next couple of years.

One very distressing fact that I have been made aware of by residents of my own district -- as well as by Ombudsman Fay and a number of other people who are experts in this particular area -- is the level of naivete on the part of these family members who are unaware of the devastating impact of private-pay contract requirements, until it is virtually too late.

The people I have spoken to in my own district, I think, believe that if they are covered by Medicaid, they are going to be entitled to Medicaid treatment, that the government is going to take care of the health care needs they face in their later years. It is only when they actually seek out a place to put their loved ones in, a place where they know they will be well cared for, that they are made aware that this governmental program we call Medicaid is, quite frankly, a sham to 11,000 New Jerseyans who may be considering the need for this care, but who will not be able to receive that quality care unless they are willing, or able, to generate enough money for this private pay contract.

So, I think the fact that you are bringing this issue to our attention today is going to put the New Jersey public on notice that they have to look more deeply into this issue; they have to understand what Medicaid does not avail them of, as well as what it might avail them of. And, I think it is our principal responsibility in this Legislature to change the current rules of the game, because I believe fundamentally -- as I know most of us do -- that we need to care for our elderly population, and not pull, if you will, a "bait and switch" trick, where they actually take advantage of the programs we have established for their own benefit.

As Assemblyman Gallo indicated, I am the prime sponsor of A-873. My bill amends the Law Against Discrimination. It adds a provision to the law which states that a nursing home whose annual Medicaid occupancy level is less than the statewide annual average occupancy level, as determined by the Commissioner of Human Services, shall not deny admission to a Medicaid-eligible individual when a bed becomes available.

In a sense, this bill provides the tool by which Assemblyman Gallo's bill can be implemented. After studying the issue, the Nursing Home Task Force concluded that the prohibition -- as found in Assemblyman Gallo's bill -- does not address the entire situation. I have found the Task Force argument to be persuasive in this regard.

First, let me answer the threshold question: Why is this bill necessary? Assume for a moment that Assemblyman Gallo's bill is

enacted by itself. In other words, the private pay contracts can no longer be required of Medicaid-eligible individuals. What are the likely consequences of this action?

The prohibition does not require the nursing home administrator or operator to admit the Medicaid-eligible individual; it simply says that if the person is admitted, it must be as a Medicaid client.

As public policy-makers, we must be cognizant of the possible consequences of our actions. Unfortunately, one of the possible consequences of enacting the prohibition is that some nursing home owners -- disgruntled over the fact that they cannot any longer require private pay contracts of their Medicaid-eligible patients -- could refuse to admit Medicaid clients altogether. This scenario would have a disastrous impact on the availability of beds for Medicaid clients. As this Committee knows, there is already a shortage of beds for Medicaid clients.

If nursing homes retaliate against the Medicaid program as a response to the enactment of the prohibition bill, then this could make a bad situation even worse. In other words, enacting the prohibition without some appropriate companion mechanism to distribute the Medicaid population that will be affected, could actually make it even more difficult for Medicaid clients to obtain nursing home beds. And, what is more disconcerting is that the situation would carry the appearance of legislative approval, since it was legislative action which prompted it.

Some mechanism is needed to prevent nursing homes from "locking out" Medicaid clients. A-873 provides that mechanism. It is directed at those homes below the statewide Medicaid occupancy level; that is, those homes which are not doing as much as other homes to care for Medicaid clients. The bill says that these homes shall not deny admission to a Medicaid-eligible person if a bed is available.

Let's apply the bill to reality, as we find it in March, 1984. The current annual statewide occupancy level is approximately 60%; that means that 60% of all the patients in nursing homes are Medicaid clients. If I operate a home whose annual Medicaid occupancy

level is below 60%, then I cannot deny admission to a Medicaid client who is applying for an available bed. If I operate a home above the 60% occupancy level, I can deny a Medicaid client admission in favor of a private pay client.

I anticipate regulatory action to flush out certain details of this bill. For example, the Department of Human Services might require all homes below the Medicaid occupancy level to maintain a bona fide waiting list. This waiting list could be inspected periodically to ensure that no home falling under the law is keeping out Medicaid clients in favor of private pay clients.

Mr. Chairman, I believe that this bill is a fair way of preventing what could be a highly undesirable consequence of prohibiting private pay contracts. The bill affects only those homes which are financially most able to admit additional Medicaid clients. Furthermore, it does not force these homes to admit only Medicaid clients; private pay patients can still be admitted, provided that they are not given preferential treatment over a Medicaid client.

I should add that the bill contains language giving the Commissioner of Human Services the prerogative to exempt homes from this law or modify the law's application. I can foresee certain instances where the law could cause severe hardship for homes with small patient populations, even though these homes fall below the annual Medicaid occupancy level. Therefore, it is important, in my judgment, to give the Commissioner substantial flexibility in the application of the law. Thank you very much, Mr. Chairman.

SENATOR CODEY: Thank you. Assemblyman, has your office had many inquiries from your constituents with regard to nursing homes?

ASSEMBLYMAN FRANKS: Mr. Chairman, I think it has been consistent over the years. I would have to guess that we get four or five a month, on an average. Sometimes it fluctuates, but I can basically rely on the fact that we will receive five to ten inquiries in any given month. And, as you indicated earlier, it is one of the most frustrating inquiries that is made of any legislator, because, frankly, one feels so helpless in one's ability to deliver the service that people are rightfully asking for.

SENATOR CODEY: Yes. I don't know your experience, or the experience of Assemblyman Gallo, but I know we, in our office, have received calls from people who have said: "I just got a call from the hospital. My mother is going to be discharged on Friday at twelve o'clock. She is going to be on the street, whether we like it or not." These are people who have been trying, as the lady who testified before said, to get a Medicaid bed, but they are unable to, and the hospital wants the patient out because they feel they shouldn't be there. It is a very sad, human, and touching story, that I am sure we have both seen and heard.

ASSEMBLYMAN FRANKS: Mr. Chairman, again, it is a sense of false protection. It is a sense of, now you know you are Medicare eligible; you have qualified; you are on a list; you are going to be taken care of, and the treatment you are going to require for your future health needs is going to be given to you. It is only when you try to seek admission to a nursing home for a loved one that this additional requirement comes from out of the blue: In order to have preference among the class of Medicare-eligible people, "P.S., it is going to cost you $20 thousand." It is then that people come to the realization that it is too late.

ASSEMBLYMAN CODEY: Okay. Thank you very much, Assemblyman.

ASSEMBLYMAN FRANKS: Thank you, Mr. Chairman.

SENATOR CODEY: Our next witness will be Mr. Elliot Solomon, First Vice President, New Jersey Association of Non-Profit Homes for the Aging.

MEMBER OF AUDIENCE: He left.

SENATOR CODEY: He left? I hope I didn't scare him away.

Is Edith Edelson here? (affirmative answer)

EDITH EDELSON: Thank you, Chairman Codey, for this chance to have something to say about this very sad situation. I am President of the Concerned Committee for the Elderly, and I am also Chairperson of the Health, Welfare Task Force of the New Jersey Federation of Senior Citizens.

The Concerned Committee concerns itself with getting visitors to residents of nursing homes. It is also concerned about legislation

and regulations to protect the residents. The Concerned Committee does not handle, or involve itself, with any individual complaints, even though it is concerned about legislation and regulation.

A few cases have come to my attention which may illustrate some of the difficulties. One is about an aunt with $90 thousand in assets upon entering a nursing home. The niece had to sign a contract, which expires this July. The aunt had no children, just the niece.

The aunt is eligible for Medicaid now, but the niece is obligated by contract to continue paying. There is no money to do so. The niece cannot care for the aunt at home because she works. The aunt had lived alone before. This is a "Catch 22" situation.

Another example: A daughter put her mother in a nursing home about one and one-half years ago. She had to sign a two year contract. The mother's money ran out, but the mother's pension and social security benefits make her ineligible for Medicaid. The daughter works and has a child. She is in a bind to pay the difference in the money the nursing home requires. The mother had lived alone and the daughter cannot care for the mother at home. So, the mother can get no help from Medicaid nor from any source at all. And, the question is, what is going to happen to this mother?

Another situation: A daughter applied to a nursing home. Someone in the nursing home said that if she would make a donation, her mother would get on the list sooner.

SENATOR CODEY: What do you mean by a donation?

MS. EDELSON: Well, that is what they called it, a contribution to the nursing home.

Some of the nursing homes said if she would make a donation the mother would get on the list sooner. At the time, the hospital was pressuring the daughter to take the mother out. It was a hectic time, and the daughter didn't realize what she was signing. She signed a contract for two years. The mother's assets are gone. The daughter told the nursing home that the mother's assets were used up. The nursing home said that since the daughter had signed the contract, she would have to continue paying.

On the question of unavailability of Medicaid beds, I spoke to the social worker on the Board of Social Services in Middlesex County. She said that there are many people waiting for nursing home placement who could not afford a private contract.

One man who needed nursing home placement waited over a year. His wife is blind and she couldn't care for him. While he had a home health aide during part of the day, he would get up at night and walk out. The police would bring him home. Finally, fortunately for that man, a year later -- or more than a year later -- he was finally placed.

The last example: A Spanish-speaking man whose wife was in a nursing home in Middlesex County, lives with his divorced son and fifteen year-old granddaughter. The granddaughter had to give up her room to him. When she returns from school, she often has to go out to find him. She has become nervous and she is now doing poorly in her studies. He had been in need of a nursing home for two years. He had been in and out of the hospital. At one time, Medicaid sent him to a nursing home in south Jersey. There were no Spanish-speaking workers there, and so he didn't want to be admitted. Actually, he would have liked to be placed in the nursing home his wife is in. The Board of Social Services has been unable to find placement for him there, or elsewhere.

Obviously, there is a great need for A-872, A-873, and A-874. And, to expedite things, I wonder if a companion bill could be introduced in the Senate to sort of speed up action on this? Thank you.

SENATOR CODEY: Excuse me. What have you found the experience to be in Middlesex County regarding how long it takes to obtain a Medicaid bed?

MS. EDELSON: I am sorry, I cannot give you those figures because I don't deal directly with these situations. We occasionally get a call, and we refer it to the Ombudsman's office.

SENATOR CODEY: Okay. Thank you very much.

We will reconvene this hearing at 1:15 P.M.

LUNCH BREAK)

AFTER LUNCH :

SENATOR CODEY: We will now reconvene this hearing. Our next witness will be Mr. Jim Cunningham, President, New Jersey Association of Health Care Facilities. Go right ahead, Mr. Cunningham.

JAMES CUNNINGHAM : Thank you very much, Mr. Chairman. Considerable public attention recently has been drawn to the admission to nursing home facilities of patients who may be private pay patients because their families agree to pay the private payment rate for a period of time that generally is specified by contract.

This private pay requirement has been forced on a number of nursing homes by a heretofore immutable factor -- inadequate nursing home care reimbursement by Medicaid. This shortcoming has been recognized not only by the industry, but by a variety of other public findings, particularly the July 21, 1983 report of the New Jersey Nursing Home Task Force to which Governor Kean referred in his 1984 Annual Message.

The New Jersey Association of Health Care Facilities represents more than 160 long-term care facilities, proprietary as well as voluntary, nonprofit. NJAHCF supports legislation that would bar mandated private pay agreements for patients who are legitimately eligible for Medicaid unless such an agreement is purely voluntary. Our support comes with the proviso that any legislative action is accompanied by safeguards that nursing homes, whose Medicaid populations are thus enlarged, do not become insolvent because of the inadequate rates.

At the same time, the legislation should consider the additional burden that is placed on private patients whose assets, although generally limited, are higher than Medicaid limits. In other words, Medicaid rates should not be set so low that private patients must, in effect, subsidize service rendered to Medicaid patients at below-cost levels.

Assembly Bills 872, 873, and 874 have been introduced to meet the problem outlined above. This package contains meaningful solutions if: one, it is amended, generally along the lines recommended by the Nursing Home Task Force; and, two, if the administration will make the financial commitment which the Governor promised in press reports, but apparently rescinded in his budgetary recommendations.

NJAHCF supports passage of A-872 with vital amendments, which we discuss below. We feel that A-873, which is designed to avoid alleged "discrimination" instead fosters reverse discrimination against patients of relatively modest means who cannot qualify for Medicaid. Nursing homes with a predominance of private pay patients generally operate above minimum standards -- particularly for nursing staff and special programs -- prescribed by the Department of Health. If they are forced to absorb heavy increases in the Medicaid population, they concomitantly will be required to operate at bare minimum in these areas and, thus, the patients who continue to pay their own way, as well as the existing Medicaid patients in their populations, will not benefit from the better staffing. Thus, the cure offered by A-873 may be worse than the disease it seeks to remedy; therefore, the bill should be held. NJAHCF recommends passage of A-874, but we think it is inadequate to meet the costs of new Medicaid patients in the last quarter of the current fiscal year.

Amendments: A crucial amendment to A-872 is a provision for incentive payments to high Medicaid occupancy facilities. The Nursing Home Task Force Report, to which the Governor referred in his annual message, says: "All members of the Committee did agree that, if private pay contracts were to be restricted, the State should implement a reimbursement differential for those nursing homes with a very high Medicaid census. Although this would add to the cost of the majority recommendations, it would be necessary to protect the solvency of some homes that might approach 100% Medicaid occupancy."

Hard-won experience by nursing homes over the years shows that Medicaid "eligibility" often results from the transfer of assets by elderly infirm persons to other family members, most often their children. For many years, this practice was not prohibited by Federal

and State law. In recent years, statutory restrictions were enacted but often are observed in the breach. A-872 provides for penalties against the elderly person who illegally divests himself of assets; often that person's mental capacity is limited by age and illness. A-872 provides no penalty for the beneficiaries of such divestiture -- children, other relatives, or friends. No court is going to fine or imprison grandma or grandpa. But, a court would take a different view of a relatively well-off son or daughter who reaped substantial financial benefits while imposing nursing home costs on the taxpayers. Section 4 should be amended to provide penalties as severe as those proposed for nursing home operators who illegally require private pay contracts. Such a criminal sanction also was a unanimous recommendation of the Task Force.

A-872, or companion legislation, should give the State better tools to detect illegal qualification of applicants to the Medicaid program. This was another unanimous recommendation of the Task Force which said: "...detection and enforcement should improve by giving either the CWAs -- county welfare agencies -- or DMAHS -- Medicaid -- access to State income tax returns, bank records, and county register records."

Massachusetts already has implemented a program that permits its Department of Public Welfare to check by computer the bank balances of public assistance recipients. The department has been able to save $25 to $30 million annually by finding and disqualifying recipients above the income level cutoff.

We think the penalties proposed against nursing home administrators by A-872 are overly harsh. Sections 1a and b would make violations of the act a crime of the third degree; this bears a penalty of three to five years imprisonment, plus a $7,500 fine. In addition to requiring return with interest of any illegal private payments, the sections d and e would impose a payment to the State of $5,000 for each claim. Furthermore, nonprofit charitable institutions face an even more severe sanction in section d, which would require them to pay the State triple the amount they received in donations or gifts from persons related to their patients. We think that reimbursement with

interest and application of a lower-degree criminal penalty would be sufficient to assure compliance.

We believe that enactment of A-872 with these amendments and an improved A-874, together with a remarkable level of nursing home construction that has paralleled the nation's and State's economic recovery and a plan worked out by this association with the Department of Human Services for the introduction of some 600 new Medicaid beds by utilizing unused space in existing facilities, will remove the necessity for passage of A-873, the "anti-discrimination" bill.

In 1983, 13 projects, new construction or enlargements of existing facilities, were opened, providing 1,358 beds. Most of these openings were in the last six months of the year. Under construction, as of February 1984, are 16 other projects which will bring 2,148 beds on line. In addition, several thousand other beds are covered by Certificates of Need that have been issued by the State Health Department. And, as an added note here, we checked with the EDA, and there are 720 additional beds in final process through their funding mechanism, which would bring 720 more beds on line.

Statistical testimony to these developments has been dramatically provided in recent months. Between January 14, 1984, and February 15, the overall Medicaid long-term care waiting list declined more than 13%, from 2,858 to 2,473. In 1983, the list had substantially exceeded 3,000.

The flexibility resulting from these developments should permit the absorption of the increased number of Medicaid patients while not denying beds to private-pay, Medicare, insurance-covered, Veterans' Administration patients, and those covered by other programs.

We noted with incredulity that the Governor's 1984-'85 budget eliminates the Department of Human Services' request of $29,408,490 for "nursing home expansion" -- that is, new beds -- and "private-pay contracts," -- which is the issue we are discussing -- to implement the reforms he called for in his Annual Message. Passage of A-872 and its signature by the Governor certainly will be celebrated by the press and the public. But, if the funds are not there to pay for the higher numbers of Medicaid patients, how will any of us deal with the resulting chaos?

This program contemplates substantial enlargement of the Medicaid population in nursing homes. This could threaten the State's widely-heralded Medicaid Waiver Program, designed to provide home health care for increasing numbers of elderly who otherwise would require nursing home services. The Task Force dealt with this problem through the following:

"It should be noted that prohibiting private pay contracts could potentially cause problems for the Medicaid Community Care Waiver, since as a condition for its approval the State promised not to allow Medicaid nursing home utilization rates to grow by more than three percent per year. Prospectively banning new private pay contracts would certainly increase utilization by more than three percent per year, although the Federal government might allow an exception due to the circumstances involved."

NJAHCF, the Legislature, and the Executive Branch have cooperated in the past to make effective a whole body of landmark law and regulation. If cooperation and good will are present on both sides of these new issues, we are confident that we can continue to build on this record of success. Thank you, sir.

SENATOR CODEY: Thank you, Mr. Cunningham. Mr. Cunningham, when did the practice of requiring private-pay contracts start, and why did it start?

MR. CUNNINGHAM: The exact year? Sometimes when one has been around in this business quite a while, one sometimes thinks it was two years ago, and it might have been six or seven; but, I would say it probably started six or seven years ago. It probably started with the advent of the critical bed shortage in this State.

SENATOR CODEY: In other words, it was a case of supply and demand? They could demand extra money because of the shortage?

MR. CUNNINGHAM: It was a case of demand, and a case of Medicaid -- not only Medicaid, but State budget problems.

SENATOR CODEY: Yes, but if there was a surplus of beds then they couldn't bargain for the private-pay.

MR. CUNNINGHAM: Well, sir, if we had beds, and if there was a surplus, yes; we would probably not have a problem. In the State of

Texas that is the situation. In fact, it runs in the reverse; Texas nursing homes run about 70% full. Thirty percent of their beds are empty at any one time, so no one has a problem with admission.

The key here is, we need beds. The State budget came somewhat into disarray about six or seven years ago. In New York it was worse; they had a retroactive cut-back on Medicaid rates. An article by the financial lending institutions started appearing in financial magazines: "Don't touch nursing homes; you will end up owning them."

We finally got the Economic Development Authority in this State to agree to cover nursing homes. This was done with some strain; Governor Byrne actually had to tell them to do it. It took about a year to get that process through, and there is a known statistic in this State that no new facility has been on line for less than three years. The three years, and the process of going through EDA has passed, and now we are finally seeing homes appear every couple of months. This will take the pressure off the system.

We are not objecting to this bill.

SENATOR CODEY: So, you are trying to say that the only reason for the private pay contract was strictly financial?

MR. CUNNINGHAM: Financial and to assure--

SENATOR CODEY: (interrupting) There was no gouging?

MR. CUNNINGHAM: (continuing) --and to assure the facility of enough private-pay patients so as to subsidize the government patients. And, the Supreme Court in this State indicated in its decision on the Indigency Case that there was nothing invidious about private-pay patients paying more than Medicaid, and subsidizing them.

SENATOR CODEY: Okay. So, you don't think there was any gouging by the operators of the homes?

MR. CUNNINGHAM: Whether you say "gouging" from the standpoint of exorbitant price, or whether it is from the standpoint of your feeling that private-pay admission agreements are not proper, I don't think there is gouging in the rate the private-pay patients pay. If private-pay admission agreements are to protect the census and vige the home balance in order to stay stable and make a profit, that is a different story.

SENATOR CODEY: Mr. Cunningham, what about the waiting list? How do nursing homes maintain the waiting list? What is the practice? Does it vary from one home to another, or is it standard throughout the industry?

MR. CUNNINGHAM: I would seriously doubt that any of them keep waiting lists. I would say they probably purge them every three or four weeks, mainly because when there is a shortage, a patient may be on 15, 20, or 25 different waiting lists. So, there would be no way of knowing, when a bed becomes available, if the patient is available or not.

So, I would say they don't even keep waiting lists -- or they purge them within a month.

SENATOR CODEY: So, the so-called waiting list really does not exist? When people talk about, "We are on a waiting list 'here' or 'there'," they are talking about--?

MR. CUNNINGHAM: I would say their name is taken and it is probably keep for a month, and then they purge the list and start anew.

SENATOR CODEY: But, in some cases this imaginary list that does not exist, suddenly does exist, and people are moved up according to their ability to negotiate a private-pay contract.

MR. CUNNINGHAM: I don't think that is done through any list. After 30 days, the list would be new.

SENATOR CODEY: It doesn't exist, but the operator tells them that it does exist for the purpose of negotiating a private-pay contract. In other words, one just applies to get on an imaginary list?

MR. CUNNINGHAM: The list could be "that long" in a month.

SENATOR CODEY: The family doesn't know there is an imaginary list.

MR. CUNNINGHAM: I don't think it was imaginary.

SENATOR CODEY: Well, you just said it was an imaginary list.

MR. CUNNINGHAM: I said it is probably purged every month, and then a new list is started.

SENATOR CODEY: But, for all intents and purposes, it is imaginary if you only keep the list for a month.

MR. CUNNINGHAM: I think it is real if you keep it for a month. That is not imaginary.

SENATOR CODEY: It may be real in the minds of the families, but it is imaginary in the minds of the operators. Because once one has been on it for a month, you say he or she is taken off it.

MR. CUNNINGHAM: I am saying this personally. We don't control admissions to facilities. We don't control the prices of the facilities, because that would involve a direct antitrust potential, from the Association's standpoint. Any price-fixing, rate-fixing, or control of an industray in that manner, is an anti-trust violtion. We do not deal in direct-admission policies or the prices of facilities at all. If we did, we could very well be faced with a $6 million or $8 million antitrust suit, and there have been a few of these around the country already.

SENATOR CODEY: All right. With regard to these contracts, what is the "standard" in the industry? Is one year the longest contract? Is it two? It is three? Or, is it whatever the marketplace can bear?

MR. CUNNINGHAM: I don't know that there is a standard. Again, as I said, we don't control this. In conversation, I have heard of some that ran for three months or six months. I have heard of contracts that ran for three years. I have never even actually seen a contract.

Of course if you are in an urban city, I don't think there is a contract at all. There is a direct Medicaid admission. And, if you get an influx of beds in an area, you will find that to be the case also.

About three or four years ago, there was a major influx of about four or five new facilities, new additions, in Burlington County, Gloucester County, and Camden County. Medicaid patients had no trouble getting a bed at all at that time, because there were actually beds waiting.

There is a similar situation right now in Union County. There are a couple of those. And, I am sure if you check with Overlook Hospital right now, and with some three or four new ones that now have

additions, they are, right now, not having any problem at all with Medicaid admissions.

SENATOR CODEY: Mr. Cunningham, as far you are concerned, you know of no nursing homes that have taken advantage of families, with regard to private-pay contracts?

MR. CUNNINGHAM: I hear about this, just as everybody else does: That private pay contracts are a definite requirement.

SENATOR CODEY: A requirement in order for them to get in? If you have the money, you can get your dad or your mother in?

MR. CUNNINGHAM: Right.

SENATOR CODEY: And, if you don't, you are on an imaginary waiting list?

MR. CUNNINGHAM: Oh, I think one could eventually get a bed, once a bed becomes available, especially if there are new openings in the area.

SENATOR CODEY: But, it just seems as though if someone is a Medicaid patient right now, and is in the hospital waiting to get into a nursing home, his or her odds are about as good as winning the Lottery.

MR. CUNNINGHAM: Unless it is in a urban area, or new beds have been built in the area, that's true. The whole key here is enough beds. If we had enough beds, we wouldn't have this problem. But there is another regulation on the books which states that once a person is in a facility for six months, if that facility is a Medicaid provider -- there are some facilities in this State that are not Medicaid providers -- that patient is "yours." The facility cannot discharge that patient. They could try litigation against the family for the balance of the contract.

SENATOR CODEY: You could limit the level of care.

MR. CUNNINGHAM: No, that I would challenge. The level of care in these facilities is the same, whether it is Medicaid, private, Blue Cross, or Medicare. There is no difference in the care in a facility, no matter what the level of the patient.

One of the things that may happen if you get into a heavy Medicaid home is, you may force them into bare-minimum standards. They

may not have the extra number of nurses that I mentioned, or the extra services. That is why every facility attempts to meet a balance. That is why there is a critical necessity here for a Medicaid occupancy incentive, to keep them solvent.

SENATOR CODEY: Okay. Thank you very much.

Our next witness will be Rita Battaglia, Nursing Home Advocacy Center of Essex County.

RITA BATTAGLIA: Thank you very much. As you know, I am basically connected with Essex County and with the families and nursing homes in the Essex County area.

Before I came down here, I spoke with the Union County Ombudsman, and tried to get a little bit of information from her.

As far as accessibility to nursing homes for direct Medicaid patients in our area is concerned, it is very limited. In Essex County we have 21 nursing homes and seven do not participate in the Medicaid program at all.

SENATOR CODEY: In other words, they refuse Medicaid patients?

MS. BATTAGLIA: They are not certified for Medicaid, right.

We have two that are strictly Medicaid homes. One is the county facility, and one is a private home that funnels its other three private pay homes into it.

The remaining homes are all looking for three months to five year's private pay before they will take a Medicaid patient in.

SENATOR CODEY: Do you want to repeat that, please?

MS. BATTAGLIA: They range from three months' private-pay to five years' private-pay.

SENATOR CODEY: As a requirement?

MS. BATTAGLIA: Yes. Now within some of these--

SENATOR CODEY: Five years. So, you are talking about a required guarantee -- if the person lives -- that is well in excess of $100 thousand, or $200 thousand, and up?

MS. BATTAGLIA: Right.

SENATOR CODEY: So, if the family will sign a contract that they will pay the nursing home over $200 thousand, as long as the

patient lives, the patient will get a bed?

MS. BATTAGLIA: Right.

SENATOR CODEY: Okay.

MS. BATTAGLIA: Now, some of these homes will say they are willing to negotiate within a few months of what they would like as a private pay contract, which they do if they can't find someone with quite as much money as they are looking for. They will negotiate to a certain extent.

In Union County, there are sixteen homes. Two will take no Medicaid whatsoever. One is a county facility, which is all Medicaid. Eleven of the homes range from between 18 months' private-pay to three years' private-pay. So, it is even a little more restrictive down there, because they are not even taking three months' private-pay.

There was reference made to the fact that when new homes are opening up they are more receptive to the direct Medicaid patient. That is questionable. They will take a certain number of direct Medicaid patients, but, again, they are still looking for the private-pay patient.

In Union County three homes opened within the last year. One is a nonprofit home, but it is very flexible; it is taking a number of direct Medicaid patients. The other two are looking for 18 months' private-pay. And, those are new facilities.

We have one in Essex County that is now in the process of filling up. They are looking for six months' private-pay while they are filling the beds. Once they are full, that will go up to 24 months' private-pay. So, this is not necessarily opening up a dramatic number of Medicaid beds.

SENATOR CODEY: What has your experience been with nursing homes, with regard to the private-pay, and also with regard to the solicitation of extra donations from the patient or the family? Have you had any experiences like that, or have you had any complaints about that from families?

MS. BATTAGLIA: In Essex County we have one nonprofit home that is pretty well known for soliciting contributions. They will take the direct Medicaid patient, but they also want the family involved, and they will approach them for contributions.

SENATOR CODEY: They won't take the patient unless there is some kind of negotiation with regard to a donation?

MS. BATTAGLIA: One experience I had involved a woman whose family lived in California. I wanted to get an application for her to fill out in order to get into a particular nursing home. They would not allow me to take an application to her in order for her to complete it unless the family was inolved. So, the woman was never able to apply for that nursing home.

SENATOR CODEY: When you say involved, do you mean involved in negotiation for a so-called "gift"?

MS. BATTAGLIA: Right.

SENATOR CODEY: So, unless one negotiates a gift, one does not get into the home?

MS. BATTAGLIA: That is generally the way it has been working, yes.

SENATOR CODEY: Okay. What about your experiences with private-pay patients in nursing homes? What have you found that to be like?

MS. BATTAGLIA: It is very prevalent. As I said, they will negotiate. If they say they are looking for a year's private-pay, and if the person can come up with nine month's private, then, if they can't find someone who has a year's worth of private-pay, they will take the nine months.

SENATOR CODEY: So, they will be flexible according to what the market is?

MS. BATTAGLIA: Right.

SENATOR CODEY: Of course, if they perceive you as being wealthy, then they ask for more?

MS. BATTAGLIA: Over a direct Medicaid, they will take any amount of private pay one can come up with.

SENATOR CODEY: How about discrimination against Medicaid patients, as opposed to private-pay? Have you had any experiences with that?

MS. BATTAGLIA: Again, if they have an bed available--

SENATOR CODEY: No, I mean in terms of treatment.

MS. BATTAGLIA: Oh, no. Usually, once they are in a home they are taken care of.

SENATOR CODEY: And, you think the level of treatment remains constant with all patients?

MS. BATTAGLIA: Yes.

SENATOR CODEY: Okay. So, you would then be in favor of legislation that would do away with the private-pay and gifts as well?

MS. BATTAGLIA: Yes, with regard to the effect it has on the patient and his or her family, and as far as the pressure to come up with the money is concerned. I am nervous as to whether it will restrict, even more, their ability to gain access to nursing home beds.

SENATOR CODEY: Tell me, today you run an Advocate Center in Essex County. If you are a Medicaid patient in the hospital, and you are going to be discharged, what do you do? Do you find a bed right away?

MS. BATTAGLIA: If a person is in the hospital, it will depend on the hospital they are dealing with. Some hospitals will hold them until they come up with a bed. But, at that point, there is no guarantee as to where they will end up. The general policy is, the first Medicaid bed offered to the patient must be accepted.

SENATOR CODEY: Could that be far away from their family?

MS. BATTAGLIA: Yes. I have had many families say they have had relatives placed in the Atlantic City area.

SENATOR CODEY: From Essex County?

MS. BATTAGLIA: Right, and the Newark area, simply because that is where the bed opened up first.

SENATOR CODEY: That is the only place that will accept a Medicaid bed? So generally, you can't get a Medicaid bed in Essex County?

MS. BATTAGLIA: It is very, very tight. Periodically we can come up with one because they haven't found a private-pay patient to fill the bed. They will then take a Medicaid patient.

SENATOR CODEY: Okay. Thank you very much.

Is John Calabria here? John is the Coordinator, Health Department Services, Department of Health.

JOHN CALABRIA: Good afternoon, I am very pleased to represent Dr. Goldstein, Commissioner of Health, at this hearing.

First of all, the Department very strongly believes that public policy must promote the dignity, and preserve the independence of, those persons it is designed to serve. Nursing home care should not be recognized as the first choice, or preferred option, in providing needed services to the elderly. Rather, community-based services which support the retention of people in their homes should be viewed as the first choice of service delivery.

We also recognize that where nursing home care is essential, public policy must be responsive in promoting reasonable and efficient access to care.

The shortage of nursing home beds for Medicaid-eligible persons began to significantly evolve in the mid to late 1970's, following an earlier one-year moratorium, in 1974, on nursing home Certificate of Need approvals, in order to permit the development of a statewide bed-need methodology. The impact of this moratorium caused deinstitutionalized psychiatric patients and the growing number of elderly Medicaid long-term care patients, combined, to fill available beds and create sizeable waiting lists.

Despite the continuous approval of additional nursing home construction during succeeding years, beds were not being built in sufficient numbers to meet the growing need. This lag has been largely attributed to the unavailability of affordable financing, which was perhaps exacerbated by the highly-publicized nursing home "scandals" of the period in other states. Additionally, the development of alternatives to nursing home care, such as residential health care and the utilization of home-based care, were hindered by Federal financing and regulatory policies which tended to encourage the traditional nursing home care. Thus, many persons who otherwise might have been more appropriately cared for in the community were forced to seek nursing home placement to meet their health and residential needs. In fact, several studies across the nation indicate that from 10% to 40% of current nursing home residents could have been cared for by an alternative level of care if it had been available and accessible.

This emphasis on nursing home care only simply increased waiting lists and created the climate for private-pay contracts and the numerous social and ethical problems such "contracts" foster. To avert these problems, the Department supports the passage of responsible legislation to prohibit the use of private-pay contracts by nursing homes as a requirement for the admission of Medicaid eligible patients.

In recognition of the systemic long-term care problems, the Department of Health has taken several positive steps. The State nursing home bed need methodology has been revised in cooperation with the recent Nursing Home Task Force to better reflect the current need situation. Of the present total of over 9,000 nursing home beds, approved through the Certificate of Need process but not yet open, over 2,700 have been approved since this revised bed need methodology went into effect in September of 1983. But, it is also important to note that the Department has utilized the opportunity the new need methodology for approval has presented to give priority to proposed facilities which include residential health-care beds in their applications. This has resulted in the approval of over 1,000 residential health care beds in the past year. The construction of these beds will also be facilitated by the Department's successful efforts to have the New Jersey Economic Development Authority include such beds as eligible for EDA financing.

Now, an upturn in the financing situation, due at least in part to the stabilization of interest rates, has resulted in the completion of over 1,300 nursing home beds just since January, 1983, with approximately 1,500 additional such beds likely to be completed by the end of this year.

In conjunction with the approval of additional beds, the Department has made increased efforts to regulate the so-called "paper bed" situation, where projects retain Certificates of Need for long periods of time, with little progress towards completion. I will note here -- I am sorry this was not included in the written statement -- that so far, in 1982 and 1983, over 1,400 beds have been voided in our new effort to regulate these so-called "paper beds." To further control this problem, the Department is considering amending its

Certificate of Need rules to limit the life of a nursing home approval to two years, with no extensions of time permitted.

Recognizing the problem of Medicaid nursing home placement and, specifically, private-pay contracts, the Department has encouraged new facilities to admit their fair share of Medicaid and discharged psychiatric patients, through the attachment of appropriate conditions to approved Certificates of Need. I would like to mention here that the Statewide Health Coordinating Council puts a condition on each and every approval for a new bed, and the Certificate of Need for these beds stipulates that seven percent of those beds must be for discharged psychiatric patients. The Department has always gone along with that recommendation of the Statewide Health Coordinating Council.

This concept had been initiated through an earlier regulation requiring the acceptance of a percentage of indigent patients as a condition of licensure. In May, 1982, the Department amended its Long-Term Care Policy Manual, which is a departmental regulation, that requires a minimum of 35% of the total bed complement of new or expanded nursing homes be available for direct admission of Medicaid-eligible patients -- that is, without private-pay contracts.

Most recently, the Department has developed a regulation, in cooperation with the Department of Human Services, to permit the temporary expansion -- without a Certificate of Need -- of existing nursing home bed capacities for placement of discharged psychiatric patients. This regulation will be effective by July 1, 1984, and will result in the availability of at least 200 additional beds for those discharged psychiatric patients who now comprise nearly half of the current Medicaid waiting list for nursing home patients.

Finally, the Department supports the recommendations of the Nursing Home Task Force -- a group which represented a strong collaborative effort among departments of State government, members of the public, and the nursing home industry. Most especially, we support the Department of Human Services in their effort to implement the Medicaid Community Care Waiver, an effort which should make community-based services more accessible to more people and obviate or postpone the need for nursing home placement. Thank you very much.

SENATOR CODEY: When do you forsee the State having enough nursing home beds?

MR. CALABRIA: I would judge that if the 1,500 beds that come on line by the end of this year, in fact do come on line-- They are under construction now, and if they come on line, according to our estimates, at or about that period of time, the State will be on its way towards meeting its needs.

The new bed methodology I mentioned, estimates four long-term care beds for all people, aged 65 to 74, and four and one-half beds for people aged 75 and over. Those are the targets we use. We apply those two ratios to the population estimate developed by the Department of Labor. Now, using that, there are more than enough approvals. There will be a substantial number, if they are all built, to meet the nursing home bed needs up to at least 1987.

SENATOR CODEY: Okay. Thank you very much.

MR. CALABRIA: Thank you.

SENATOR CODEY: Our next witness will be Mr. Edward Tetleman, Assistant Public Advocate from the Department of the Public Advocate.

EDWARD TETELMAN: Thank you very much, Senator Codey. I am here representing Commissioner Rodriguez, who regrets that he cannot be here. He is arguing the Conroy case today before the Supreme Court.

The Department of the Public Advocate has long been involved in the issue of long-term care. We have been involved in litigation in New Jersey Health Care Facilities vs. Finley, which found that nursing homes are quasi-public entities. That means they are licensed by the State; there is State involvement in these institutions; and there is also prohibition, essentially, against discrimination, under this case.

We are also involved in the health planning process, and on the Nursing Home Task Force, which examined the issues that are being talked about here today.

Over the years, we have worked with the industry to try and resolve these problems, but we don't always agree. We don't agree, and we differ over the gate-keeping mechanism -- and that is what we are talking about here, we are talking about gate-keeping; people getting into homes that are quasi-public entities in the State. This has been

recognized by the Governor in his State of the State Message, and I think we have to act on this as soon as possible. It has been lingering too long. It raises an important issue. The most important issue is the bargaining power that disadvantaged people have in this society, between low and moderate income people and people who are requesting the necessary service.

Congressman Claude Pepper, in talking about the Federal legislation, called the type of issue we are talking about-- He said that these contracts are nothing less than "blackmail" when he was talking about the passage of the Federal legislation.

What we are asking now is that State legislation complement the Federal legislation, so we can enforce things on a statewide level.

Now, you asked today about the contracts. Let me read to you a phrase from a contract that is in our possession. This contract states that: "One, you will provide $1,000 in security deposit upon admission; and, two, the signatory is to understand and agree that the nursing home will not accept a patient under the Medicaid program, unless the patient has been a private-paying in this facility for a minimal of two years from the date of admission." These two requirements preclude any direct admission for a Medicaid patient. In this particular case, the person's father's per diem base rate had gone up from $47 a day to $57. He wrote to this institution and he said that his father was eligible as of March, and as of May, when he wrote this letter, he was still under the private-pay contract.

I think the most telling thing is what he wrote at the end of the letter. He said: "At the present time, my father's sole means of support consists of monthly social security payments and a small private pension. These are not adequate to cover the cost of his required nursing care. All other available resources acquired by my parents during their productive years were previously used to provide medical care for my mother, who suffered a similar severe stroke in 1971, and who finally died in 1973. After seven years of living with us, her last two years were spent in two nursing homes, with approximately one year in the present nursing home we are talking about, as a private-pay patient.

"Aside from these sources, I provide all other payments for my father's care. These, when combined with payments previously made on behalf of my mother to your nursing home, have reduced my own family's financial resources to a point of very serious concern, and threatens our own security.

"Your decision to convert my father's status to Medicaid would enable us to regroup ourselves somewhat after nine long years of perseverance."

I think that sort of encapsulates some of the things we have heard here today. This is a practice which we want to eliminate. We think it is long overdue. Patients that are eligible for Medicaid, should be able to get it. A-872, which is sponsored by Assemblyman Gallo, will be able to do this. It will make it an enforceable tool on the State level, not on the Federal level.

It also telegraphs a message to the industry that we will not tolerate this practice. It is strong medicine to protect our needy citizens and families from unconscionable practices.

We have heard that the industry claims they can't afford to accept these patients. However, we are talking here about, on the national level, a $19 billion industry. The poor profit market has grown extensively, and continues to grow. The changes throughout the nation are now making incursions into New Jersey. In December of last year, we had, on line, approved CN's -- Certificates of Need for beds -- for 6,234 beds. There is certainly a profit to be made here, or people wouldn't be going into the business. In fact, some stock reports, which we have obtained and excerpted from, talk about that. As of February 11, 1982, Manor Care, which is a major chain, and which is now moving into this State, had their consultants write: "The company has always targeted the more affluent patient market, both by providing high quality facilities and services, and by careful selection of locations in affluent, suburban areas.

"Fundamental to Manor Care's profitability has been the ability of both its nursing centers and its hospital to attract a high percentage of private-pay patients. These patients' bills are paid from personal funds and private insurance, as opposed to public-pay

patients, whose bills are paid by third-parties, such as Medicaid and Medicare.

"Manor Care's private-pay occupancy was approximately 61% during fiscal 1981, as compared to an industry average of less than 40%."

These stock analysts are reviewing this in terms of analyzing the desirability of purchasing stock in this chain. There is clearly a profit to be made here.

Congressman Franks, just to turn to the other issue, also testified on his bill, A-873, about opening the gate and keeping it open. This is particularly important, and I can't underestimate and overemphasize the importance of this.

This is a very fair bill -- A-873. It doesn't say "total nondiscrimination." What it says is that it allocates fair-share amongst all the nursing homes. It doesn't say you have to have 100%. What it says is that under 60%, you have to take on a first-come, first-serve basis. If we ever reach the level where everyone is 100%, I am sure we will have to reexamine the issue at that time. We have always attempted to balance these issues, and this bill does balance it. It balances profitability, quality of care, cost, and access.

It has been said in the past, and we have heard out in the field, that nursing homes can make a substantial profit if operated efficiently, at a 75%-80% Medicaid census. So, the present statewide average of 60% is more than equitable. The only other reason why someone wouldn't take a Medicaid patient, outside of profit, would be by reason of social and medical undesirability -- a heavy-care patient, or based on poverty or minority status. A-873 would eliminate this discrimination against low income people with debilitating conditions.

We have already heard testimony about the new beds, I won't go into that. We have already heard about what goes on with them. I think if A-873 is rejected, there is only one choice for us, and that is to go to a total nondiscrimination basis; not have any formula at all; and, really push the issue. I think this bill offers a more balanced approach. It is a New Jersey approach, which I think is to balance things, and to try and find a reasonable solution to a difficult problem. Thank you. Do you have any questions?

SENATOR CODEY: Thank you very much, Mr. Tetelman, we appreciate your testimony.

Our next witness will be Mr. Meyer Schreiber, Coalition for the Protection of Vulnerable Adults.

MEYER SCHREIBER: My name is Meyer Schreiber. I am an Associate Professor of Social Welfare at Kean College of New Jersey, in Union. I am here in two capacities today: First, to speak for the New Jersey Coalition of Vulnerable Adults, a group which I have the pleasure to serve as their Chairperson; and, second, as a private citizen, speaking in the public interest. I should say that I also have a relative in a nursing home, so I personally feel some of the problems the Committee is concerned about.

The New Jersey Coalition for the Protection of Vulnerable Adults is a State organization made up of individuals and organizations at the State, county, and local levels. It is concerned about, and with, the many adults and older adults in the community who, because of mental, physical, financial, and other difficulties, cannot provide for their own basic needs without help and protection from the community.

Our members have daily and ongoing contacts with individuals and families who are facing major difficulties and problems in caring for beloved family members. They share their sensitivity to such people's needs, and they have a concern about how the State of New Jersey can help facilitate possible solutions to some of these perplexing problems.

Admission to a New Jersey nursing home is one of these persistant and complex problems that face such individuals and their families, and the many community agencies to whom they turn for help and guidance.

Our coalition firmly supports the position of the Governor in asking the Legislature to enact new public policy to do away with the prepayment for admission to a nursing home. Most of us are well aware, both as professionals and as family members, of the many moral, ethical, and philosophical issues that prepayment leaves in its wake. Many of us, as professionals, hear about the additional burdens family members have to carry in order to meet the demands of a nursing home,

in terms of the dollars they have to pay as a prerequisite to admission. The time has come when you in the Legislature, and we the public, need to outlaw this terrible practice. We cannot stand silently by while this practice harms those with no resources, as well as those who are consigned to linger on and on awaiting nursing home placement.

The Coalition members recommend consideration of the New York State Program, where their is no differential between the Medicaid fee that the nursing home receives and the private-pay contract arrangement that the home has made. New York has had considerable experience in the form of some terrible nursing home scandals, which led to reform in that State and all over the country. We believe that this model is well worth considering because morally it also affirms that the affluent and the poor -- the "haves" and the "have-nots" -- will be treated equally in a facility, through a program where the emphasis needs to be upon the "caring," as there is no "curing" function possible.

Summing up, the New Jersey Coalition for the Protection of Vulnerable Adults wishes to thank the Governor for taking the leadership in giving this needed legislation a sense of urgency, and it wishes to commend this Legislative Committee for creating an opportunity to bring to the attention of the public the sense of importance required to deal with this issue, and the need for public support to end an evil that has persisted all too long.

I would like to express some of my own views, as a citizen acting in the public interest, particularly in terms of how public policy is developed.

First, much of what the public and legislators and State government learns about nursing homes comes from the nursing home industry. Here is a well organized, well financed, and highly articulate group of individuals, both in the private and non-private sector, who enjoy easy acceptance in places in the State where decisions are made. There is no similar opportunity given to the private sector in order to learn the views, the experiences, or the suggestions of consumers, such as families, individuals, and public interest groups.

The industry spokesmen constantly refer to losing money. Would they be willing to open their books to public scrutiny? I would submit more and more nursing homes, like other health care facilities, are part of major business enterprises in our country, as has been indicated by a member of the Public Advocate's staff.

I, as a citizen, am very much interested in the fact that this is an industry that talks about the cost, and yet I would like to know much more about their lobbying activities. I wonder if the industry would like to share with us how much money they use to lobby in order to enhance the position of the nursing home industry in the State?

Secondly, I would like to turn my attention to something that has been mentioned a great deal today. Much has been said about the Governor's Task Force. I note that in Commissioner Albanese's statement, he said this was the most truly comprehensive report that had ever been made regarding this area. I find it hard to believe that this is called a truly comprehensive report, when many of the committees only had several meetings. But, what further concerns me is not only the fact that it is not comprehensive and in-depth, but it lacks firm data, which many committees, including the Committee on Private-Pay indicated. Look at the membership of the Committee on Private-Pay contracts. I wonder about how our public policy is being made?

There were thirteen members on that Committee, three from the nursing home industry, two from the Governor's office, three from the Department of Human Services, two from the Department of Law and Public Safety, one from a county welfare agency, one from the office of the Ombudsman, and one from the Public Advocate's office. That is a strange alliance between State government and the industry. Where were the consumers? Where were the family members? Where were the academics? Where were the public interest people?

Now, I will admit that at least this work has had some positive effects, and that it represents advanced work on a problem that needs to be solved. But, unlike the Commissioner's testimony, and the other testimony I have heard, this is only the beginning. It is the beginning of a process.

I note the reports were not distributed widely. I have seen more copies of it here today on the table than I have ever seen before. Where are the members of the public, who received copies of these in the mail -- again, including consumers in the public interest? Where was the opportunity for people to feed into these task forces and these committees, in order to reflect a lot of the personal and professional experience that was out there?

So, I would review this report as an interim one, and certainly not a finished product. It is one that needs to be dealt with much further.

Third, let's look at State government. When we had a nursing home scandal, the Office of the Ombudsman for the Institutionalized Elderly was originally created to deal specifically with abuses, such as those that abound in nursing homes -- following up on the New York scandals. The Ombudsman has indicated that he views private-pay contracts as highly undesirable and very problematic, but that he cannot do anything unless families coopèrate -- unless there is a complaint and the evidence is in.

I would submit that he is dealing with only part of the problem. The legislation creating his office, gives him subpoena and investigative powers, and he certainly could have used these powers to do a systematic investigation of homes. It is no secret to those of us who are professionals -- and I am a social worker educator, and I hear this at least three times a week -- that there are some homes that do so much traffic in private-pay, that this is practically the only way one can get a bed. Now, it seems to me, that under oath one could find out a great deal about the practice and the methods used in dealing with private-pay contracts, prepayment, and all the other kinds of problems that exist.

It would certainly put before the public, the Legislature, and the Governor the dimensions of this problem, and the human tragedy involved. Now, why do I suggest investigation? Because in talking to so many relatives who have been held up, the one thing they all say is, "As long as I have a relative who is alive in a nursing home, I have a hostage -- or the nursing home has a hostage -- and I cannot put that person in jeopardy."

In a similar vein, the State Department of Human Services makes constant references to the cost involved with some of the suggested solutions to the problem. The Department seems to worry only about money. Human values take a back seat. To the public, other reasons (are important) to the spokespersons of this particular Department. Yet, the Department of Human Services has a mandate to serve the less-advantaged and the less-fortunate. The adult, and the older adult who need nursing home care, need a sense of humanity, rather than a sense of financial eligibility.

Let me share a practice with the Committee that is hardly known, to show how public policy deals with human tragedy. Many years ago, the State schools for the mentally retarded -- now smelling sweeter as "developmental centers" -- had waiting lists. A very strong parent movement came to the Legislature, and the Legislature said there existed an inequity, since some people were admitted and others were on a waiting list. The legislature provided for "purchase of service" for those on the waiting list in order to give them the same opportunity to be served as those who were already being served. Today, or a year ago, when I saw the figures, the State of New Jersey was spending $29 million for out-of-state purchase of care for people needing residential treatment for the problem identified as mental retardation.

I think this indicates the lack of power on the part of the families who have relatives in nursing homes. They are not as well organized, and they don't have an outraged Legislature who will indicate what has to be done.

Fourth, I would like to deal with what I call folk myths, because I can't find a more accurate term to describe what I am talking about. Last week, Channel 13 had on an excellent program. It was a three-part series on pre-payment. Regretably, they perpetuated two of these folk myths.

The first myth is that private-pay patients and their families help to support the Medicaid patient. This is a distortion which creates a red herring to cover the issues involved. Like our two-system medical care system in America -- one for the well-off, and one for the have-nots, which is seen in so many hospitals -- poor

people get poor service. Private-pay homes supposedly offer better services. But, it seems to me the suggestion that one group supports or assists another group is the kind of untruth that is geared to serve the interest of the nursing home owners, and others, in their desire to get more money for their services.

I think what they are really referring to is the fact that in many pay facilities, the service is not as good as in some of the other facilities, such as those in my own county of Essex, which are referred to as the Cadillacs of the nursing home industry.

The second folk myth, as I call it, is that divestiture of assets is a frequently-encountered event, and that it happens all the time. Everyone has his or her favorite anecdote, and isn't it interesting that such stories seem to come from nursing home owners? If this is true, why don't the nursing home owners report such incidents, since much of this is contrary to law. The law provides that within a two-year period such divestiture is illegal. To me, it seems as though there are a lot of poor, tired people out there waiting for beds. Let's not make it appear as though there are a lot of assets and money converted for this purpose. I say this, because if one looks at the hard data and the statistics on poverty amongst people over sixty years of age, isn't it interesting that one-third of social security recipients need supplementation? Isn't it interesting that county welfare boards talk about the increasing requests for services from older people, who just can't make due. They are coming in more and more for food stamps and other forms of assistance.

I believe that these myths have a social function, and that is to distort the truth and make things look better for the nursing home industry.

Finally, in terms of what has to be done, and what can be done, I think this hearing is a valuable tool for focusing public attention on the subject. Most of us have not had an opportunity to make our views known, nor to share our views in the public arena, until the spotlight was placed upon these practices, as this Committee and Channel 13 have done.

I personally feel that we need the kind of thing New York has done. We need to deal with this on a first-come, first-serve basis, so hospitals do not get backed up with a lot of older people who cannot be admitted into these homes. I think we have to work towards better standards of service. I think that the Ombudsman, who is required by legislation to do some reporting, should be asked to submit an annual report, dealing with the basic issues this Committee is looking at today.

So, I will end by saying that in view of some of the demographic changes and improved public health measures, all of us will live to be older, and, regrettably, our community resources and our imagination to deal with the needs of the current elderly, as well as those of us who are getting older, has not kept pace with this need. We will need nursing homes for a long time. Thus, it is our obligation to our elders and our parents to see to it that they are well cared for, without the indignity and hurts that the profit system imposes.

SENATOR CODEY: Thank you very much, Mr. Schreiber.

Our next witness will be Alice Glazer of the Concerned Friends and Families of Nursing Home Patients.

ALICE GLAZER: I would like to say first that this is my first appearance before a Senate Committee. I was not familiar with the format. I do not have any statement ready for you of any kind. The only thing I have is this article, which I will refer to, okay?

SENATOR CODEY: Just speak off the cuff; don't worry about it.

MS. GLAZER: Thank you, Mr. Chairman. I am Alice Glazer. I come here also as a private citizen, and as the President of a group called the Concerned Friends and Families of Nursing Home Patients.

SENATOR CODEY: Excuse me. Could we have some quiet, please? You will have to speak a little louder also, Alice.

MS. GLAZER: Okay, I will try. First, I want to thank the sponsors of the bill. I want to thank this Committee. I want to thank WCTC, and The New Jersey Nightly News, for their broadcast the other night.

I agree with Mr. Tetelman, whom I have never met before. He has come out with some absolutely fantastic kinds of statements that I, myself, was hesitant to make. I want to congratulate him. He has said a lot of things that are in everyone's hearts and minds.

The New Jersey Nightly News did a three-part series that I would like to refer to. The last part dealt with an interview with two directors of non-profit nursing homes. One was the Central New Jersey Jewish Home for the Aged, which is the home I am directly involved with. There was an interview with a Mr. William Sewicki, I believe his name was, who spoke about his experience in getting his father-in-law into the home. I don't know if you saw the broadcast.

What I have to say is, that experience is almost identical to mine, back in 1975.

SENATOR CODEY: Why don't you relate that experience to us?

MS. GLAZER: Okay. In 1975, my mother was ill and desperately in need of a home -- a nursing home. We were recommended to the Central New Jersey Jewish Home for the Aged in Somerset. I was given an application, plus a form to fill out -- a financial form for the children of the patient. In due course, I received a call from the president of the home that we were to have a meeting -- the home and my mother's children.

My brothers and I went down and met with the president and with Elliot Solomon, the director. The experience was absolutely horrendous, because they demanded a $10 thousand pledge.

SENATOR CODEY: They demanded a what?

MS. GLAZER: A $10 thousand pledge. They wanted a $10 thousand pledge. My mother was a Medicaid patient -- $10 thousand, and it was a five-year pledge.

SENATOR CODEY: Do you mean the $10 thousand was spread out over five years?

MS. GLAZER: We had to sign for five years in order to pay this $10 thousand pledge. It wasn't an up-front thing. It was over five years -- yearly. Right?

SENATOR CODEY: Oh, okay. So, you had to give them $2 thousand a year for five years?

MS. GLAZER: Yes. Right. From each child. There were three of us. It was not $10 thousand from each child, but--

SENATOR CODEY: Collectively?

MS. GLAZER: Collectively, correct. When we spoke about our financial problems at the time, they looked at us as if to say, "So what? This is the procedure." And, the president of the home went on to delve into personal aspects of our lives that were absolutely humiliating. We had to sit there and take this kind of thing. I couldn't believe my ears.

My mother was in desperate need of a home at that point. She had to be relocated from another place. We had two weeks to relocate her, I think it was, at the time.

At any rate, during this inquisition -- and I really believe it was an inquisition -- I said to the president of the home, "Are you saying that if we don't sign this pledge, you will not accept my mother?" And, he said, "That's right."

Now, I refused to sign the pledge. I am skimming over this interview, because even though it is eight and one-half years later, it is still a very painful kind of thing for me.

SENATOR CODEY: Was this pledge in addition to a private-pay contract?

MS. GLAZER: Well, my mother was a Medicaid patient.

SENATOR CODEY: She was a Medicaid patient?

MS. GLAZER: Yes. She was Medicaid.

SENATOR CODEY: Did they also require her to be a private-pay patient for a while?

MS. GLAZER: No, they were going to take her in as a Medicaid patient, as long as we pledged this amount of money.

SENATOR CODEY: Ten thousand dollars.

MS. GLAZER: Their argument was that Medicaid does not pay enough; that they had to pay the mortgage, or what have you.

As I said, I refused to sign the pledge, but my brothers signed it. That was my experience and that was my first encounter with the administration of this home. My mother entered September of 1975, she died in May of 1977, and for all that time, I was there almost every single day.

Let me put this to everyone, weekly visits to a nursing home-- Children who come once a week on a Sunday afternoon for a few hours, don't know anything, absolutely nothing about what goes on behind the doors.

This particular home is the most magnificent edifice anyone would want to see. As Mr. Tetelman said, it is the Cadillac of nursing homes. If this is the Cadillac of nursing homes, using a cliche, what are the Fords like?

It is magnificent to look at. The paintings, the wall trimmings, and everything about this home are just lovely. The potential is there.

I don't think it is appropriate for me to go into the health care at this time. This is not what this Committee is about. I am here to support the bills.

I brought an article that was printed in the New York Times. The reporter is doing a series on nursing homes. She heard about us and did this series. There are all kinds of allegations in here, but this applies to what this Committee is here for, because it talks about giving pledges.

I also have to say -- I don't know if this is pertinent to what we are talking about -- that as a result of this article, three of us named here, the New York Times, and the reporter were sued for libel by Elliot Solomon and the Central New Jersey Jewish Home for the Aged.

They asked us to retract and apologize before the final suit. My mother was already dead. Those of us who had parents in the home, have lost our parents. They are dead. We didn't have to continue this and go through this energy-draining, emotionally-draining experience. But, we could not, in good conscience back out.

We have been fighting this. You know, there is a libel suit that is laying dormant somewhere. And I have to again address myself to what the gentleman before me said. He said you should open the books of some of these homes -- private paying homes -- and look at what the truths really are.

We have depositions that were taken from the director of this home. They are open to the public, as you well know. Look through

those depositions and see the actual money they have, because under oath things were said that you couldn't possibly hear anywhere else. I happen to have it with me, but it is the only copy I have.

Again, he also spoke about hostages. It is so important that people understand this. I couldn't find people to come forth -- I have contact with people in the nursing home today -- and talk about their experiences, because their parents are still alive.

I went out to speak to Betty Tierny before. I had never met her. I asked her, "Why didn't you mention the name of the home?" She said, "How could I? My mother is still alive." These people are hostages. There are all kinds of feelings that their parents are going to be harassed. The age-old saying there is, "If you don't like it, take her out," right? But there is also fear of intimidation.

I received two anonymous calls last week from two family members who have their parents in there. They told me they will never identify themselves until their parents pass away. But, meanwhile, they should know there are people here supporting them.

I don't know what else--

SENATOR CODEY: Well, you placed something here. This is a financial statement? Shall I call it that?

MS. GLAZER: Yes. Everyone gets a financial statement. This still goes on today.

SENATOR CODEY: This is from a nursing home, and they want to know how much you and your spouse make per week?

MS. GLAZER: Absolutely. And, that goes to each child of a parent. It is incredible. In 1975, by the way, when I was interviewed, there were 40 empty beds. The home had just opened a few months before that. I found out later that my other had already been admitted by the Admissions Committee, and -- you know -- they gave us this whole spiel.

This case is in the courts. Everything that I have said here is documented. It is not in the courts; the home, obviously, is not bringing this to court. That's it.

SENATOR CODEY: Thank you very much for your testimony, Ms. Glazer.

Our next witness will be Jeryl Turco of the Lincoln Park and Andover Intermediate Care Centers. Is she here? (not present)

Okay. This concludes the hearing today. Thank you very much.

(HEARING CONCLUDED)

JOHN J. FAY, JR.
OMBUDSMAN

STATE OF NEW JERSEY
OFFICE OF THE OMBUDSMAN
FOR THE INSTITUTIONALIZED ELDERLY
CN 808, Trenton, New Jersey 08625
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March 19, 1984

The Honorable Richard J. Codey
Chairman, Senate Institutions
Health And Welfare Committee

and

The Honorable George J. Otlowski
Chairman, Assembly Institutions,
Health And Welfare Committee

The prevailing system of discrimination that we are speaking of here today that exists in the long term care facilities within the State of New Jersey is somewhat unique and insidious in that it is not aimed at any particular minority, religion, or ethnic group. It is a type that discriminates against the very old, the very sick, the very poor, and in short the most vulnerable. It is the kind of evil that a number of states such as Maryland, New York, Massachusetts, Minnesota, Washington and Connecticut have addressed by taking legal measures to eliminate.

Our office has found on the basis of complaints received and investigations conducted that the prevailing practice at the time of admission for a long term care facility is to require a family member of a Medicaid-eligible individual to agree to pay privately by signing a contract for a term of anywhere between six months and three years as a pre-requisite to the facility accepting payment from Medicaid. The average cost per year for a private paying patient is $20,000.00. For the average working class family, this kind of expense could add up to approximately $60,000.00 and would create a tremendous financial burden that most of these families would find totally unaffordable. This terrible financial predicament in which loving family members find themselves caught, has created tremendous hardship, distress and sadness for thousands of citizens of the State of New Jersey.

I might also point out that there are a growing number of cases where the elderly patient has outlived his or her family, has no one to sign and pay for an agreement of this kind, and consequently under the present system would never gain admission to a nursing home.

Since the establishment of our office and particularly during the last few years we have seen many examples of how elderly frail men and women have been victimized because of this discriminatory practice. We know of cases in which helpless and needy patients have been forced into boarding homes where they receive totally insufficient medical care because they could not break through the financial "brick walls" that they met when trying to gain admission into a nursing home. We know of other cases in which citizens of New Jersey have been forced to find and ultimately be placed in facilities of other states because this practice has prevented them from finding care here in their own home State. Clearly, the needs of this segment of the elderly population are not being met, and I am gratified that hopefully swift action will be taken in addressing and eliminating this discrimination, so that these needs can be met.

I am pleased to report that the State Nursing Home Task Force that was recently convened to study and evaluate problems and concerns that relate to long term care, shared concern for the problems we are speaking of today and recommended its elimination as well. Presently Assembly Bills 872, 873 and 874 are pending that enjoy strong bipartisan support, designed and intended to also eliminate this practice. Finally, I would like to quote from the State of the State Address delivered by Governor Thomas H. Kean earlier this year, with regard to his feelings on the practice of requiring Medicaid-eligible individuals to sign private pay contracts as a condition of admission to a nursing home:

> "This predatory practice victimizes our older citizens and their families and it is widespread throughout the State. It is not uncommon for the families of senior citizens who want to enter a nursing home and who are eligible for Medicaid to be confronted with much higher private pay rates. In some cases, the terms of the contract require the payment of $2,000 per month for two years, regardless of the length of the actual stay. But they are exacted as a cost of gaining admission to the nursing home. This practice presents families with a cruel choice between providing care for a loved one and extraordinary financial sacrifice. It should be stopped now."

Members of the Committee, I agree with the Governor, and I speak for myself and my office and the many individuals of our State that have suffered through this agony that this practice is cruel and without any unnecessary delay it should be eliminated so that the elderly citizens of our State will no longer have to fear that their well-being will depend on their ability to pay for it.

John J. Fay, Jr.
Ombudsman

SUMMARY OF LEGAL ACTION TAKEN BY OTHER STATES

Maryland

The Attorney General of Maryland issued an opinion on July 7, 1982, declaring that the requirement of private pay contracts as a pre-condition to admission was illegal. This opinion was challenged in Federal District Court which refused to hear the case but instead referred it to the Office of Hearing Examiner, Department of Health and Mental Hygiene which is similar to our Office of Administrative Law. The hearing examiner upheld the opinion of the State Attorney General.

New York

In Glengariff Corp. v. Snook (N.Y. Supreme Ct. Special Term, January 4, 1984), the Court held that a private pay contract requiring additional payment other than that which Medicaid provided was void because such a practice was contrary to public policy under both State and Federal law.

Massachusetts

A regulation states that "[p]roviders of long term care...must not refuse to accept an eligible Medical Assistance recipient if a bed is available at the level of care required by the patient...." 106 C.M.R. 450.201. This regulation was upheld in Superior Court in Massachusetts Federation of Nursing Homes v. Sharp (Civil Action #18915 Suffolk County 1977).

Minnesota

Minnesota has enacted a statute which has been challenged, upheld and affirmed that requires that the private pay rates be no higher than those rates established by Medicaid. Minnesota Association of Health Care Facilities v. Minnesota Department of Public Welfare, 602 F.2d 150 (8th Cir 1979). As a result of this law the problem that is the subject of this hearing appears to be nonexistent.

Washington

In Washington there has been an administrative directive issued that states: 1) A Medicaid-eligible individual or his or her relatives cannot be compelled to sign a private pay contract as a condition for entering a nursing home; 2) At the time an individual becomes eligible for Medicaid the individual can no longer be required to pay private rates under the contract; and 3) Nursing homes may not refuse to admit a Medicaid patient solely on the ground that the patient is a Medicaid recipient.

Connecticut

In Connecticut, a statute requires that for purposes of admission all applicants are to be treated equally and are to be admitted on a first come, first serve basis without regard to the method of payment whether it be private or Medicaid, Conn. Gen. Stat. Ann § 19-614(a).

(A)

1983 OPENINGS

FACILITY	COUNTY	# OF ADDITIONAL BEDS
Fair Lawn Manor	Bergen	157
Eastern Shore Nursing	Cape May	120
West Hudson Hospital	Hudson	46
Leisure Chateau Care Center	Ocean	120
Country Manor Nursing Home	Ocean	18
Toms River Convalescent Center	Ocean	10
Manchester Manor	Ocean	180
St. Joseph's Hospital	Passaic	135
Greenbrook Nursing Home	Somerset	2
Delaire Nursing Center	Union	180
Rahway Geriatric Center	Union	120
Berkeley Heights Convalescent Center	Union	120
Phillipsburg Convalescent Center (1/84)	Warren	150
		TOTAL 1,358

(B)

UNDER CONSTRUCTION - February, 1984

Facility	County	Beds
Briarwood Manor	Atlantic	240
Green Wood Skilled Nursing	Atlantic	120
Plaza Nursing Home	Camden	120
Braodway Care Facility	Essex	420
Cedar Grove Manor	Essex	180
Harbor View Health Care Center	Hudson	180
Hamilton Manor	Mercer	180
Edison Estates Rehab.	Middlesex	120
Lakeview Manor Nursing Home	Ocean	120
Manahawkin Convalescent Center	Ocean	120
Southgate Health Care Center	Salem	120
Franklin Convalescent Center	Somerset	60
Cranford Health Center	Union	60
Ashbrook Nursing Home	Union	18
House of the Good Shepherd	Warren	18
Warren Haven	Warren	72
		2,148

54. DEPARTMENT OF HUMAN SERVICES--Continued
20. PHYSICAL AND MENTAL HEALTH
24. SPECIAL HEALTH SERVICES
7540. DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

	Actual[a] FY 1982	Actual[b] FY 1983	Budgeted[b] FY 1984	Revised[b] FY 1984	Department[b] Estimate FY 1985	Budget[b] Estimate FY 1985
Hospital Inpatient Service						
Per diem	$184.94	$204.58	$238.09	$231.18	$261.23	$251.99
Patient days	1,253,202	1,213,362	1,241,000	1,213,343	1,213,343	1,213,343
Gross annual cost	$231,764,664	$248,229,687	$295,469,319	$280,500,000	$316,965,000	$305,750,000
Administrative Patient Days[c]						
Per diem	-----	-----	$49.44	$51.91	$54.50	$54.50
Patient days	-----	-----	75,000	71,431	68,037	68,037
Gross annual cost	-----	-----	$3,708,000	$3,708,000	$3,708,000	$3,708,000
Hospital Outpatient Services						
Visits	922,975	859,051	932,205	859,051	859,051	859,051
Cost per visit	$66.62	$74.73	$80.73	$83.70	$93.74	$91.23
Gross annual cost	$61,488,584	$64,198,814	$75,250,500	$71,903,000	$80,531,000	$78,371,000
Physician Services						
Visits	4,862,505	4,309,362	4,888,378	4,445,057	4,588,821	4,588,821
Cost per visit	$12.84	$12.94	$13.21	$13.05	$13.15	$13.15
Gross annual cost	$62,434,563	$55,763,139	$64,575,381	$58,008,000	$60,343,000	$60,343,000
Prescription Drugs						
Prescriptions	7,835,833	7,082,601	7,932,602	7,382,341	7,691,715[i]	7,691,715[i]
Cost per prescriptions	$8.33	$8.93	$10.07	$9.57	$10.64[i]	$10.64[i]
Gross annual cost	$65,272,497	$63,247,624	$79,881,300	$70,649,000	$81,840,000	$81,840,000
Home Health Care						
Visits	479,705	484,809	468,199	506,033	526,511	526,511
Average cost per visit	$29.58	$32.04	$37.09	$34.64	$37.57	$37.57
Gross annual cost	$14,189,673	$15,533,294	$17,365,500	$17,529,000	$19,781,000	$19,781,000
Medical Day Care						
Visits	40,347	60,130	60,317	69,128	79,490	79,490
Average cost per visit	$21.95	$22.19	$25.59	$23.97	$25.89	$25.41
Gross annual cost	$885,455	$1,334,277	$1,543,512	$1,657,000	$2,058,000	$2,019,800
All Other Services (Gross)	$49,231,911	$65,017,371	$54,276,487	$73,731,000	$82,611,906	$80,367,000
Special Program Costs--retroactive payments (Gross)[d]	$1,634,793	$2,000,000	$1,000,000	$2,000,000	$2,000,000	$2,000,000
AFDC grant increase	-----	-----	-----	-----	$6,962,648	$6,962,648
Nursing home expansion (Private Pay Contracts)	-----	-----	-----	-----	$29,408,490	-----
Personal care initiative	-----	-----	$7,894,109	$5,000,000	$19,439,000	$19,439,000
Community care initiative	-----	-----	$11,977,203	$10,500,000	$13,821,000	$13,821,000
Gross annual cost	$753,362,972	$817,521,980	$948,001,311	$928,256,000	$1,086,658,044	$1,035,248,448
Less:						
Copayments effective July 1, 1983	-----	-----	-$9,462,500	-----	-----	-----
Management initiatives	-----	-----	-17,269,100	-16,205,000	-11,288,000	-11,288,000
Net Annual Cost	$753,362,972	$817,521,980	$921,269,711	$912,051,000	$1,075,370,044[f]	$1,023,960,448[f]
State share (General Fund)	$387,680,585	$428,017,718[e]	$476,298,915	$464,240,465	$543,580,188[f]	$516,825,000[f]
State share (Casino Revenue Fund)	-----	-----	$10,500,000	$10,500,000	$17,561,000	$17,561,000
Federal share	$365,682,387	$382,763,791	$434,470,796	$424,468,535	$504,333,365[j]	$480,294,000[j]
Pharmaceutical Assistance to the Aged and Disabled[g]						
Aged						
Average monthly recipients	248,263	201,000	200,000	192,000	182,000	182,000
Average monthly prescription per recipient	1.5	1.5	1.5	1.5	1.5	1.5
Annual prescriptions	4,468,734	3,618,000	3,600,000	3,456,000	3,276,000[i]	3,276,000[i]
Cost per prescription (excludes co-payment)	$8.79	$10.86	$11.05	$11.41	$12.52[i]	$12.45[i]
Gross annual cost	$39,280,172	$39,293,242	$39,780,000	$39,432,960	$41,048,000	$40,786,400
Aged--Expanded Program[g]						
Average monthly recipients	28,100	60,953	85,000	68,600	69,000	69,000
Average monthly prescriptions per recipient	1.5	1.5	1.5	1.5	1.5	1.5
Annual prescriptions	506,962	1,097,154	1,530,000	1,234,800	1,242,000[i]	1,242,000[i]
Cost per prescription (excludes copayment)	$10.19	$10.90	$11.55	$11.88	$12.99[i]	$12.91[i]
Annual cost	$5,155,753	$11,958,979	$17,671,500	$14,668,642	$16,132,000	$16,032,780
Disabled[g]						
Average monthly recipients	18,799	25,693	28,000	28,900	25,000	25,000
Average monthly prescriptions per recipient	2.0	1.5	1.67	1.58	1.58	1.58
Annual prescriptions	451,176	462,474	500,000	549,100	475,000[i]	475,000[i]
Cost per prescription (excludes copayment)	$10.42	$11.96	$11.80	$12.27	$13.58[i]	$13.51[i]
Annual cost	$4,701,254	$5,531,189	$5,900,000	$6,738,239	$6,452,000[h]	$6,419,000[h]
Gross annual cost	$49,137,179	$56,783,410	$63,351,500	$60,839,841	$62,072,000[h]	$61,678,780[h]
General Treasury	$39,280,172	$39,293,242	$39,780,000	$39,432,960	$41,048,000[h]	$40,786,400[h]
Casino Revenue Fund[g]	$9,857,007	$17,490,168	$23,571,500	$21,406,881	$21,024,000[h]	$20,892,000[h]
Management and Administrative Services						
Claims Processed						
Prudential	4,697,918	5,342,998	5,356,000	5,547,543	6,200,000	6,200,000
Blue Cross	8,121,218	8,353,895	8,150,030	8,485,650	8,740,000	8,740,000
Division	299,600	300,000	310,400	310,000	317,000	317,000
Costs for claims processed--Prudential	$7,265,435	$7,454,352	$8,600,000	$7,827,070	$8,449,280	$8,449,280
Costs for claims processed--Blue Cross	$5,248,240	$5,575,447	$6,100,000	$5,854,219	$6,402,960	$6,402,960
Costs for claims processed--Division	$265,407	$278,677	$298,000	$292,611	$301,760	$301,760
Average cost per claim--Prudential	$1.55	$1.40	$1.61	$1.41	$1.36	$1.36
Average cost per claim--Blue Cross	$0.65	$0.67	$0.75	$0.69	$0.73	$0.73
Average cost per claim--Division	$0.88	$0.93	$0.96	$0.94	$0.95	$0.95

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Dolores Turco
Executive Administrator

March 19, 1984

Senate Institutions Health
and Welfare Commi-tee
CN -042
State House
Trenton, New Jersey 08625

Dear Honorable Senate Committee Members:

I am taking the liberty of submitting the following testimony to the Senate Institutions Health and Welfare Committee in response to the subject of private pay contracts and nursing home bed shortage. I represent the Lincoln Park and Andover Intermediate Care Centers and Nursing Homes totalling approximately 1,400 long term care beds in which eighty per cent are presently Medicaid recipients.

I would like to take this opportunity to present our views on the subject in hope that they may be of benefit to you in your evaluation of this dilemma.

I am very concerned about legislation proposed to outlaw private pay contracts for Medicaid eligible patients which will cost the Program an additional twelve million dollars per year.

In order to understand the total impact of such legislation, it is important for you to be aware of some of the background of preadmission criteria and the financial inequities of the Medicaid Program.

Firstly, the intent of private pay contracts for Medicaid patients was to discourage patients from transferring their assets to their families in order to become eligible for Medicaid bebefits. This widely abused practice cheated the Medicaid Program, taxpayers, the nursing home and truly medically indigent patients because Medicaid beds were being occupied by those patients who could afford and should pay their own way.

Secondly you may not be aware that in most cases Medicaid rate setting which should reimburse reasonable costs does not even reimburse actual costs of caring for Medicaid patients. Consequently in many facilities private paying patients are subsidizing the Medicaid Program which is

contrary to the intent of the reimbursement regulations. Unfortunately this can lead to an unhealthy financial situation in facilities with excessive percentages of Medicaid populations. With our size and extremely high medically indigent population, if we were to lose this source of private pay patients it would create a serious financial hardship to the facilities. However, I believe this could be avoided by the provision in the private pay legislation that would implement a reimbursement differential for those homes with high Medicaid populations (65% or over). This would encourage facilities to admit greater numbers of Medicaid patients instead of penalizing them. It is a known fact that any facilities with 90% or 100% Medicaid quotas face insolvency.

In our situation although we are under contractual agreement to accept thirty per cent Medicaid patients, our facilities far exceed these requirements and eighty per cent of our patient population is Medicaid. We have developed a reputation with hospitals, psychiatric institutions, social workers, Department of Health officials and the community that we are one of the few facilities in the State of New Jersey that accept most hardship cases.

There is one other issue regarding private contracts that I believe is significant enough to bring to your attention. There are a number of families who even though the patient may be medically indigent, the family earns upper middle or upper income levels and could contribute to their parents' care, especially if there are several relatives involved. In our experience, we have found from a social point of view, that sometimes when a family is completely relieved of all financial obligations for a parent, unfortunately it is misconstrued as to alleviate all moral and ethical responsibilities as well leaving the nursing home resident very much alone and resulting in a traumatic adjustment for the patient. In situations where families can afford to contribute to the care of their loved ones I do not believe it is the intent of the Medicaid Program to make these patients the responsibility of the State and the taxpayers.

May I also take this opportunity to commend the new administration's Department of Human Services and Department of Health whom I believe are making great progress toward alleviating the nursing home bed shortage. Already 1,358 more long term care beds have been made available and 2,148 are currently under construction and can be expected in the near future. The hospitals are converting underutilized acute care beds to meet the demands of long term care and relieve their facilities of a costly burden. More and more home health care services have become available in the community which can accomodate some of the patients who do not require twenty-four hour nursing supervision. However, they are a more costly alternative to nursing home care and can not replace a protective environment required by so many long term care prospects. The proposal currently under evaluation to allow nursing homes to temporarily exceed licensed capacity if they meet certain criteria is definitely a viable short term solution to the problem. All

of these efforts have had a very positive impact and are effective strides towards resolving the nursing home bed shortage dilemma.

I would like to respectfully present to the committee one recommendation in addition that I believe would substantially reduce the discharge psychiatric waiting list which are the most difficult patients to place and currently costing the Medicaid Program and taxpayers three and four times the cost than if they were appropriately placed in long term care facilities. If nursing homes were given an incentive to their rate to accept this type of admission who requires more preadmission screenings and evaluation, initial observation, crisis intervention and follow-up services, I believe more facilities would be willing to accept discharged psychiatric patients. The savings could be up to forty million dollars per year based on the January 1984 waiting list figure of 780: 491 in State hospitals and 289 in County hospitals.

I would like to thank the committee for giving us this opportunity to express our views. We feel very optimistic that with an open communication between the department, the public and the health care industry, it will not be too long in the future before we can hope to see a resolution to the nursing home bed shortage dilemma.

Sincerely,

LINCOLN PARK INTERMEDIATE CARE CENTER
LINCOLN PARK NURSING HOME
ANDOVER INTERMEDIATE CARE CENTER
ANDOVER NURSING HOME

Jeryl Turco,
Administrator

JT/jt

NJANPHA
Founded 1931

New Jersey Association of Non-Profit Homes for the Aging

CENTER FOR HEALTH AFFAIRS 760 Alexander Road, CN1, Princeton, New Jersey 08540
Telephone 609-452-1161

The New Jersey Association of Non-Profit Homes for the Aging is pleased to present its comments on nursing home bed supply and private pay contracts to the Senate Institutions, Health and Welfare Committee.

The Association represents 85 not-for-profit facilities across the state, which provide shelter and services to over 10,000 older citizens. They are sponsored by communities that care for their elderly -- religious groups, fraternal organizations, counties, foundations, ethnic groups and voluntary associations. Our members provide nursing home care, residential care, life care and independent retirement housing.

We suggest that you view the issues of bed supply and private pay contracts within the context of intense government attempts to regulate an industry that grew in response to an unprecedented surge in the need for long term care services. The present controversy is an attempt to adjust a far-reaching, but fragmented, regulatory system with many players on the state and federal levels. Compounding the difficulty, the state system is divided between two departments. The complexity and number of players makes coordination difficult and necessitates compensation whenever changes are desired within the delivery system. With this in mind, we submit that the shortage of beds results from the following factors:

1) The older population continues to increase more rapidly than the rest of the population. Among the old, those 85 and older are growing at an even faster rate -- and they are the major users of long term care. Several years ago, the state mistakenly imposed a moratorium on new certificates of need for nursing homes. The current shortage stems in part from lost development time during that moratorium.

2) The cost of long term care is such that most users resort to Medicaid to pay for the service. The increase in the state Medicaid budget is, as a result, relentless. Given the prospect of a financial hemmorhage to the state, rates are set artificially low; true cost is recognized only for facilities with very low costs. Homes with high Medicaid census run on slender margins. Furthermore, the payment system is based on compliance with minimum standards, and does not recognize higher service levels. For example, the Medicaid program, year before last, reduced the limit on nursing costs, on the rationale that facilities would still be able to meet minimum standards. Thus, the home desiring, for whatever reason, to provide better-than-basic care must finance the higher quality by methods that depend on type of ownership:

- the county home makes up the shortfall through the county operating budget, which is highly visible and vulnerable to pressure to keep property taxes low;

- the voluntary home compensates with charitable donations and fund development activities, the success of which depends in turn on the perceived quality of the facility and its services in the sponsoring community;

- the proprietary home compensates by watching the proportion of Medicaid recipients (if the Medicaid census goes too high, they begin to lose money), or by use of the private pay contract, which also prevents a fall below the break-even point.

Another direct result of state payment policies is that the lending community is reluctant to finance new construction, or even facility replacement.

3) A final reason for the shortage stems from the regulatory system's failure to change with the changing user population and related factors:

- the DRG program has created pressure to discharge patients earlier -- and with heavier care needs -- to homes;

- Medicaid recipients now stay half a day longer when they get sick and go to the hospital than they did in 1978, according to our latest study.

Since the presence of too many patients with heavy needs disrupts the ability of a home to provide care under the current payment system, Medicaid patients with greater needs resort to county facilities, which, with 18% of the beds in the state, care for 25% of the skilled patients (the highest level of care). If the State desires greater access for Medicaid recipients, it should provide an incentive to pay the additional cost incurred by facilities taking patients with heavier-than-usual needs.

We thus recommend that other means to improve the long term care system be pursued, including:

- Enact an incentive for heavy care patients;
- Make provision for homes that provide better-than-basic care;
- Improve the long term care environment through better medical care and coordination; and
- Support creation of supportive housing and community services, which would forestall the crises and deterioration that lead to the need for nursing home care in the first place.

In conclusion, these issues were treated extensively in the Report of the Nursing Home Task Force of the State of New Jersey, submitted to the Governor last July. We were party to the Report's recommendations, which include programs for increasing the bed supply. We commend it to you as a basis for action, in place of a fragmented attempt to deal with one aspect of a complex system at a time.

Thank you.

DRH
3/14/84