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

before

ASSEMBLY CORRECTIONS, HEALTH & HUMAN SERVICES COMMITTEE

on

(Medicaid Reimbursement for Nursing Homes)

June 25, 1985
Roosevelt Hospital
Menlo Park, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Assemblyman George J. Otlowski, Chairman
Assemblyman Richard F. Visotcky
Assemblyman Paul Cuprowski

ALSO PRESENT:

David Price
Office of Legislative Services
Aide, Assembly Corrections, Health & Human Services Committee

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ASSEMBLYMAN GEORGE J. OTLOWSKI (Chairman): We are going to call this hearing to order. My name is George Otlowski. I am the Chairman of the Assembly Corrections, Health & Human Services Committee. I have a very brief statement that I am going to read:

The purpose of this hearing is to review the problem of providing adequate reimbursement to nursing homes in New Jersey which are participating in the Medicaid Program, and particularly to the county operated nursing homes.

This Committee is concerned with the issue of quality care for nursing home residents and the question of higher reimbursement to provide this care to severely ill patients in all nursing facilities.

The counties have argued that they have higher operating costs for their nursing homes than other nursing homes and are hoping to gain higher reimbursement rates through a peer grouping system.

I am sure that the individuals speaking today will have a great deal to say about these issues and proposed solutions to this problem. The Committee hopes that the testimony presented today will provide a better perspective on the problems involved in this important policy area, and that it will help us to better see all of the dimensions of the subject.

As usual, I would like to ask the witnesses to keep their testimony brief. Additionally, although I did not request any information from the Departments of Health and Human Services and the Office of the Ombudsman for the Institutionalized Elderly on the status of recommendations made to the Governor as a result of the Bel Air incident, I would like each Department to address, to the best of their knowledge, what has been done to implement these recommendations.

I would also request that each Department submit, in writing, an update of their efforts to the Committee.

That is a brief outline of the bill and the purpose for this hearing. We are going to begin with Commissioner Albanese. Commissioner, we are ready.

COMMISSIONER GEORGE J. ALBANESE: Thank you, Mr. Chairman. I have Tom Russo, the Director of Medical Assistance and Health Services with me, and Rick Speranza, a member of our rate setting staff. I do not have any prepared remarks. Basically, I will talk from an outline.

I came here today to support peer grouping for our county nursing homes. I think it is important and essential in sustaining our nursing home industry in the State of New Jersey. I also feel peer grouping, as it is being proposed, can be used to expand and strengthen the system, particularly in the area of community care, which is becoming more of the answer for our elderly population than an alternative.

While simply using the $20 million for the nursing homes would be, one might say, politically expedient, I do not think it is necessarily the answer to the long-term problem of the State of New Jersey. It is my opinion that a portion of that money should be utilized through the Board of Chosen Freeholders for the development and expansion of community care for our elderly population.

I think we have to recognize something in the State of New Jersey, if not in this country: We do have a changing health care system, particularly with DRGs. We are experiencing a change in the patients in our long-term care system, and we are beginning to look at and examine the effects of DRGs on another system, which is long-term care.

We have already recommended the merging of the ICF A&B rates, which would increase nursing services. That was recommended to this body at the previous hearing, and it was also recommended at the Joint Appropriations Committee meeting. We feel that is an appropriate way of increasing the level of care in our facilities, while reducing the administrative cost at the State level.

I think, based in empirical data that will be developed in the future not only by the Department but by the nursing home industry, we will also be making recommendations on the heavy care cost of patients in the private nursing home industry in the State of New Jersey. I think there is a change; we are experiencing more heavy care patients throughout the entire nursing system in the State of New Jersey.

However, I would like to caution everyone in the State of New Jersey about having a knee-jerk reaction to any particular problem. I recall that at the Bel Air Nursing Home hearings, Senator Hagedorn

immediately said that we should increase Medicaid rates; that was one of the reasons why we had the Bel Air Nursing Home problem. That was not based on empirical data, nor a systematic review.

We took a look at Bel Air. Let me just read to you an analysis of Bel Air, as it relates to the conditions that exist there. We found that there was no correlation between the amount of Medicaid reimbursement and the quality of care. In fact, in critical categories, such as food service, nursing care, special patient care, and general services, Bel Air consistently spent under the Medicaid reimbursement ceiling.

Had the management spent more on these critical care categories, they would have received additional reimbursement. The one area where Bel Air exceeded allowable limited was in compensation for its administrator and assistant administrator -- the husband and wife who are 100% owners of the facility.

So, as you can see, they were not even spending up to the allowable Medicaid limits. So, what I recommend today is, one, to support peer grouping for the county nursing homes. I think it is necessary to sustain their operations. It also can be used to expand a long term care system -- particularly community care -- by using the Boards of Chosen Freeholders and the Human Services Advisory Council as a mechanism.

I think there should be a review of heavy care in private industry. I am sure there are facilities that are experiencing heavy costs that should be addressed by the State of New Jersey. I think this should be done on a systematic basis with empirical data so that we can comfortably back to your Committee, and through your Committee to the Legislature, to make any necessary changes.

Finally, let's not have a knee-jerk reaction because as I have clearly shown, in Bel Air the Medicaid rate did not cause any of the problems at the Bel Air Nursing Home. I thank you very much for your attention.

Technical questions will be answered by Mr. Russo, or if they relate to rate setting they will be answered by Mr. Speranza.

ASSEMBLYMAN OTLOWSKI: Commissioner, the only question I have to ask relates to your suggestion about an initial review -- a complete review.

COMMISSIONER ALBANESE: I think we can go ahead with peer grouping as it relates to the county facilities. However, in all fairness to the private sector -- private nursing homes -- I think a similar review should be done to determine heavy care costs and what kinds of adjustments should be made by the State of New Jersey to recognize, particularly, the changing character of the patients in the nursing home industry because of the changing conditions in the acute care system. I think they can be taken separate and apart.

ASSEMBLYMAN OTLOWSKI: Commissioner, what other states have already undertaken this very program we are talking about.

THOMAS RUSSO: It is my understanding that two states have attempted to address the heavy care patient issue, and they are Maryland and Massachusetts. They are the only two states I know of that have any kind of special consideration in their rate reimbursement system.

The reimbursement system, as designed, does compensate for levels of care. In other words, the more nursing care a patient needs, the higher the reimbursement to the nursing home will be. As you know, there are three levels of care reimbursement in Medicaid: Intermediate A, B, and the skilled level. Each of these levels require a higher number of nurses.

ASSEMBLYMAN OTLOWSKI: Excuse me. Freeholder-Director Capestro, may I just talk to you for a moment? (At which time Assemblyman Otlowski confers with Freeholder Capestro).

I'm sorry, Mr. Russo, please continue.

MR. RUSSO: Mr. Chairman, I was saying that the Medicaid reimbursement system does recognize different levels of care. It does provide a higher reimbursement for the sicker patient. I think the issue the Commissioner is raising is the fact that in the hospitals we now have the DRG Program; we have a squeezing of hospitals to get the patients out faster, and we have a squeezing on hospital admissions so that they cannot even admit some patients who were admitted in the past. A lot of these patients are finding their way into nursing homes, and they are in a more acute state than they were in the past.

I think nursing homes are presently getting some heavier care patients than had existed in the past. These are the kinds of issues we should be looking into, as the Commissioner mentioned.

We are seeing a gradual change in the health care system. In the past, some patients were taken care of as inpatients in hospitals, but they are not getting into hospitals as inpatients today. They are possibly going to nursing homes, or they are being discharged from the hospitals faster and then they are being put into a nursing home.

So, I think we really have to look at these types of patients in terms of reimbursement.

ASSEMBLYMAN OTLOWSKI: Of course, one of the things we are going to be confronted with -- and this will probably be developed during testimony today, but I think we ought to open this door now -- is, how can the Department of Human Services ask counties to use their savings from the peer grouping system in order to expand certain services, when the counties may have to discontinue certain services because of the elimination of revenue sharing?

COMMISSIONER ALBANESE: Well, the peer grouping concept was brought about prior to any real statement of reducing revenue sharing. I personally think that the concept of peer grouping has its merit in sustaining the operation.

However, the State of New Jersey, as well as the counties in New Jersey, is probably facing one of the most critical areas of government: How are we going to deal with our elderly population? The reason we have put a need to share some of those savings with community care into the proposal is, if New Jersey simply continues with building nursing home beds, by the year 2000 some people estimate that the Medicaid portion of the reimbursement for nursing homes will amount to around $1 billion alone. So, we see community care, or community services -- keeping the elderly at home -- as an ability to do what the senior citizens and the elderly want in the State of New Jersey, and that is to provide home health care, which is cheaper. We have a demonstration program right now which will provide that. It is cheaper and we can serve more people in the State of New Jersey.

ASSEMBLYMAN OTLOWSKI: Commissioner, I have one other question I wanted to ask you. Does the home care program that you are talking about fit into the total approach, and into the different classifications of illness which will take place?

COMMISSIONER ALBANESE: It will not necessarily fit into a study of the rates in nursing homes. You see, I no longer talk about nursing homes as being the only answer for the elderly. I talk about a continuum of care and an array of services that started, in fact, in Middlesex County with the Channeling Program. Not every senior citizen has to go from his home to a nursing home. There is a variety of services that can keep an elderly person at home with the family.

As we said yesterday, a person can move through a system prior to being put in a nursing home. This might include a residential health care facility with a lesser degree of nursing care.

So, what we are trying to provide in the State of New Jersey is this continuum in order to give people what used to be called an alternative. I think that is the answer. I think, based on the numbers and based on the dollars we are talking about this State, and all the states in this country have to get into community care so that they can more effectively use the nursing home bed.

I know for a fact, from my service in county government -- I am sure we can point this out in many other areas -- that there are people in nursing homes today because there was no community care alternative that would allow them to stay at home 10 years ago. There was no other alternative.

Now, if one has a community care program in his particular county or jurisdiction, he might be able to get supervision, medication, or certain kinds of assistance that will allow him to stay in the community. That will do something for the entire system. We probably have something like 25% of the people in nursing homes who do not belong there. Once they "attrit" out of the system, the nursing home beds in the State of New Jersey will increase for those people who really need nursing home beds. We have to be very conscious of that fact.

We can no longer afford to allow someone to just use a nursing home bed because there is no other alternative; we have to provide the alternatives.

ASSEMBLYMAN OTLOWSKI: Commissioner, if counties wish to expend their services with their savings from peer grouping, should that decision be made by the elected Freeholders? The question arises, why should non-elected people decide how funds are expended? What is your reaction to that?

COMMISSIONER ALBANESE: We use the same process that we use with the Human Service Advisory Council's system in the State of New Jersey. It is in existence in all 21 counties. The Human Service Advisory Council provides recommendations to the Board of Chosen Freeholders. The Board of Chosen Freeholders has the final say in the utilization of the money, but, in fact, they are getting community input as to what the need in Middlesex County is, for example, and how we should allocate our dollars. It is then up to the Board of Chosen Freeholders; they have the final say in that matter.

ASSEMBLYMAN OTLOWSKI: Commissioner, unless you have something else to add, I think we can now go to the Freeholder from Mercer County in order to look at it from that aspect. I know you have to be in court and I do not what to hold you here unnecessarily.

COMMISSIONER ALBANESE: We have staff here to answer any questions you might have as a result of other testimony. Thank you very much.

ASSEMBLYMAN OTLOWSKI: Thank you, Commissioner.

Assemblyman Paul Cuprowski is entering the room. He is on my left. On my right is the Freeholder-Director of Middlesex County, Steve Capestro, who is our host today.

FREEHOLDER ANTHONY CIMINO: Good morning, Mr. Chairman and members of the Committee. My name is Anthony Cimino, and I am a Freeholder from Mercer County. I also serve as the Chairman of the NJAC Human Services Committee. I am delighted to be here today to testify on behalf of the New Jersey Association of Counties with regard to a subject that has received considerable attention within our Association.

Let me begin by stating our very strong support for the establishment of peer grouping for county operated nursing homes. We believe that a separate class allowing county operated nursing homes to be rated against each other rather than against private facilities is justifiably needed. County operated nursing homes have higher operating costs than either proprietary facilities or non-profit nursing homes for a number of factors including the age of our physical facilities, the number of long-time employees, and the fact that county nursing homes are normally "facilities of last resort," accepting patients that no other nursing homes will admit, such as heavy-care patients, individuals with behavior problems, and multiply-disabled persons.

Because the current rate setting system does not reflect these higher costs, county governments have been forced to appropriate local property tax dollars to make up the difference. The end result is that our already overburdened property taxpayers are footing a $20 million bill that could instead be paid with increased Federal Medicaid funds available through peer grouping. Therefore, peer grouping for county operated nursing homes is critically needed and long overdue.

I would now like to briefly discuss the specific conditions attached to the peer grouping proposal as set forth by the Department of Human Services. County governments recognize the need for the State of New Jersey to be held harmless for the 50% match of Federal Medicaid funds and are willing to allocate county funds to draw down these Federal dollars. We accept this provision without question. As the old saying goes, "Half a loaf is better than none."

The much more difficult question for our Association is whether a quarter of a loaf is better than none. I am referring, of course, to the stipulation that counties be required to allocate 50% of their net savings on the expansion of community-based long term care programs. From a purely philosophical position, we would argue that the counties should be free to use these savings in any manner they so choose, whether it be for funding needed programs or providing for property tax relief. It seems reasonable to argue that counties should be free of any State dictate in this area, since it will be county not State dollars that will be used to match Federal funds.

However, from a more pragmatic point of view, county governments understand the need for expanded community based care and other social service programs, and we are sympathetic to the objectives of the Department's stated policy regarding the allocation of county savings. The New Jersey Association of Counties, through its Human Services Committee, reviewed the Department's original proposal and requested certain modifications. The Department's response was generally favorable although it did not go quite as far as we might have hoped. Nonetheless, the Board of Directors of the New Jersey Association of Counties voted to endorse the peer grouping proposal with the modifications agreed to by the Department of Human Services. The important point to understand about this exchange between the Department and our Association is that both the Department and the counties demonstrated a willingness and an ability to work together to achieve common goals.

What all of this tells us is that there is absolutely no need for legislation that would mandate a fixed percentage of county savings be used for expanded community-based programs. A statutory mandate would be counter-productive, and may, in fact, doom the entire proposal to failure. Rather, what is needed is a policy that will allow for maximum flexibility so that the allocation of these funds can be tailored to individual county's needs.

The plain and simple truth is that some counties can live with a quarter of a loaf, while others can not and should not be forced to. We have too much at stake in peer grouping to let it fall victim to rigid requirements and artificial percentages. Therefore, the New Jersey Association of Counties strongly recommends that the expansion of community-based, long-term care and other human service programs be left to negotiation between the Department of Human Services and the individual counties.

In closing, I would like to express our Association's appreciation to Commissioner George Albanese and his staff for their very fine cooperation in advancing the peer group initiative. I would also like to take the opportunity to thank this Committee for allowing us to come before you to comment on this very important subject. Thank you very much, Assemblyman.

ASSEMBLYMAN OTLOWSKI: Thank you. Just to bring this into focus, you are saying that your position is that no legislation is needed in this area at all? The only thing that is needed is for the Commissioner to devise the necessary regulations; the legislation already exists, is that what you are saying?

FREEHOLDER CIMINO: Assemblyman, we are saying that other than the legislation, we would understand that it is necessary to hold the State harmless. We do not feel there is any necessity for additional mandates to counties. The counties, go through their own Human Services Advisory Commissions -- which are basically made up of the service providers -- to the Boards of Freeholders, and they are cognizant of what their problems are with the specific counties.

Additionally, the Human Services Advisory Commissions' list of priorities -- for instance, in the case of Mercer -- does outline, within the specific priorities in initial protective service, adult care, and respite care, some of the very critical needs. So, we feel that individual counties, through negotiation with the Commissioner, can come up with the appropriate answers.

ASSEMBLYMAN OTLOWSKI: Thank you very much.

FREEHOLDER CIMINO: Thank you.

ASSEMBLYMAN OTLOWSKI: Assemblyman Cuprowski, did you have a question?

ASSEMBLYMAN CUPROWSKI: Not at this moment.

ASSEMBLYMAN OTLOWSKI: May we have Freeholder Walter Luger of Morris County? Good morning, Freeholder.

FREEHOLDER WALTER LUGER: How are you? Good morning, Mr. Chairman, ladies and gentlemen: My name is Walter Luger, and I am a member of the Board of Chosen Freeholders of Morris County. I am here today as a representative of my Board.

I also come wearing two more hats for I am the Freeholder liaison for Human Services and my Board's representative to the New Jersey Association of Counties, where I sit on the Legislative Committee.

I want to convey my Board's strong endorsement of the peer grouping concept, and our willingness to see that innovative approach to help solve some of our social problems become a reality.

We would also like to extend our thanks to the State Department of Human Services for coming up with the peer grouping concept, for it is another landmark in the working relationships between the State and counties.

I must convey to you our belief that this Committee should draft legislation to institutionalize the peer grouping concept, even as we caution against fixing any amounts by law, since our needs are so varied.

We are very aware that under the initial proposals the anticipated savings to Morris County come to more than $2.3 million, and using a target of 50% means that Morris County could be funding new programs worth more than $1.15 million.

I think the Comprehensive Human Services Plan for Morris County, which I have submitted in support of our testimony, gives you some idea of how far-reaching our concerns are, and how relieved we will be if some of the scarce dollars we will need come from the peer grouping plan.

What is not in the plan are the human equations that make up the varied services the county intends to supply, not only for the elderly and disabled, but all those who need our help because they cannot help themselves.

Let me give you some statistics to round out the picture: According to updated information from the 1980 census, we estimate there are now 53,000 elderly residents in Morris County.

That is a 23% increase in those over age 60 since the 1970 census, and the estimated 3,700 of them living at the poverty level constitute the primary at-risk population. This is truly the greying of America, and Morris County, like the other counties, is showing its age.

We also have about 7,000 persons who are developmentally disabled and at least 150 of them are older than 65.

The ranks of the handicapped also continue to swell, for Morris County has 1,251 adults who are legally blind and more than 1,800 children who are visually impaired.

We count almost 9,000 frail aged who are living alone.

These numbers may not be impressive when compared to those found in urban centers, but examined against a total population of slightly more than 400,000, you can begin to see the dimensions of the problems that must be addressed.

Right now, Morris County is appointing an informal committee to do the study planning for the peer group initiative and using the Comprehensive Human Service Plan for our foundation, we believe we will be able to achieve most of our goals.

With me is John Merrigan, Administrator of Morris View, our county nursing facility. If there are any questions, we will attempt to answer them.

I would also like to take this opportunity to thank the Committee again for its time and kindness in listening to me.

ASSEMBLYMAN OTLOWSKI: Thank you very much, Freeholder. I see that on your first page, probably in the sixth or seventh paragraph, you say: "I must convey to you our belief that this Committee should draft legislation to institutionalize the peer grouping [illegible] even as we caution against fixing any amounts by law since our needs are so varied." We have a bill before us, A-3811, is one that I am sponsoring and it does precisely that. Are you saying that you are in agreement with that bill?

FREEHOLDER LUGER: Yes.

ASSEMBLYMAN OTLOWSKI: You cited figures concerning the growth and expansion of the whole elderly population. Do you think in view of that, that comprehensive legislation is needed? Should it also be so flexible that it will provide for the variations in the different counties and areas involved?

FREEHOLDER LUGER: That is basically what we are saying. We are in agreement with peer grouping, but I think the counties have to realize what their problems are. We have our own master plan. I think we can work with that master plan by using that money.

Really, I think we are in agreement; we are saying that flexibility is the thing we are looking for.

ASSEMBLYMAN OTLOWSKI: Frankly, that is the same thing I want to achieve. I would hope that you and the other Freeholders take a

good look at that bill. I want to make sure that the flexibility we are talking about is in that bill, and that you are not locked-in so tightly by law that you cannot recognize the variations of the different areas, or even in different institutions.

Would you do me the kindness to have your nursing home people take a good look at that bill?

FREEHOLDER LUGER: I have Mr. Merrigan with me, and I am sure he already had a good look at it before we prepared this testimony, but I would be happy to have him address it.

ASSEMBLYMAN OTLOWSKI: In your opinion, Mr. Merrigan, does this bill meet the needs we are talking about?

MR. MERRIGAN: Yes, it does. In my estimation it does.

ASSEMBLYMAN OTLOWSKI: So from your testimony, it appears as though we are on the right track.

FREEHOLDER LUGER: Absolutely.

ASSEMBLYMAN OTLOWSKI: Thank you very much.

FREEHOLDER LUGER: Thank you very much, Assemblyman.

ASSEMBLYMAN OTLOWSKI: Excuse me, Freeholder, Assemblyman Cuprowski has a question.

ASSEMBLYMAN CUPROWSKI: Freeholder, I believe you said you had 53,000 institutionalized elderly within your county, is that correct?

FREEHOLDER LUGER: We said we have 53,000 elderly residents in the county.

ASSEMBLYMAN CUPROWSKI: Elderly residents in the County?

FREEHOLDER LUGER: Yes.

ASSEMBLYMAN CUPROWSKI: How many of these residents are institutionalized? Do you have any figures on that?

FREEHOLDER LUGER: I don't know how many we have at Morris View.

MR. MERRIGAN: Three hundred and seventy-one.

FREEHOLDER LUGER: We have 371, and we also have a number of people at Greystone. I would say there are at least 300 or 400 people who really do not belong in Greystone but they are there because there is no place else for them. They really should be in nursing homes.

ASSEMBLYMAN OTLOWSKI: Assemblyman, are you asking for the total figure?

ASSEMBLYMAN CUPROWSKI: Well, I believe he mentioned there were 53,000 seniors in the county. I am just trying to get a figure on how many are actually institutionalized, or need institutionalization, if you will.

FREEHOLDER LUGER: What we are saying is, we have that many in the county. We are also saying 3,700 of these people are living at the poverty level. So, they are certainly going to need some support, whether it be community based service or institutionalization. They are going to need support, and this is why we are looking for as much flexibility as we can possibly get. We can then direct those dollars toward the people who really need them, whether it means institutionalizing them, providing for them in private nursing homes, or whatever. We would like to have the ability to help them.

ASSEMBLYMAN CUPROWSKI: Mr. Chairman, one thing that should be pointed out -- if it needs pointing out -- is that nursing homes do not necessarily mean only the elderly. They are, in fact, for the chronically ill, people who are not senior citizens, comatose patients, etc.

FREEHOLDER LUGER: I think we had a good example of that in our county just recently. Fortunately, it has come to a blessed end.

ASSEMBLYMAN CUPROWSKI: The Karen Ann Quinlan situation?

FREEHOLDER LUGER: Yes, exactly. We are certainly well aware of your interest in that, and it appreciate it.

ASSEMBLYMAN CUPROWSKI: Thank you very much.

ASSEMBLYMAN OTLOWSKI: Thank you very much.

May we now hear from John Fay, the former Ombudsman?

JOHN FAY: Good morning, George. I am here as a former Ombudsman and legislator who sat in on the long-term care study many years ago. From my 10 year's experience, one of my strongest conclusions was that long-term care is an area which is sadly neglected, under-funded, and too often used as the place where only the very poorest and the very sick were sent.

I think the Freeholder from Morris County, a somewhat wealthier county within the 21 counties in New Jersey, pointed out their very real problems. We can escalate that as we move around our State, especially into our urban counties where there are larger numbers of poor, elderly sick people.

This problem is getting worse; it is not going to get better. Every statistic tells us about the population explosion among the elderly. Ten years ago, when we started working on this problem we were talking about 60- and 70-year-olds; however, the 1980 census shows us that the fastest growing age group is now 80- and 90-year-olds.

ASSEMBLYMAN OTLOWSKI: Thank God for that, Jack.

MR. FAY: Yes, if one is well and has a family. However, the population that the county hospitals and some of the boarding homes are ending up with consists of very old, sick people who are outliving their families. They most certainly do not have the $20 thousand per year for private-pay contracts. They most certainly are not in the position to make that kind of contribution to get into nursing homes.

So, what we are left with are horrible alternatives: People who do not get into a county hospital. The waiting list for every county hospital is growing longer and longer. If one is alone because he has outlived his family, he is all by himself and he does not know where to turn.

As most of us here know, we are dealing with a bureaucratic maze on any given day. This is a major bill. You are talking about a major breakthrough. The county hospitals do deserve recognition because they are the only ones in the State that I know of-- They are the long-term care bed of last resort.

No one knows better than Freeholder Capestro from Middlesex County that when Middlesex made a major contribution by adding long-term care beds to the county hospitals, they were faced with the reality that there were not enough dollars to go along with this county operation.

I agree with Commissioner Albanese, that we need a broad picture. I agree that there should be flexibility in order to start pouring funds into well-planned and well-operated home health programs.

By the way, Union County has an excellent program that can be used as a model.

What you are doing today is most significant and needed. If this was not done, if this bill was not here, if this recognition and awareness was not given, I insist that we would be building toward a major State human disaster because of this growing population.

ASSEMBLYMAN OTLOWSKI: Jack, so your position is that you are strongly in favor of this bill?

MR. FAY: Absolutely. It is long overdue.

ASSEMBLYMAN OTLOWSKI: Just off the top of your head, we released a lot of bills yesterday; this fits into that whole pattern and package, doesn't it? Wouldn't you say we are actually gearing up the whole State for better care?

MR. FAY: You know, we are speaking as a State, but, really, we should be speaking as a nation. Everything we discovered in New Jersey, and the nursing home scandals in New York, Texas, and California, plus the boarding home tragedies, was not localized to the State of New Jersey. The growing homeless population is all part of a broad, frightening picture. Where do you think the homeless are coming from? They are coming from Greystone and Marlboro; they are coming from neighborhoods that can't or won't handle them; they are coming from families they have either outlived, or who, for a variety of other reasons, have left them by themselves.

I think we are one of the few states in the Union that is taking this step forward, insofar as planning a statewide program is concerned. When we talk about the elderly, we think about the retirement communities in Ocean, Monmouth, and Middlesex Counties. We are talking about a relatively healthy and well-off group. However, at $20 thousand, plus, per year in a nursing home, it does not take long for middle class people who have worked and saved money all their lives to go from middle-class to Medicaid-eligible if the husband dies, or if the wife breaks her hip or gets very sick. So, what you did yesterday was to make a major commitment on the boarding home level. The nursing home area is an altogether different world.

I am saying that within this whole picture, especially in New Jersey, the county hospitals have played a major role, and they absolutely need the recognition you and your Committee are giving them by what you are doing. You are saying, "Yes, this is a major area. No, it does not have anybody who lobbies for it. It doesn't have anyone, outside of the Freeholders, to recognize it. It doesn't have the constituency to lobby for it." Without this step, the whole State plan is remiss. Without this major commitment, a) to the county hospitals, and, b) to home health care, it is a faulty plan.

So, I am glad, after all these years and all the tragedies and horrors we have gone through, that we are at least getting to the point of having a consistent, comprehensive, humane State plan.

ASSEMBLYMAN OTLOWSKI: Thank you. Assemblyman Cuprowski?

ASSEMBLYMAN CUPROWSKI: Mr. Fay, to your knowledge, do all 21 counties have county-run, long-term care facilities?

MR. FAY: I believe 20 of the 21 counties have varying operations. I can't think of the one county that does not have it, but to the best of my knowledge, 20 of the 21 counties do have this type of operation.

ASSEMBLYMAN CUPROWSKI: Thank you.

ASSEMBLYMAN OTLOWSKI: Jack, just one thing. David called this to my attention and he suggested I ask you this question, based upon your experience as a Legislator, a Freeholder, and, finally, as an Ombudsman. This is in line with the savings that could take place for the counties. Are you of the opinion that the counties should be free to use the funds in any way they see fit, or should the funds go for property tax relief? Can you answer that, off the top of your heard?

MR. FAY: George, off the top of my head, I believe that the money should be committed to a form of long-term care, with the top priority being home-health care. I think this is an area that, when we talk of long-term care, has been sadly neglected.

ASSEMBLYMAN OTLOWSKI: You see that as a big development?

MR. FAY: I think of it as a major development. They have never been funded properly. We have a few model programs that are working well.

I would not just leave any of the savings that come out of this to the county budget. I think you have made a commitment to county hospitals, to the people they serve, and to the people they could be serving in communities, in homes, and in senior citizen housing, for example. Why not a clinic program? Why not a team of visiting nurses and health professionals who would move around and go to the areas where the people live, for instance in Perth Amboy. Why not move around the neighborhoods one day a week and offer preventive health as well as diagnostic care?

ASSEMBLYMAN OTLOWSKI: I would like to make one more request of you, if it is possible. Would you remain? After this is over, I would like to talk to you about several areas regarding this. By that time we should have the benefit of the testimony given by people who are here. Will you do that?

MR. FAY: Of course.

ASSEMBLYMAN OTLOWSKI: Thank you very much.

May we now hear from Mr. James Cunningham? Jim, please tell us who you are and what organization you represent.

JAMES E. CUNNINGHAM: I am Jim Cunningham, President of the New Jersey Health Care Facilities. Thank you for the opportunity to testify before you on the very vital subjects of the adequacy of Medicaid reimbursement and the examination of peer grouping for county nursing homes.

First, let me deal with the peer grouping issue. The counties say they deserve special treatment because their facilities house many seriously ill Medicaid patients, and the cost of medical and nursing services for these so-called "heavy-care" patients exceeds current Medicaid reimbursements.

Our Association, which represents both proprietary and non-profit private nursing homes, agrees that Medicaid rates are inadequate for heavy-care patients. Any nursing home with a large percentage of seriously ill patients finds it very difficult today to provide, at Medicaid reimbursement rates, the staffing necessary for the quality care these patients require and deserve.

In addition, New Jersey's diagnostic-related group hospital rate-setting system has shortened the length of an average patient's hospital stay. A result has been to increase the number of nursing home patients requiring more costly care. The situation will only worsen as State health officials project the number of New Jersey residents over the age of 85 will increase from 72,231 in 1980 to 158,100 by the year 2000.

We can't fault county facilities and county officials for seeking a more appropriate reimbursement level for severely ill patients. But peer grouping, which would discriminate against patients in private nursing homes with large Medicaid, and heavy-care populations, is an unjust solution, especially since our facilities -- unlike county nursing homes -- cannot rely on tax subsidies to offset losses. If you apply the peer grouping situation, you run the real risk of hurting many patients in heavy-care facilities while not necessarily improving care in government operated nursing homes.

A claim similar to that being made by county governments in New Jersey was made by hospital units in Maryland, two years ago. The result was that the Maryland Legislature did increase rates to hospital-based, long-term care units, supposedly due to the fact that they have heavier care populations than nursing homes. In the meantime, however, the Maryland Legislature commissioned a study to determine whether that, in fact, was true. The results of that study indicate that these units and the nursing homes have the same type of patients, and the increased reimbursement to the hospital units was rescinded. The Maryland study -- a copy of which is included in my material as "Appendix A" -- was an impartial study. We question whether the New Jersey study, done by an accounting firm which, as I understand it, does work for the county facilities, could be classified as equally objective.

Recent newspaper articles, also attached as part of "Appendix A," seem to indicate that management reports of county nursing homes, done by consulting groups retained by the counties themselves, show over-staffing, high cost, and waste. This is similar to the findings of the Maryland study.

A better approach would be to follow the example of the States of Massachusetts and Maryland. They were mentioned earlier today. Both have established a separate and more realistic reimbursement rate for heavy-care patients, whether they reside in public or private nursing homes. We urge the New Jersey Legislature to reach the same solution. You can easily do so by passage of an amended version of A-3494, sponsored by Assemblyman Felice and the other members of this Committee.

This bill calls for the implementation of one level of ICF care at 2.5 hours of nursing care per patient per day, as recommended by an impartial study completed by Applied Management Sciences in 1983. Our Association recommends that this legislation be amended to increase skilled care to three hours, and to also add a heavy-care category at three hours per patient, per day. This would solve the county nursing homes' problems if they are truly burdened by heavy-care cases. The increased staffing at all levels would go a long way toward eliminating the marginal type nursing home which has distressed not [illegible] and the Legislature, but our Association as well.

The second subject, adequate reimbursement, was at least partially dealt with in the foregoing. Other trouble spots are in establishing high, medium, or low nursing personnel salary regions by Medicaid. These catgories unjustly penalize many nursing homes and make staff recruitment difficult. Also, another problem is the fact that the Director of Nursing is not reimbursed under a separate line item. Since last November, we have been discussing changes in these areas with Medicaid.

Again, I thank you for the opportunity to testify. This appears to be one of the lengthier statements we have delivered to you; however, it was necessitated by the very critical topics at hand. I would be very happy to answer any questions you may have.

ASSEMBLYMAN OTLOWSKI: Jim, the thrust of your testimony and approach is the fact that you are opposed to this proposed method; you feel it should be based upon the intensity of the illness, am I correct? Does that summarize your position?

MR. CUNNINGHAM: Yes, heavy care. In fact, Utah has now taken the same approach that Massachusetts and Maryland has, and their Legislature -- because there the Legislature does reimbursement, unlike New Jersey -- has established heavy-care payment also.

What we are saying is, "Sure, we agree with the counties. There is heavy care and they need the money, but this will give it to them; however, it will give it to everybody, fairly and equally, and not in an unjust manner."

ASSEMBLYMAN OTLOWSKI: Would there be a difference in the cost?

MR. CUNNINGHAM: Absolutely. There will be an increase in--

ASSEMBLYMAN OTLOWSKI: How much, off the top of your head?

MR. CUNNINGHAM: I couldn't even guess. The study of two and one-half hours in the one level of ICF, which was completed two years ago, would cost -- at that point the figure was $7.2 million. So, you are looking at probably $15 or $20 million.

ASSEMBLYMAN OTLOWSKI: On top of what we are proposing?

MR. CUNNINGHAM: What we are saying is, do this instead.

ASSEMBLYMAN OTLOWSKI: Do what you are saying, but then your plan would be $40 million, rather than absorbing the $20 million we are talking about.

MR. CUNNINGHAM: No, it would have a Federal match.

ASSEMBLYMAN OTLOWSKI: But, the overall cost would be increased by $20 million.

MR. CUNNINGHAM: The Federal government will match the State by $10 million, and that type of thing. I am sure Medicaid could do the workups. The workup on the one level of ICF was completed.

ASSEMBLYMAN OTLOWSKI: And that is developed in the appendix to your testimony?

MR. CUNNINGHAM: Right. That is the thickest document.

ASSEMBLYMAN OTLOWSKI: I think Assemblyman Cuprowski has some questions he would like to ask.

ASSEMBLYMAN CUPROWSKI: Yes. Mr. Cunningham, would you agree with the statement, or at least a part of the statement in the bill which says, "Operating costs at government operated nursing homes tend

to be higher than either proprietary or voluntary facilities due to the factors of aging buildings, a greater number of long-term employees..." in addition to the highest percentage of heavy-care and Medicaid patients that you were talking about before?

MR. CUNNINGHAM: I agree that their costs are definitely higher. Some of them probably have aging plants. Some of our people have aging plants too. Some of our people have lengthy employees and the added costs you get in the counties also. The government benefits are probably higher for counties than they are for the private market.

However, when you read the Maryland study, there are higher costs. The Maryland study says, "absolutely," the care is no different, there are just higher cost places. But, they do need the nursing money. I am not quarreling with that. Patients in nursing homes today are totally different than they were in the old days, and there is a lot of heavy care that you not only do not get paid for but if you do it with the minimal staff that was in before, you cannot do a decent job. We do not want any marginal facility to be permitted to be out there operating at those kinds of levels because it hurts the entire industry when something blows up and reaches the media.

ASSEMBLYMAN CUPROWSKI: I have another question. Your statement indicated that the New Jersey DRG rate-setting system for hospitals has shortened the length of hospital stay for a patient. The result has been an increase in nursing home patients who require more costly care. Are there any studies to that effect? Do you have any documentation on that?

MR. CUNNINGHAM: Within two weeks we will be able to submit to you another study done by a non-vested group. Oddly enough, this one will again be done by the research group out of Maryland. An unbiased study was completed. The documentation is being fed into the computers, as they do now.

The impact of the DRG system on long-term care in New Jersey will be completed within the next two or three weeks, and we will see that you get a copy of that study.

The Health Insurance Program, or HIP, in Washington is very interested in it because down there they are looking at the prospect of

a reimbursement system for Medicare, and some of the big issues are: Are they getting sicker people? Are they dumping them out of the hospital too early? Do the facilities have to staff up to take care of them, or can they take care of them? And, is there a need for heavy-care payment under Medicare also?

So, that study will probably be completed in about three weeks.

ASSEMBLYMAN CUPROWSKI: But, the study is going to include--

MR. CUNNINGHAM: It will show the impact of the DRG system -- the hospital DRG system -- on long-term care.

ASSEMBLYMAN CUPROWSKI: In what geographical location are we talking about?

MR. CUNNINGHAM: The entire State of New Jersey.

ASSEMBLYMAN CUPROWSKI: The entire State of New Jersey?

MR. CUNNINGHAM: It was going to be used nationally, but they used New Jersey instead. It was fairly easy to do this in New Jersey since the DRG system was already here, doing the pre-DRG and post-DRG by calling up records of "before" and "after." I think they do their statistical numbers in the sample. It has to be a qualified sample, probably certified. If I recall, 57 of the facilities in this State are in that sample.

ASSEMBLYMAN CUPROWSKI: I apologize, but who commissioned that particular study?

MR. CUNNINGHAM: We are paying for it as an Association. We are not involved in it because if we were, people would look at it with a slanted eye. If it was done by government, we would look at it with a slanted eye. So, it was necessary for it to be done by a totally unbiased, outside group. We are paying for part of it. The American Health Care Association in Washington is funding the balance of it.

ASSEMBLYMAN CUPROWSKI: Thank you.

ASSEMBLYMAN OTLOWSKI: Thank you very much. You are going to make that available to us, aren't you?

MR. CUNNINGHAM: Absolutely. (see appendix, page 1x)

ASSEMBLYMAN OTLOWSKI: Thank you.

I would like to call Tom Russo back to the microphone again for a moment. Mr. Russo, will you come up here, please?

Tom, you are the big expert on Medicaid. You heard the testimony of Jim Cunningham. He makes no bones about the fact that what he is advocating is more costly. After dealing with Medicaid all these years, from your point of view what is your immediate reaction to his proposal?

MR. RUSSO: What Mr. Cunningham is proposing is to require additional hours of nursing care for the levels we now have. His proposal is to increase intermediate care levels to 2.5 hours, skilled nursing levels to 3 hours, and to add a new category of heavy care at 3 hours. Now, that would provide nursing facilities at all levels, the county, the proprietary, and the non-profit level, with the ability to provide additional nurses to care for patients at all levels.

However, his proposal -- as was mentioned -- does have a price tag on it. I would guess a price tag of about $10 million in additional State funding is a fair ball park estimate, as opposed to peer grouping, which has no cost to the State at all. But, peer grouping addresses only the county facilities.

ASSEMBLYMAN OTLOWSKI: I think you put your finger right on the nub when you said that peer grouping has no cost to the State at all.

MR. RUSSO: That's correct.

ASSEMBLYMAN OTLOWSKI: His plan could cost the State anywhere from $10 million to maybe even $20 million.

MR. RUSSO: Well, the total cost would probably be about $20 million. One-half of that would come from the Federal government and the other half would come from the State government.

ASSEMBLYMAN OTLOWSKI: Of course, he is going to make more information available to us, but from your knowledge do you know if the system he is advocating is working anyplace at the present time?

MR. RUSSO: Well, every state is different. If you look at the 50 states that participate in the Medicaid program, and if you look at their reimbursement systems and their standards for nursing homes, they are totally different. Each state provides different rates; they all have different systems; they have different requirements for nursing coverage; and, it is difficult to compare one state with

another. However, at this time I do not think too many states, based upon the information we heard today -- we were talking about Maryland and Massachusetts and Mr. Cunningham mentioned Utah -- three out of 50 states are apparently addressing the heavy-care issue problem, which, to my knowledge, leaves 45 states that are not addressing it at this time.

ASSEMBLYMAN OTLOWSKI: Of course, my bill was designed primarily to be of help to the counties because of some of the financial problems they are facing. Do you see what Jim is advancing and advocating as a separate issue? Do you see us dealing with the county problem because the county has immediate problems. Of course, Jim would tell you that they also have immediate problems in the nursing homes.

In any event, if we deal with this problem in the counties, we can then deal with what he is talking about separately.

MR. RUSSO: I completely agree with you, Mr. Chairman. I think this is a two-problem approach. The issue of peer grouping is definitely needed. I think the concept is sound, and it will definitely benefit counties. It will help them with their reimbursement problem; it will help them with their budget issues; and, it will enable us to provide additional community and home care, over and above what is not now being provided.

Mr. Chairman, peer grouping as it is being proposed, and as it is supported by the Department of Human Services, should definitely be supported. However, I do not think we can ignore the issue of the heavy-care patients.

ASSEMBLYMAN OTLOWSKI: But that should be treated separately.

MR. RUSSO: I think that should be a separate issue, and we can deal with that separately.

ASSEMBLYMAN OTLOWSKI: Thank you very much.

MR. RUSSO: You're welcome.

ASSEMBLYMAN OTLOWSKI: You are going to stay here, aren't you? I may need you, all right?

MR. RUSSO: I'll be here.

ASSEMBLYMAN OTLOWSKI: Thank you very much.

Oh, Tom, one other thing, please. Is the budget for 1986 adequate to handle any significant enhancement of nursing home standards?

MR. RUSSO: Not really, Mr. Chairman. The budget is a continuation budget. It takes into consideration the inflation factor, and the addition of new beds that are coming on line next year. However, it is essentially a continuation budget. If we talk about adding something, such as nursing hour requirements and combining the two ICF levels into one level, we will need additional funds for that purpose. It is not in the budget.

ASSEMBLYMAN OTLOWSKI: Thank you.

Commissioner Goldstein, I do not want to hold you up. If you are ready to speak, we are ready to hear you.

Commissioner, I would like to make a preliminary statement. Yesterday we dealt with a very comprehensive package on nursing homes, boarding homes, and residential homes. I would just like to tell you that we are very grateful to you and to your Department for all the [illegible] a lot of staff work went into that; it was not just a matter of legislative effort, and it made sense when it came before the Committee yesterday. As a matter of fact, that made it a whole lot easier for the Committee to deal with.

As I said yesterday, I want to compliment the Commissioner of Human Services and, by the same token, I want to compliment you for the wonderful attitude you had; you were helpful, cooperative, and you looked for solutions. As a matter of fact, I think over the years I have chaired this Committee, yesterday was really a good moment for all of us because I saw all of us pulling together. I just wanted to say this, and it was very difficult for me to say it as a partisan Democrat. But, in any event, a really noble, nonpartisan effort put this package together, and I just want to tell you I appreciate all your help.

I told this to Commissioner Albanese, and I am not telling you the same thing. I hope we will continue in this same vein.

Now, to get to the problem at hand, Commissioner, we are ready for your statement.

COMMISSIONER J. RICHARD GOLDSTEIN: First, thank you for the kind words. Let me just say that we appreciate the Committee's interest, and your interest in particular, in helping us to resolve the problems we have been having in this area.

It is my understanding that the focus of this hearing is on two issues, primarily peer grouping, and whether or not the number of nursing care hours is or is not adequate.

As part of the Department's efforts to improve the quality of care in nursing homes, we recommended to the Governor in the initial report you have seen, that facility licensing standards be comprehensively rewritten, and we requested money in our budget to do so.

The facility standards are separate and apart from staffing standards, which we also feel should be reexamined. The Department supports this reexamination, as does Ombudsman Jack D'Ambrosio, and Commissioner Albanese.

The original study was performed several years ago. I understand it was funded by the nursing home industry, but it was performed jointly between an independent consultant and the Department of Human Services. The purpose of a reassessment study would be to assess the severity of illness of a statistical sample of patients and to determine the optimum mix of caretakers necessary to deliver quality care to the ill, elderly population.

I should point out, critically, that we support merging the ICF A&B rates now, and the study should follow as soon as possible. We do not want the study to hold up the merging of the ICF A&B rates.

I would also like to give the Committee a short update on the overall nursing home situation since my last testimony. The Department conducted two weekend blitzes, completely unannounced. Our inspectors met in set locations and were told explicitly at that time where they would be inspecting. The list of homes we inspected was drawn up from a list provided by Human Services, the Ombudsman, and the Health Department, so we would hit the homes that had the poorest track records.

A total of approximately 50 homes were inspected in those two weekend blitzes. Of these, minor violations were found in many of the homes, but of those with violations only two were serious enough for the Department to curtail admissions. Although I am profoundly concerned about these violations, when put into perspective, only two homes out of a selected list of 50 were unsatisfactory. Two unsatisfactory homes out of a statewide total of approximately 300 should provide some reassurance to the public that what we have is a problem and not a crisis.

We are prepared -- I have people with me -- to update you on these areas, should you be interested in them.

In terms of the peer grouping situation, the Department does support peer grouping.

ASSEMBLYMAN OTLOWSKI: Commissioner, David just called my attention to the fact that one of the recommendations made was to expand the centralized computer bank for the Department of Health. Are you working on that?

COMMISSIONER GOLDSTEIN: Oh, yes. We are working quite heavily on that. There is about a 300- or 400-page computer printout, which I haven't gone through yet. It is on my desk.

Ted, can you make a more specific comment on that computer effort?

THEODORE SEAMANS: Yes, I can. The computer printout that the Commissioner is referring to is a printout of all violations in all agencies since 1981, which were returned to the agencies for their critique. After these violations are compiled, they will be made available to the three agencies -- as was in our directive. We will now cull from that a method by which we can make appropriate periodic reports for the public to evaluate the nursing home agencies. So, we are in the midst of this very ambitious project and we are moving along very quickly on it.

ASSEMBLYMAN OTLOWSKI: Let me ask you this: when this is finally finished, will a member of the public be able to call your Department to get information on a specific nursing home?

MR. SEAMANS: That information is available to the public right now.

ASSEMBLYMAN OTLOWSKI: Thank you very much.

COMMISSIONER GOLDSTEIN: But, in addition to that, the Department is going ahead and developing a consumer oriented report on each nursing home in this State. We haven't yet done that. It is complex. We are trying to find ways to tell people meaningful information without pointing out that the lawn wasn't cut -- you know, without having them read a summary total of minor violations and reaching the wrong conclusion.

So, we are trying to cast a report that will be meaningful to the consumer, and put the nursing home in good perspective.

ASSEMBLYMAN OTLOWSKI: Commissioner, in that same area, do you remember we said the Office of the Ombudsman for Institutionalized Elderly would use undercover agents to review patent abuses? Is that working out?

COMMISSIONER GOLDSTEIN: You will have to ask the Ombudsman that question.

ASSEMBLYMAN OTLOWSKI: I believe he came in with you. We will ask him that in a moment.

COMMISSIONER GOLDSTEIN: We have recommended in at least one situation that he provide an undercover agent for a complaint we had.

ASSEMBLYMAN OTLOWSKI: Commissioner, is it your position that peer grouping would be helpful to the counties, and that you support that position?

COMMISSIONER GOLDSTEIN: Yes.

ASSEMBLYMAN OTLOWSKI: Everybody has an opinion about saving, but no one does anything about it. Commissioner, there is some debate about the savings that will result from this. How should the counties use those savings?

COMMISSIONER GOLDSTEIN: Uncompensated care, obviously. Put it in an uncompensated care pool.

ASSEMBLYMAN OTLOWSKI: That answers that question. Assemblyman Cuprowski?

ASSEMBLYMAN CUPROWSKI: Commissioner, I have a question in reference to the two nursing homes you closed to new admissions as a result of the blitz inspections. Other than closing them what was--

There was a reason for closing them to new admissions, but what was done in addition to closing them to new admissions?

COMMISSIONER GOLDSTEIN: Curtailment of admissions is the way we currently tell a nursing home we do not like their operation. That hurts them financially. We tell them exactly what the violations are. We find the violations, and they have a period of time to correct them. After they correct the violations, we go back to reinspect in order to make certain that they are now in compliance so that they can readmit patients.

ASSEMBLYMAN CUPROWSKI: As you probably know, there are several bills in the Legislature, as you probably know, which deal with some additional authority — for example, with the Medicaid funds — when there are life-threatening types of violations. In addition, there are other bills in the Legislature that basically came out of the hearings relative to the Bel Air situation.

COMMISSIONER GOLDSTEIN: I can't comment on any of the bills right now, except to say, philosophically, the Department has asked for [illegible] capabilities, in order to get off the block of just curtailing admissions. We would like to take more action. We would like to take faster action, where it is possible.

Let me also point out the situation with Bel Air, where the Department was successful in taking action. Again, that was voluntary action which the owner agreed to. It was not a court-ordered action. The owner was under such public pressure that he decided to comply with the Health Department's request. A receiver was assigned. The receiver did a good job. The facility is in compliance. The curtailments have been lifted. The owner has submitted a list of perspective buyers to the Department, and we are currently reviewing the list to see if one of those buyers meets with our approval. So, that situation has been turned around.

Again, that was done on a voluntary basis, with media attention. We want to be in a situation where we can put a home in receivership much more quickly than we have been able to; however, the current way it works is that the facility goes back to the original owner once the violations are corrected. We feel this just does not

accomplish anything. So, that is the main thing we are looking for: The requirement that it has to be sold.

ASSEMBLYMAN OTLOWSKI: Commissioner, I do not have anything else.

COMMISSIONER GOLDSTEIN: Your Committee did submit several questions to us, and Charlie Buttaci has prepared testimony. He can read it, or he can submit it to you. It deals with the care formulas. Basically, we think the formula is fine. We think the way hospitals get priced for their services is fine. So, the only issue is whether or not we require the right number of nursing care hours, and, given whatever the number we say the formula is, is it correct when translating that into dollars and payment schedules. We do not think the formula needs attention, but we do think the reappraisal of nursing care hours should be conducted. It probably should be done every three or four years anyway. As the population in our nursing homes ages, and as treatment changes over a period of time, we think that has to be constantly looked at.

ASSEMBLYMAN OTLOWSKI: Rather than reading those, could you just summarize them so they can become part of the record, please?

CHARLES BUTTACHI: Yes. In accordance with the Chairman's June 17th request of Commissioner Goldstein, the Department would like to submit the following information for the Committee's review.

COMMISSIONER GOLDSTEIN: This is the summary?

MR. BUTTACHI: Yes.

COMMISSIONER GOLDSTEIN: Okay.

MR. BUTTACHI: Number one, the care guidelines which describe the methodology used to establish nursing homes rates.

Number two, the means and reasonableness limits which were used for rate-setting purposes to compute the 1983, 1984, and 1985 rates.

Number three, the median runs as of December 31, 1982, 1983, and 1984, which reflect data for each nursing home as to their costs on the variables used to determine nursing home rates for 1982, 1983, 1984, and 1985.

In point of fact, Human Services would do their inspections, and we would do ours. They were separate and distinct. Serious problems would be reported both ways. But, basically, both organizations were dealing with problems in their own fashion. We basically had the facility portion of the problem. We basically had the patient portion. So, we had process; they had outcome.

We are now getting much closer together. This month, as a demonstration -- we have done this in three homes so far -- we have combined the exit interviews to the nursing home -- that is, Human Services staff and Health Department staff are there, and they collectively report the findings, violations, and concerns we have to the nursing home. That has proved to be much more productive.

I would also like to point out that money may at times be a problem for some nursing homes, the key problem does not appear to be financial. I think that is indicative of the fact that Bel Air was under the screens. In other words, they could have been getting more money in their rates. For whatever their reason was, they elected not to [illegible] less expensively than the system would allow them to charge. So, this is one case where throwing more money at a problem doesn't seem to relate to the problem.

Whether or not our patients need more nursing care hours is of concern, and I think we are going to have to look at this carefully. We are also anticipating several thousand more nursing home beds coming on-line, and we have to recognize the cost impact of that while still maintaining a sufficient level of care for our elderly population.

ASSEMBLYMAN OTLOWSKI: I would like to thank the Commissioner and his staff for their contribution to this complex subject. As a matter of fact, I want to express our deep appreciation for your cooperation and your help on this once again. Thank you very much.

May we hear from the Ombudsman, please? Rather than making a statement-- Are you going to insist on making a statement?

JACK R. D'AMBROSIO, JR.: I will not insist on anything you do not want, Mr. Chairman.

ASSEMBLYMAN OTLOWSKI: Then you are a friend. I want to ask you if at the present time you have increased some of your operations by disguising people in order for them to investigate complaints? Will you just tell us what you have done with that?

OMBUDSMAN D'AMBROSIO: Yes, Assemblyman. What we are preparing to do is to request additional staff. I am hoping, since the budget went through yesterday, we will get that additional staff.

After the fiscal year begins, we are prepared to start zeroing in on certain facilities that are exhibiting pattern-and-practice type problems, so we can use undercover agents in those facilities.

For the first time, I think we will also be in a position to not only react to complaints received, but we will be able to take a more aggressive position and start developing our own list of both the facilities which show deficiencies and repeated violations, and the facilities which may be adhering to State minimums but are not providing the care they should, according to those minimums.

ASSEMBLYMAN OTLOWSKI: So, indeed, your approach has become more intensive.

OMBUDSMAN D'AMBROSIO: It will, yes.

ASSEMBLYMAN OTLOWSKI: It will?

OMBUDSMAN D'AMBROSIO: Yes, it will as--

ASSEMBLYMAN OTLOWSKI: You are setting that up now?

OMBUDSMAN D'AMBROSIO: Yes, we are trying to organize now so that we will have more of an effect.

ASSEMBLYMAN OTLOWSKI: After it is set up, will you do me the kindness of getting in touch with one of our staff members and inform us that it is set up? We will then be able to call you and review it.

OMBUDSMAN D'AMBROSIO: Yes.

ASSEMBLYMAN OTLOWSKI: One other question regarding peer grouping being helpful to the counties. What is your position on that?

OMBUDSMAN D'AMBROSIO: We absolutely favor and support the peer grouping study. We have felt this way about the Medicaid reimbursement issue as a whole for a long time. We have both sides telling us things. One says it is sufficient, and one says it is not

sufficient. We have always supported a general study of the rate as a whole, and we still support that. We certainly support the peer grouping study.

ASSEMBLYMAN OTLOWSKI: In the present case we are dealing with peer grouping in county hospitals, and you are in favor of that. Are you of the opinion that the other subject Jim Cunningham was talking about should be treated separately and not be confused with the peer grouping?

OMBUDSMAN D'AMBROSIO: I would like to see the issue as a whole studied. I certainly would not want to put one off for the other because I think we need to address the issue as quickly as possible.

ASSEMBLYMAN OTLOWSKI: When you submit some of your supplementary material, Jim, I hope you make it available to the Ombudsman and to the Commissioner of Health.

MR. CUNNINGHAM: Yes, we have already promised to do that.

ASSEMBLYMAN OTLOWSKI: Good. Thank you, Mr. D'Ambrosio.

[illegible] D'AMBROSIO: Thank you very much.

ASSEMBLYMAN OTLOWSKI: Can we hear from Mary Kirschman, the Assistant Administrator of Roosevelt Hospital?

MARY KAY KIRSCHMAN: Good morning. I am Mary Kay Kirschman, and I am the Assistant Administrator for Nursing here at Roosevelt Hospital. I was pleased to be asked by the New Jersey State Nurses Association to present testimony today concerning the concept of peer grouping. I do plan to leave the issues of the adequacy of Medicaid rates to the financial people; instead, I will concentrate on the results of reimbursement rates, and the adequacy of nursing care hours, which are reimbursed by Medicaid. My testimony will be brief.

Under the Medicaid program, a patient with the greatest need for care in a nursing home is entitled a skilled patient -- Medicaid Level 3. If he were any sicker, he would have to be in a general hospital for acute care. I think someone brought up the concept of DRGs this morning, which is creating the situation where sicker patients are arriving at nursing homes.

In a 24-hour period, Medicaid will pay for only two hours and forty-five minutes.

ASSEMBLYMAN OTLOWSKI: Mary, excuse me. I would never take you to a political convention. Would you speak a little louder, please?

MS. KIRSCHMAN: Certainly. I apologize. Let me just repeat one issue. Under the Medicaid program, a patient with the greatest need for care in a nursing home is entitled a skilled patient -- Medicaid Level 3. If this patient were any sicker, he would be in a general hospital, receiving acute care. The issue of DRGs has caused the sicker patients to arrive at the doors of nursing homes in recent months.

As an example--

ASSEMBLYMAN OTLOWSKI: Are you saying that nursing homes now have a bigger problem as a result of DRGs?

MS. KIRSCHMAN: Absolutely. We are receiving more patients who need more nursing care -- indeed, they are in need of medical care when they come to our facilities.

However, for this kind of patient in a 24-hour period, Medicaid would reimburse for two hours and forty-five minutes of nursing care, and that is round the clock in that 24-hour period.

On a 50-bed unit -- which is a common thing in a large county institution -- that would translate into 19-1/2 nursing staff members for that 24-hour period, or six and one-half people on a given shift. That would not take into account a staff member's illness, days off, or vacations.

ASSEMBLYMAN OTLOWSKI: Mary, what point are you trying to make?

MS. KIRSCHMAN: Well, in short, what is reimbursable for this very sick -- if you will -- skilled nursing care patient is a limited number of staff, and of that limited number, a very small number are registered nurses.

ASSEMBLYMAN OTLOWSKI: Would the peer grouping legislation provide an opportunity to increase staff?

MS. KIRSCHMAN: Well, I believe the peer grouping concept would address the issue that the large county nursing homes face. We have to take care of these patients, and indeed we do admit them and

provide the nursing care they require. Sometimes the private nursing homes do not admit them at the rate we do. Thus, we are left to provide the care and also to absorb the cost of that care. I think peer grouping would address that discrepancy and assist the county nursing homes in meeting that patient care requirement.

ASSEMBLYMAN OTLOWSKI: From where you sit, and from your experience, what do you think of this peer grouping approach?

MS. KIRSCHMAN: Personally and professionally, I think it is a godsend because it finally addresses the difficult type patient that only the county nursing homes take in such great numbers. It certainly addresses the need for the care I said we have been providing, but we have been providing that care at great expense and at great difficulty.

ASSEMBLYMAN OTLOWSKI: So, your position is strongly in favor of peer grouping?

MS. KIRSCHMAN: Yes.

ASSEMBLYMAN OTLOWSKI: Do you see the peer grouping program as interfering or jeopardizing nursing homes and their treatment of the

MS. KIRSCHMAN: No, I do not, for a few reasons. Many of the families of the patients who come to Roosevelt Hospital tell us that private nursing homes are very often unwilling to accept family members into their facility because the care is so complex; they cannot provide it, given the current reimbursement. So, those patients continue to come to us rather than to the private nursing homes.

For example, we have patients who need every single piece of skilled nursing care that is available. In other words, their care requires tracheostomies, tubes, medicines, and this includes cancer patients -- everything that could possibly be considered "skilled" often comes to our doors in the shape of one patient who needs it all.

ASSEMBLYMAN OTLOWSKI: Mary, do you think this peer grouping bill should be enacted separate from the proposition that Jim Cunningham presented? Do you see this as two separate issues?

MS. KIRSCHMAN: I would think they should be treated separately, yes, since this does address a greater problem; it is a problem that needs to be addressed rapidly.

(see appendix, page 92x for Ms. Kirschman's written statement)

ASSEMBLYMAN OTLOWSKI: While you are sitting there, is Doris Horenkamp present? (affirmative reply) Doris, do you want to come up here, please?

Doris, you heard the testimony Mary gave. From your position, what do you have to add to that?

DORIS HORENKAMP: Well, I was also asked by the New Jersey State Nurses Association to address the issue of raising the number of hours of reimbursement for the Medicaid Level 4B patient, which is the lowest level of care provided.

ASSEMBLYMAN OTLOWSKI: And, you are advocating that the level of nursing care should be increased?

MS. HORENKAMP: Definitely.

ASSEMBLYMAN OTLOWSKI: Why are you advocating that nursing care should be increased?

MS. HORENKAMP: Well, the current level of reimbursement for the 4B patient translates into 21 minutes of direct care per patient, per eight-hour shift. If you are familiar with the Medicaid guidelines for nursing care documentation, you are aware that the scope of the nursing care nurses are required to provide to the patients goes beyond physical care. We are expected to address all the needs of the patients: Psychosocial teaching, family counseling, evaluation, and all aspects of patient care, plus medication reactions. Yet, we are only allowed 21 minutes per patient in which to do that.

Raising the level of reimbursement hours would certainly not allow us to address all the needs of the patients, but it would afford us a better opportunity to address those needs.

ASSEMBLYMAN OTLOWSKI: From where you sit, with the experience you have, and from the tale of woe that you heard from the Freeholders, are you in favor of peer grouping?

MS. HORENKAMP: I am in favor of raising the level of reimbursement for all skilled patients, based on the care they require.

ASSEMBLYMAN OTLOWSKI: You don't seem to be enthusiastic.

MS. HORENKAMP: Oh, I am enthusiastic about it.

ASSEMBLYMAN OTLOWSKI: There is no question in your mind that it would be helpful?

MS. HORENKAMP: Very definitely. If we are talking about quality of care; quality requires time.

ASSEMBLYMAN OTLOWSKI: It would increase the quality of care in your opinion?

MS. HORENKAMP: Absolutely.

(see appendix, page 94x for Ms. Horenkamp's written statement)

ASSEMBLYMAN OTLOWSKI: Girls, thank you very much.

May we hear from Professor Meyer Schreiber? Professor, I was going to hold you for last so you would be able to summarize some of the things that were said; however, I want to put you on now because from here on in, I am going to push hard to try to conclude this hearing by 1:00.

PROFESSOR MEYER SCHREIBER: I am glad you did not save me until last because I believe I represent a viewpoint that has not been expressed at all. It has been very dismaying to see the omission of this viewpoint.

I have a very short statement I would like to read. My name is Meyer Schreiber. I have the pleasure to serve as President of New Jersey's Coalition for Nursing Home Reform. This organization is made up of relatives, friends, and professionals interested in the quality of life of nursing home residents. It developed about four months ago as a successor group to the New Jersey Coalition Banning Nursing Home Discrimination.

As relatives and citizens, we seek constructive and substantial participation in the development of a nursing home system which will be truly responsive to the needs of those it serves.

The nursing home system in New Jersey suffers from a major imbalance of power between the nursing home industry which provides the services, and the actual and potential consumers who are given, need, or want services. This near monopoly of power by the nursing home people, planners, and regulators results from their special knowledge, organization, and control of public information, as well as the moneys they have at their disposal to influence legislation and regulation. This manner of operating harms services by allowing providers to use their power to favor themselves and to seek large profits, thus making those who need services more dependent on them.

As representatives of citizens and consumers advocating for needed services and care, we are concerned about assessing and evaluating the services returned to the community for the government dollar. We feel we have a responsibility to speak out for those 3700 or more people who are in nursing homes who can't do so for themselves.

We plan to evaluate programs, to indicate inequities and problems, and to bring such information to the Committee's attention, as well as to the attention of the public.

We believe such consumer involvement is an excellent way for citizens and consumers to regain some control over the programs which affect nursing home residents. Thus, for example, the reimbursement system for Medicaid costs is more tailored to meet the nursing home operators' objectives than patients' need for quality care.

Medicaid reimbursement covers lots of items that the general public is not aware of, such as depreciation. The major problem here is accountability. The public does not have any information on what costs are, or what audit records are, as they are not available to the public. There is no assurance that the public dollar bears a direct relationship to the quality of care.

The State Department of Health is responsible for reviewing cost reports and setting a nursing home's rate, which then goes to the Department of Human Services. This has become a very technical process. If Medicaid accepts such recommendations, the rate becomes fixed in place for a year. The facility can appeal, and recently, in one year, 40% did so.

The Department of Health also licenses nursing homes. To become knowledgeable about the costs involved, one would have to buy manuals from the Department of Health at a cost of $106.50. These are purchased by accountants, lawyers, and facility owners. They are not accessible to the general public; thus, this practically prohibits the public's right to know.

Therefore, our group sees economics rather than humanity governing the programs of nursing homes, where there seems to be a high relationship between patient care and high profits. Knowledge of this frightens many of us who are older and who feel we might end our lives in institutions like nursing homes.

Certainly, under such circumstances, the institutionalized older person may be viewed as being in double jeopardy. Regulation is not always a panacea either, as recent responses to the Bel Air situation have shown. Indeed, this indicates the continuing nature of problems in the nursing home industry.

There are cries for new laws and regulations, but we find the regulations are not always enforced. Nursing homes indulge in all sorts of practices.

Let me share a few examples of things I have personally experienced. My mother-in-law is in a nursing home which calls itself a "model nursing home." We pay through the nose for a private-pay contract. The nursing home also asked for private-pay for the first three months while she was on Medicaid. We asked for our money back. The nursing home did not want to give it to us until we threatened a law suit. We indicated that it would be based on the claim that they could not double the bill. However, in speaking to many other people, we find that they have been double billed. No one, from the Ombudsman [illegible] horses" has ever told, educated, or helped people to understand that they have recourse and they can get their money back.

A few weeks ago, while visiting the nursing home where my mother-in-law is, there was a third person in the room. I called a social worker who said they had permission from Medicaid to put a third bed in the room. I called the Department of Health and they went to investigate; they said the home did not have permission. This "model home" has done this frequently.

Another example: While Bel Air was very much in the news, where were the regulatory agencies who should have been suing Bel Air to get back the money that Medicaid paid, through the nose, for care that was not care and for quality which was not there?

I look with a little skepticism as some of the things we heard this morning. The Record in Hackensack summed up its recent superb series on Bel Air with the headline: "Impotent Bureaucracy Fails Elderly." Their series, called "Nightmare of Neglect," said, "We cannot wait, as this series shows, for years until the Department of

Human Services, the Department of Health, and the Ombudsman get their acts together. It is sad that people who say they represent themselves as guardians of the public safety have failed. We have to hold these people as much responsible as the nursing homes themselves."

Americans have turned over responsibility for older people who are sick and poor to the State. What happens to older people is not determined by families but by bureaucracies. The nursing home industry, although privately owned for the most part, is dependent upon vast infusions of public funds. Lack of effective public pressure is, of course, the basic reason for the failure of legislation and regulation. The primary victims, the residents and patients, are unable to protest against their lot.

Many patients do not have concerned relatives, or if they do have truly concerned relatives, there is a concern that the nursing home patient is a hostage. That does not facilitate an effective lobby for needed changes.

The financial victims, the taxpayers, are no more effectively organized to combat this form of waste than the others. Older people and their senior citizens organizations who are strong lobbyists on some issues such as Social Security, have not had much of an impact on nursing home policy.

What we as a new citizens' coalition seek includes:

One, the consumer should have access to quality nursing home care without hardship or humiliation.

Two, consumers should have a voice in how the care is planned and how it is provided.

Three, any board or group set up to develop policy or advise on policy matters should include consumers, to protect and present the needs of the consumer in matters such as rate setting or oversight regulation.

Four, accountability for tax dollars received by providers of such long-term care is a major concern which we hope will be overcome through reimbursement systems which focus on the quality of care. This is a major objective of our group's activity.

Five, effective regulation enforcement of nursing home standards is needed to enhance the quality of care.

Six, cooperation between citizens, consumers, health care providers, and State officials is needed. We feel that some of this cooperation can be accomplished in the following ways:

We feel any reports by regulatory agencies of a nursing home should be available in clear, concise, English at the nursing home, and it should be available for families to review.

We feel that when a nursing home has not adhered to standards, there should be a public posting that the nursing home's license is in jeopardy, or that it is not adhering to the standards they are supposed to.

We feel that any complaints about any nursing home should be logged by the agencies involved.

We feel that Medicaid discrimination should be eliminated.

Mr. Chairman, I would like to thank you on behalf of consumers and relatives for this opportunity to present another point of view which we think is sorely needed in this total picture.

ASSEMBLYMAN OTLOWSKI: Professor, I just asked our staff people to meet with you and to go over the bills that were released yesterday because, frankly, I think the bills we released yesterday deal with some of the problem you mentioned.

When you get the opportunity -- which I hope will be in the very near future -- our staff people will have all of that ready for you so you can go over it. I am sure you will find that we will be able to answer some of these problems you talked about.

PROFESSOR SCHREIBER: Mr. Chairman, I would just like to persist and consider, for a moment, the whole question of rate setting. There is a very fine technical group of people in the State Department of Health. Some of the people involved are here. If you have $106.50 and you buy the manuals, even if you have a doctorate they are impossible to read because they are geared to the level of an accountant-economist, or someone who is very bureaucratically oriented. Merely setting a rate is no assurance of quality care.

We would like to ask the Committee to consider, while you are dealing with the issue of county nursing homes and legislation, how consumers can be included and be allowed to comment on what a decent

rate is, because we must educate ourselves. We are going to know as much as the Cunninghams and all the others about what goes into this kind of material.

The public has no chance to comment. If I feel my gas bill is not right, I can write to an agency and get some action. If I have questions regarding other matters of public policy, as a consumer my views are welcome. Insofar as nursing homes are concerned right now, the only thing I can do is to write a letter to a particular Commissioner or call their staff -- who are often very cooperative -- but there is no built-in way for the consumer to be acknowledged.

You heard the Ombudsman speak about having undercover people. Some of us have some very deep concerns. We have "over-cover" people. We have people, such as myself, who go to nursing homes two or three times a week. We can tell people about what is happening. None of the three agencies has ever asked relatives to tell them what is going on; in fact, they ignore us. We are there Sunday when staff is reduced; we are there Saturday; we are there in the evening; we are there in the morning. We relatives can tell Mr. D'Ambrosio and all the others about what goes on.

Now, unless there is some acknowledgement of this, we are going to persist and cling to the issues so we bring about some concern about quality of care. As Mr. Albanese indicated, there is no relationship between the rate and what we vaguely call quality care. Unless the Legislature is going to get interested in this, we are up against it because, Mr. Chairman, as you said, we don't know when we may need one of these facilities. For our own sakes, we must make sure that we protect those who are there presently and those who, regretably, will be going there in the future.

ASSEMBLYMAN OTLOWSKI: Thank you very much, Professor.

PROFESSOR SCHREIBER: Thank you.

ASSEMBLYMAN OTLOWSKI: May we hear from Dennis Hett, please?

DENNIS R. HETT: Thank you, Mr. Chairman. I will be brief. For the record, I am Dennis Hett, Executive Director of the New Jersey Association of Non-Profit Homes for the Aging, which represents 102 not-for-profit facilities, among which are ten of the county homes.

ASSEMBLYMAN OTLOWSKI: Excuse me, before you begin, are these non-profit organizations building new facilities? Are they building any new facilities at the present time?

MR. HETT: Yes.

ASSEMBLYMAN OTLOWSKI: There are?

MR. HETT: There are some new facilities being built. Some expansion is going on.

ASSEMBLYMAN OTLOWSKI: Off the top of your head, how many are being built?

MR. HETT: Do you mean in the non-profit sector alone, or in the sector as a whole?

ASSEMBLYMAN OTLOWSKI: Is there anyone here from the Department of Community Affairs? (no response) Do me a favor, David (speaking to staff aide) get in touch with the Department of Community Affairs tomorrow.

PROFESSOR SCHREIBER: Mr. Chairman, they have no relatives in nursing homes.

ASSEMBLYMAN OTLOWSKI: Excuse me, Professor?

PROFESSOR SCHREIBER: In terms of nursing homes, Community Affairs has no relevance to nursing homes.

ASSEMBLYMAN OTLOWSKI: This is something else. This triggered off something that I was supposed to do yesterday, and I did not do it.

David, will you get in touch with Commissioner Renna's office and tell him -- and I am sure I am speaking for the other Committee members -- that we will sponsor a method of financing. The present method of financing nursing homes does not work. Let them come up with a workable scheme and we will sponsor the legislation.

MR. HETT: If I may go along on that tangent, we would like to be able to participate in that because many of our facilities have reported having trouble with getting their bonds rated.

ASSEMBLYMAN OTLOWSKI: Great. That is very important. When we get that memorandum, and when we refer it to Legislative Services to draw up the bill, we will call upon you for your help. In that way we will get a working bill.

MR. HETT: Okay, fine. Thank you.

As I was saying, the Association represents 10 of the county homes, and we are in full support of peer grouping. We have been in support of this concept for some time. We have litigated the issue in the case of Twin Oaks versus the Commissioner of Human Services, which was decided in 1982. At that point, it was suggested that legislation be sought, so we have consistently supported this concept.

ASSEMBLYMAN OTLOWSKI: Dennis, let me ask you another question.

MR. HETT: Certainly.

ASSEMBLYMAN OTLOWSKI: I want to speed this up a little bit. What is your position on peer grouping?

MR. HETT: We support peer grouping on the basis that it helps the counties in the support of their homes. The counties, just because of the nature of county homes -- civil service, longevity, inefficiencies of layout, and not so much the age of the plant as the way the plant is laid out because there are very small units and, therefore, they are inefficient -- some other treatment. Applying the costs of voluntaries and proprietaries is not the way to do it.

ASSEMBLYMAN OTLOWSKI: So, from where you sit, you are in favor of peer grouping?

MR. HETT: Yes, we are.

ASSEMBLYMAN OTLOWSKI: Did you want to add something else to your testimony, Dennis?

MR. HETT: Yes, I just wanted to say we should not confuse the issue of heavy-care with this. There is some overlap but--

ASSEMBLYMAN OTLOWSKI: Are you saying that it should be treated separately?

MR. HETT: Yes, it should be.

ASSEMBLYMAN OTLOWSKI: I agree.

MR. HETT: Let me give you a little more fuel for that. We are seeing more and more of the rising prevalence of dementia, such as Alzheimer's Disease, as a trigger for institutionalization. That is a whole different ball game. It requires more nursing personnel -- not just nurses but aides as well.

In addition to that, the nursing home population is becoming sicker, not just because of DRGs, but because of the beefing up of the boarding home industry you are promoting through yesterday's legislation, and because of better case management as well.

We will see a heavier reliance on nursing homes in the future, and we are also going to have other alternatives.

Finally, on the issue of home and community-based services, you should seriously consider working up a "nursing home without walls" program to supplement this. Currently, most homes and community-based services are provided by organizations that do not necessarily have expertise in geriatric care; whereas, some qualified nursing homes could serve as providers in that instance.

I would direct you to the New York State Nursing Homes Without Walls Program as an example. I would recommend that program to you very highly.

ASSEMBLYMAN OTLOWSKI: I hope that you will stay with us because we are going to be developing new legislation. I hope you will be watching it closely so you can be of help to us.

MR. HETT: I certainly will.

ASSEMBLYMAN OTLOWSKI: Dennis, thank you very much.

MR. HETT: Thank you, sir.

(see appendix, page 96x for Mr. Hett's written statement)

ASSEMBLYMAN OTLOWSKI: May we hear from Victor Kattak, please?

VICTOR KATTAK: Mr. Chairman, in the interest of brevity I will keep it kind of--

ASSEMBLYMAN OTLOWSKI: Victor, in the interest of brevity and in the interest of time, I need your help. Rather than read your statement, will you just summarize it, please?

MR. KATTAK: Yes. I am also wearing two hats today. I am the Executive Director of a long-term care facility in Passaic County, and I am the Chairman of the New Jersey Nursing Home Association.

We developed this program in the early '80s with the help of Samuel Klein Associates. Mr. Honig, Mr. Walters, and Mr. Potkin set the guidelines for putting together the information and data we needed

to present to the State Department of Health. Thanks to Mr. Russo, who directed us, we put together this data in the interest of getting the information they needed to pursue peer grouping.

Basically, everyone has said just about all that has to be said.

ASSEMBLYMAN OTLOWSKI: Are you in favor of it, from where you sit?

MR. KATTAK: I am in favor of it, and I direct my statements to Mr. Fay, who saw just about everything he could see in county homes. I say as an administrator that this peer grouping is a must in order for us to keep progressing in the long-term care field. In order to maintain a steady pace with the DRGs and the change in the delivery of health care services in the State of New Jersey, we need help from the counties for us to continue to give better quality care to our patients.

ASSEMBLYMAN OTLOWSKI: Do you agree with some of the things that have been said here? For instance, it has been said by the nursing home people that peer grouping should be treated separately, and that very sick patients are a separate issue. Should that be treated separately, in your opinion?

MR. KATTAK: Absolutely. I believe it is a different concept and it should be treated as such.

ASSEMBLYMAN OTLOWSKI: Is there anything else you want to add?

MR. KATTAK: No. Many of the administrators are here today and I want to thank them for coming to add their support. I hope this becomes a reality because we have been working on it for a long time.

ASSEMBLYMAN OTLOWSKI: I am glad you mentioned that. I just want to point out something the Professor said. You know, we are all in this together. I think we have reached the point where we are all working together. If we can keep this pace up, I think we will really have something here in the State of New Jersey.

Victor, thank you very much.

MR. KATTAK: Thank you very much.

(see appendix, page 98x for Mr. Kattak's written statement)

ASSEMBLYMAN OTLOWSKI: May we hear from James Jordan? Jim, do you want to tell us who you are and what organization you represent?

JAMES W. JORDAN, JR.: Thank you, Mr. Chairman. I am James Jordan. I am the Director of the Department of Health and Rehabilitation in Essex County. I will also make my comments very brief. I would just like to--

ASSEMBLYMAN OTLOWSKI: Thank you very much.

MR. JORDAN: I understand the time constraints.

ASSEMBLYMAN OTLOWSKI: Of course, in your case there will be special allowances made because of the size of your county. But, nevertheless, thank you very much.

MR. JORDAN: I think most of the comments in support of peer grouping have been made. We strongly support this concept.

ASSEMBLYMAN OTLOWSKI: Do you think it is going to be very helpful to you?

MR. JORDAN: Definitely; it will be. The original concept, which has been negotiated over a four-year period, was to provide relief to county nursing homes and to recognize that county nursing homes have a higher operating cost.

ASSEMBLYMAN OTLOWSKI: Do you also think that the Freeholders should be the ones who determine how the money should be used -- you know, the savings?

MR. JORDAN: We feel very strongly about this point. We think the Freeholders should determine how the additional revenues should be expended. In the original negotiations, the counties agreed to forgive the State of its 50% share in additional reimbursements. We feel the State Department of Human Services should not be in the position of determining how the Federal dollars -- the new revenues coming to counties -- should be expended.

ASSEMBLYMAN OTLOWSKI: That should be left to the Freeholders?

MR. JORDAN: That should be for the Freeholders, and in my form of government, the County Executive.

ASSEMBLYMAN VISOTCKY: Without limitation? Should they have the discretion to use it for any purpose they want?

MR. JORDAN: The original concept was to provide relief to counties because they have higher operating costs when running these nursing homes. Now this concept has been expanded at the 11th hour to include providing community-based services.

Now, we recognize there is a need for additional community-based services; everyone recognizes that. However, we are trying to maintain the services we are currently providing. We think these dollars should be used for that purpose. That is what peer grouping is all about.

An additional use of Federal dollars, which should be coming to counties for community-based services, is not the intended purpose.

ASSEMBLYMAN OTLOWSKI: Jim, we were talking about one other thing. My bill is flexible in the whole area of how the money should be used. Do you want it to remain that way?

MR. JORDAN: Yes, I do. I think that would help most of the counties.

ASSEMBLYMAN OTLOWSKI: Is there anything else you want to add at this point, Jim?

MR. JORDAN: No, I would just like to support the comments of the Professor. I think he made some very important comments. In Essex County, we have a very active Relatives Association, and we include them in the budget process. We think that an active organization, such as this one, only helps to improve the quality of services given.

ASSEMBLYMAN OTLOWSKI: Just to amplify that remark, obviously the Professor is talking as someone who is greatly concerned; he is now experiencing this personally. We want to take that road. I think we took a giant step yesterday. Hopefully, we will get to some of those problems by the end of the year.

MR. JORDAN: I think that major progress was made yesterday by this Committee. We would not like to see the issue confused because peer grouping is important to counties, and it will provide some relief, although the reimbursement rate is not the major factor; quality of care is the major factor. This will certainly provide relief. It will help counties to continue to maintain these services.

ASSEMBLYMAN OTLOWSKI: Assemblyman, do you have a question?

ASSEMBLYMAN VISOTCKY: Do you know how much of a savings this would actually bring to Essex County?

MR. JORDAN: We estimate approximately -- based on last year's rates — $2 million. That is a significant amount.

ASSEMBLYMAN VISOTCKY: Thank you.

ASSEMBLYMAN OTLOWSKI: Jim, thank you very much.

MR. JORDAN: Thank you.

(see appendix, page 101x for Mr. Jordan's written statement)

ASSEMBLYMAN OTLOWSKI: May we hear from Robert B. Knapp, please?

ROBERT B. KNAPP: Thank you, Mr. Chairman and ladies and gentlemen of the Committee, I also, for the sake of brevity, will submit my statement to the members.

ASSEMBLYMAN OTLOWSKI: May we have one, please?

MR. KNAPP: Absolutely, sir.

I will attempt to glean the important issues that we in Hudson County feel ought to be put on record today.

[illegible] Robert Knapp, and I am Assistant to William J. Jones, Director of the Hudson County Department of Health and Social Services. In this capacity, I have been requested to testify here today in his behalf, and also in behalf of Edward F. Clark, Hudson County Executive.

We agree with our colleagues in the nursing home field that peer grouping and your legislation is necessary and vital. It is a vital piece of legislation which will benefit the county's citizens. However, it is important for us to add a caveat to this: We strongly object to the method the State has chosen to permit the funding of peer grouping and Medicaid payments.

It is our understanding that for a peer grouping payment to be made under the Medicaid Program, the counties would be required to pay a 50% State share of the Medicaid dollars in order to draw down the 50% in Federal dollars.

We strongly object to the State's subterfuge and effort to put the counties into the Medicaid payment business.

As you know, statistics show that Hudson County has the lowest per capita income in the State of New Jersey.

Once before, the State Department of Human Services and the ICF/MR Program misled the State Legislature by creating a program whereby the ICF Program was created under the subterfuge of bringing in Federal dollars. However, a review of that Program will clearly show that while some Federal dollars were brought into the State of New Jersey, counties were still billed additional moneys for the care of patients and there was no reduction in the cost of operations, making it appear as though no Federal moneys were received.

In effect, while some moneys were brought into the State, these moneys did not reduce the cost of operations to the counties nor to the taxpayers. Consequently, we are concerned that the suggested method of paying for the legislation through Medicaid will become another "monkey trap" and the counties will once again be put in a position of paying for Medicaid when, clearly, the enabling legislation for Medicaid demanded that Medicaid be a State/Federal program, without county participation -- and we stress "without county participation."

The announcement for this public hearing made reference to "other State legislation." In representing Mr. Clark, Director Jones, and myself, I would like to say that we feel very strongly about the proposed piece of legislation with regard to deficiencies and the withholding of Medicaid moneys which has been publicized in the local papers. We object strongly to any legislation which would withhold Medicaid moneys for a litany of deficiencies, as promulgated either by the Department of Health or Medicaid personnel.

We feel there is a complete misunderstanding regarding the use of deficiency reports and the meaning of deficiencies, or, in fact, the fairness of deficiencies.

Many deficiencies have to do with the geographic architecture of the facilities. Consequently, Hudson County's facilities, because of their nature, are subject to deficiencies and criticism. We would obviously object to the withholding of Medicaid funds until a new structure is built.

We also object to the interpretation of the 514 standards that are not subjected to uniform interpretation. If one inspector

ASSEMBLYMAN CUPROWSKI: Okay. The bill basically says, "...to correct life-threatening violations." Are you opposed to that?

MR. KNAPP: Absolutely not. What we are opposed to--

ASSEMBLYMAN CUPROWSKI: That's what the bill says; that is why I am asking.

MR. KNAPP: No, we are in favor of correcting every deficiency, from life safety to the most minor deficiency involving patient care and physical plant. However, in our opinion, the withholding of Medicaid moneys is not the answer; it is not the type of procedure which should be followed.

ASSEMBLYMAN CUPROWSKI: Even in life threatening situations?

MR. KNAPP: Depending on the situation.

ASSEMBLYMAN CUPROWSKI: Well, I am telling you what the bill says now, as of yesterday. The bill says that they will not be able to withhold the money; we used the co-signer procedure. The Commissioner of the Department of Human Services would have to co-sign where there are life-threatening situations, and they would have to be corrected. That is what the bill says.

ASSEMBLYMAN OTLOWSKI: Assemblyman, I think it would be beneficial for you to make the bill with the amendments available so that Mr. Knapp can get a complete understanding of the bill. As you pointed out, the amendments change some of the things he was complaining about in his testimony. Am I correct about that?

ASSEMBLYMAN CUPROWSKI: The intent of that bill was never, ever to withhold the Medicaid money simply because three light bulbs were out. That was never the intent of the bill, regardless of how some people might have interpreted it.

To clarify the bill, we made amendments, Mr. Chairman. It would only be done under "life-threatening conditions and violations." Then, and only then would that part of the bill be exercised by the Commissioner on a co-signing basis.

ASSEMBLYMAN OTLOWSKI: I would suggest that the bill, with the amendments, be made available to Mr. Knapp. All right?

MR. KNAPP: Thank you, sir.

ASSEMBLYMAN OTLOWSKI: Just one thing: You are in favor of peer grouping for the counties, aren't you?

MR. KNAPP: Yes, except in the area of requiring counties to produce 50% of the money in order to draw down the Federal end of it. In fact, our position is that if there is any draw-down, or any advancement, the State should provide that 50%.

ASSEMBLYMAN OTLOWSKI: I'm pretty sure that has been worked out with the counties. You will not be hurt by that. Again, one of the groups we were working with was the county officials, and I think there is an understanding regarding that issue. I suggest you talk to the Freeholders' Association because I think we have a complete understanding about that.

The anxiety that you express is no longer there. Will you talk to them about that?

MR. KNAPP: Will that be a part of the bill, sir?

ASSEMBLYMAN OTLOWSKI: Yes.

ASSEMBLYMAN CUPROWSKI: Mr. Chairman?

ASSEMBLYMAN OTLOWSKI: Yes?

ASSEMBLYMAN CUPROWSKI: Can we have staff indicate what the potential savings would be for Hudson County under this particular legislation?

ASSEMBLYMAN OTLOWSKI: Yes. David Price, will you get someone in Legislative Services to work that up so it can be made available to Assemblyman Cuprowski? In turn, he can make it available to Hudson County.

MR. PRICE: It is $7 million dollars.

ASSEMBLYMAN CUPROWSKI: Half of that is $3-1/2 million.

ASSEMBLYMAN OTLOWSKI: What is the figure for Hudson County? Will you say that again?

MEMBER OF AUDIENCE: It is $7 million Federal and State; $3-1/2 million is the State portion.

ASSEMBLYMAN OTLOWSKI: Assemblyman, are you satisfied with that?

ASSEMBLYMAN CUPROWSKI: Knowing those numbers, I just want to know what the position of the county is at this point. I assume the county will support and welcome this bill.

MR. KNAPP: Absolutely. That was in my statement. However, our reservation was the requirement for the county to advance the 50%. That was our concern.

ASSEMBLYMAN OTLOWSKI: Again, I would suggest, Assemblyman--

ASSEMBLYMAN CUPROWSKI: Mr. Knapp, I just wanted to--

ASSEMBLYMAN OTLOWSKI: Excuse me. You know, Assemblyman, the testimony made here has been worked out with the Counties' Association.

ASSEMBLYMAN CUPROWSKI: I understand that.

ASSEMBLYMAN OTLOWSKI: I think you should check with them to see if Hudson County has any differences with the Association.

MR. KNAPP: I'm sorry. The Association of--

ASSEMBLYMAN OTLOWSKI: Of Counties.

MR. KNAPP: That is the Freeholder--

ASSEMBLYMAN OTLOWSKI: Right.

MR. KNAPP: Well, they didn't make it known.

ASSEMBLYMAN OTLOWSKI: They were the group we called upon when working this whole thing up. All right?

ASSEMBLYMAN CUPROWSKI: I think the question remains whether we are talking about saving $3-1/2 million or $7 million; is that the position you are taking?

MR. KNAPP: No. Again, we are in favor of peer grouping. However, the one caveat we wanted to bring to your attention was the requirement for the counties to come up with that 50%. The Chairman has now indicated that this has been worked out.

ASSEMBLYMAN OTLOWSKI: With the counties.

MR. KNAPP: With the counties.

ASSEMBLYMAN OTLOWSKI: Yes, and they are satisfied.

MR. KNAPP: We were not aware of that.

ASSEMBLYMAN OTLOWSKI: I don't know if Hudson County has any objection to this in view of the fact that it was worked out by the counties.

ASSEMBLYMAN CUPROWSKI: I assume they would have some input into the county organization that is supposed to represent them.

MR. KNAPP: Neither the County Executive nor the Department head was informed of any type of--

ASSEMBLYMAN OTLOWSKI: I suggest you take that up with them, and if there is any difference then talk with your Assemblyman, all right?

MR. KNAPP: Thank you very much.

ASSEMBLYMAN OTLOWSKI: Thank you.

May we hear from Nathan Honig, please?

ASSEMBLYMAN CUPROWSKI: Mr. Chairman, while Mr. Honig is sitting down, would the representative from the counties like to comment on Mr. Knapp's concern regarding input from Hudson County?

MR. KATTAK: The counties have all received a letter stating--

ASSEMBLYMAN OTLOWSKI: Wait a minute. Please come up to the front so we can get your comments on the record. These girls are good, but they are not that good. Will you give us your name, please?

MR. KATTAK: Yes. I am Victor Kattak.

ASSEMBLYMAN OTLOWSKI: Assemblyman, what is your question?

ASSEMBLYMAN CUPROWSKI: Based on the comments made by Mr. Knapp about the lack of input from Hudson County into the County Association, I thought the Association would like to comment on or at least clarify that matter.

MR. KATTAK: I would like to clarify that if the gentleman has not been privy to the information. We have all received this information through the NJAC, plus a caveat or a stipulation that 50% of the funds were to be used by the county for community based programs.

We are working with the Department of Human Services to come up with programs where we would use 50% of the funds allocated according to the figures given to us by the Department of Health, for the community-based programs; that is what we are all doing now. This information has gone to the Freeholders of each county through the Association.

ASSEMBLYMAN OTLOWSKI: So, Mr. Knapp should go back to his Freeholder representative?

MR. KATTAK: I believe so. I believe everyone has that information. We are working very hard to try and get this in before July 31. Thank you.

ASSEMBLYMAN OTLOWSKI: Is that all right, Assemblyman?

ASSEMBLYMAN CUPROWSKI: Yes. Thank you.

(see appendix, page 106x for Mr. Kattak's written statement)

ASSEMBLYMAN OTLOWSKI: Mr. Honig?

NATHAN HONIG: Mr. Chairman and Assemblymen, my name is Nathan Honig. I am a partner in the firm of Samuel Klein and Company, Certified Public Accountants of Newark, New Jersey. Our firm has been engaged by several of the counties which operate nursing homes. If I go any deeper into describing our engagement, I will be accused of giving a commercial.

ASSEMBLYMAN OTLOWSKI: Excuse me. Let me ask you a question so we know what you have submitted here. First of all, you gave us statement.

MR. HONIG: That's right, sir.

ASSEMBLYMAN OTLOWSKI: Attached to your statement is the Medicaid Reimbursement Position Paper: "The Indispensable Need for a Peer Grouping for County Operated Nursing Homes in the State of New Jersey." What is that?

MR. HONIG: That was prepared for the County Nursing Home Administrators' Association, to provide them with technical assistance in connection with the peer grouping program, and the need for the peer grouping program. So, there is a lot of technical information in that document presented to the County Administrators' Association.

ASSEMBLYMAN OTLOWSKI: Thank you very much.

MR. HONIG: Most of the points I make in my short statement have already been covered by previous speakers. However, I would like to mention one thing that I closed my statement with: The case for peer grouping is documented in our report -- the one you just referred to, Mr. Chairman -- and the Governor, in his State of the State Message, recommended the adoption of peer grouping.

Of course, I urge the Committee and the Legislature to adopt the legislation that was discussed here today.

ASSEMBLYMAN OTLOWSKI: You are in favor of the legislation, and you are speaking for what group?

MR. HONIG: I am speaking as a member of a firm which is working with the County Nursing Home Administrators' Association, and also as a member of the firm that represents 14 of the 18 counties which operate nursing homes in the peer grouping effort.

ASSEMBLYMAN OTLOWSKI: So, you are speaking for a wide range of groups?

MR. HONIG: Yes, sir.

ASSEMBLYMAN OTLOWSKI: And, those groups, through you, are in favor of peer grouping?

MR. HONIG: All 14 of the 18 counties are in favor of peer grouping. I assume those we do not represent are also in favor of the concept.

ASSEMBLYMAN OTLOWSKI: You want the bill to remain as it is so the counties have the flexibility to use discretion when using that money?

MR. HONIG: In our opinion, the County Freeholders, who are closest to their constituents, should have the authority, as elected officials, to use those funds to the best of their ability and determination.

ASSEMBLYMAN OTLOWSKI: Let me ask you this: You sat here-- Thank you for your patience because with the exception of people who submitted their names this morning in order to be heard, you are the last of the people to be heard. I want to express my appreciation for your patience.

From what you heard today, do you have anything special to add for the record?

MR. HONIG: No, I do not. I think what had to be said on this topic has already been said by the previous speakers. I can only urge adoption of the legislation.

ASSEMBLYMAN OTLOWSKI: Speaking for the Committee, I want to thank you for your comprehensive approach to this matter. I am sure this will be of great importance to our staff people, and also to the ultimate design of the bill when it is implementated.

MR. HONIG: Thank you, Mr. Chairman. I have some letters here that were received on this matter.

ASSEMBLYMAN OTLOWSKI: May I have them, sir?

MR. HONIG: You many have this, and I think it would be interesting for the Committee to have this information.

ASSEMBLYMAN OTLOWSKI: Yes. Are you giving us the whole thing?

MR. HONIG: Yes.

ASSEMBLYMAN OTLOWSKI: For the purpose of the record, Mr. Honig is submitting letters which were sent to the Department of Community Services. The letters deal with this entire subject.

MR. HONIG: Yes, sir.

ASSEMBLYMAN OTLOWSKI: As a matter of fact, they are also supplemented with statistical data.

ASSEMBLYMAN OTLOWSKI: Yes, statistical data regarding the amount of distribution the counties may expect.

ASSEMBLYMAN OTLOWSKI: What is this model letter of intent for peer grouping?

MR. HONIG: It is a letter of intent that was requested by the Department of Human Services. It is to have the counties which operate housing codes commit themselves regarding some of the matters discussed in the letter. I do not know the extent to which those commitments have been made.

ASSEMBLYMAN OTLOWSKI: Thank you very much.

MR. HONIG: Thank you. I appreciate the opportunity to appear before the Committee.

ASSEMBLYMAN CUPROWSKI: Mr. Chairman, one quick question: Mr. Honig, I believe your study includes the Hudson County Hospitals -- Pollack Hospital and Meadowview Hospital -- is that correct?

MR. HONIG: Yes.

ASSEMBLYMAN CUPROWSKI: Thank you.

ASSEMBLYMAN OTLOWSKI: Does it include Roosevelt Hospital?

MR. HONIG: No, it does not. I believe that the Freeholders may be acting on a resolution to have it included.

ASSEMBLYMAN OTLOWSKI: How about Essex and Union Counties?

MR. HONIG: Yes, Essex and Union Counties as well.

ASSEMBLYMAN OTLOWSKI: Just as a gratuity, why don't you write to Freeholder-Director Capestro and tell him what you have done with the other counties?

MR. HONIG: Yes. We have been in touch with--

ASSEMBLYMAN OTLOWSKI: Because I think you have done a very thorough job.

MR. HONIG: Thank you, sir.

(see appendix, page 114x for Mr. Honig's written statement)

ASSEMBLYMAN OTLOWSKI: Thank you very much.

May we hear from Robert J. Collins, Monmouth County?

ROBERT J. COLLINS: In the interest of time, Mr. Chairman--

ASSEMBLYMAN OTLOWSKI: I notice you are doing that now by talking while you are walking. (laughter)

MR. COLLINS: I didn't know if I would be able to attend today, so I sent you a letter. It should be in your office right now.

ASSEMBLYMAN OTLOWSKI: Robert, will you give us your name and tell us who you are representing?

MR. COLLINS: I am Robert J. Collins. I am the County Administrator of Monmouth County. We are one of the 18 eligible counties; however, we did not retain Samuel Klein. I just met with them, and we support what they have done.

I was asked specifically to come before your Committee to let the other counties know that although we have not been as active as some, we do support peer grouping.

ASSEMBLYMAN OTLOWSKI: You are speaking for Monmouth County, and Monmouth County supports it?

MR. COLLINS: Yes, we do. We would prefer flexibility; it should be the Freeholders' decision on how the funds would be--

ASSEMBLYMAN OTLOWSKI: I am sure the bill is going to stand that way. That is the general consensus. I do not think that there will be any change in that.

Thank you very much, Robert.

MR. COLLINS: Thank you.

ASSEMBLYMAN OTLOWSKI: May we now hear from Ann Miner? Ann, thank you for all your help this morning.

Senator Fay just reminded me that I have to be somewhere else at 1:00. If I do not get the chance to wrap this hearing up -- and I hope I do -- I am going to ask Assemblyman Cuprowski to wrap it up.

Ann, will you give us your name and tell us who you represent, please?

ANN MINER: I am Ann Miner. I am the Director of Human Services for Mercer County. I am speaking on behalf of County Executive, Bill Mathesius. You have our letter. We support peer grouping. We sent a letter to the State, stating that we support peer grouping.

The County Executive is concerned. He feels that elected officials -- the County Executives and the Boards of Freeholders -- should be allowed to have the flexibility not only to expand but also to shore up. One of the issues we have raised on several occasions is, we have nursing homes, home-health programs, and a variety of other community-based programs in our county that need shoring up. Rather than simply expand, we need the flexibility and the ability to keep our base solid, without building on top of it.

That is basically what the County Executive's letter says. In Mercer County, we do not feel that we are mandated to any particular amount. From what I understand, and from what has been said today, [illegible] would not mandate a specific amount. We agree. We do not need a mandate, either from the Legislature or from the Department of Human Services.

We have worked very closely with the Department throughout this process. One of our Freeholder-Directors spoke with you earlier this morning. He has been heavily involved with the NJAC position, and we are supportive of having maximum flexibility.

If you have any questions, I will be glad to answer them.

ASSEMBLYMAN OTLOWSKI: Ann, thank you for all your help this morning. I really appreciate it. If we need anything, I am sure we can call on you.

MS. MINER: Dave always knows how to reach me.

ASSEMBLYMAN OTLOWSKI: Thank you very much.

MS. MINER: You are welcome.

(see appendix, page 159x for County Executive Bill Mathesius' letter)

ASSEMBLYMAN OTLOWSKI: May we hear from Patricia Devaney? Patricia, do you want to give us your name and tell us who you represent? You have come a long way -- from Cape May.

PATRICIA A. DAVANEY: Yes. I am Pat Davaney, and I am the Human Services Administrator for Cape May County. I did travel two and one-half hours to make this meeting; and, yes, it was hard to leave.

In light of the distance I had to travel, I would like to read the statement my Freeholder-Director, Gerald Thornton, who also oversees the Department of Human Services, would like me to read to you today.

ASSEMBLYMAN OTLOWSKI: How many pages is it?

MS. MINER: Two.

ASSEMBLYMAN OTLOWSKI: Please be brief.

MS. MINER: It will be the briefest thing you have ever heard.

ASSEMBLYMAN OTLOWSKI: Okay, read it. Anyone who comes from Cape May has a right to read "Gone With the Wind." (laughter)

MS. MINER: First and foremost, we are in support of peer grouping. We think it is a recognition of the cost assumed by county facilities in providing nursing home care to a population not served by the private sector.

Although we do recognize the right of county government to control its resources, we also recognize the county's responsibility to provide a community care system that is rational and responsive to the long-term care needs of its residents. So, we appreciate the fact that there will be moneys directed into Human Services, or community-based services, and, as I understand from the legislation, there will be no specific amount established for that purpose.

In addition, we think one of the benefits of the compromise worked out between NJAC and the Department of Human Services regarding the philosophical and the practical aspects of peer grouping is the introduction of and dependence upon the Human Services Advisory Councils, which can bring a community perspective into the advocacy and service development portion of this plan.

Accordingly, we would like to see the negotiation aspect of this continued. This would serve to prevent legislation from addressing or requiring that specific criteria be placed on the counties. It would allow us to use maximum participation and

flexibility in whatever decisions the counties make, in terms of where services should be developed.

ASSEMBLYMAN OTLOWSKI: Let me ask you this: Your Board of Freeholders favors peer grouping?

MS. MINER: Absolutely.

ASSEMBLYMAN OTLOWSKI: They favor the discretionary aspects that are in this bill?

MS. MINER: Yes, they do.

ASSEMBLYMAN OTLOWSKI: They want the Freeholders to have the ultimate authority in how the savings can be used?

MS. MINER: Yes.

ASSEMBLYMAN OTLOWSKI: Is there anything else you want to add?

MS. MINER: No, there isn't; not at this time

ASSEMBLYMAN OTLOWSKI: I want to thank you very much for coming here, Patricia, and for the distance you traveled and the patience you have exhibited by staying with us throughout this hearing.

A senatorial courtesy [illegible] have wound this hearing up today. I am very pleased with the hearing. I think we received a lot of benefit from it. As a matter of fact, when the record is analyzed by our staff people, I think we are going to learn a lot.

I am particularly pleased by the fact that there was a great sense of harmony thoughout this hearing. I can't believe the luck we are having with some of these hearings in the past few days.

I would like to thank everyone who has done his or her homework, and for being so helpful to us. You will be kept posted as this issue develops. Thank you very, very much. The hearing is now concluded.

HEARING CONCLUDED

APPENDIX

APPENDIX "A"

APPENDIX ~A2

Annapolis Legislative Report

10400 Connecticut Avenue, Suite 300
Kensington, Maryland 20895
(301) 933-9660 Baltimore line: 792-4837
L. Malcolm Rodman, C.A.E.
– Executive Director

from the **Health Facilities Association of Maryland**

April, 1985 FINAL REPORT: 1985 Session:

HFAM, IN BEHALF OF ITS NURSING HOME MEMBERSHIP, LOGS A NEAR-PERFECT SESSION: BUDGET FUNDS MEDICAID REIMBURSEMENT SYSTEM...COST CONTAINMENT MEASURES DO NOT PENALIZE NURSING HOMES... PUNITIVE BILLS, INCLUDING CASH FINE MEASURE, ALL DEFEATED.

MEDICAID BUDGET, FY 86: HFAM found continued Legislative support for the State's Medicaid nursing home payment formula...as the budget committees of the Legislature accepted without cuts the Governor's budget to fund the program through the fiscal year which begins next July 1st. HFAM's analysis of the program, contained in a widely-circulated White Paper, showed occupancy statewide averaging 96.9%, with Medicaid patients gaining access to nursing home care. Our data showed hospital lengths of stay for heavy care patients continue to drop, as nursing homes are encouraged to admit these patients. And, contrary to some claims, we proved that nursing homes ~~are increasing their staffs to~~ adequately serve heavy special patients.

END OF PRIVILEGED STATUS FOR 6 HOSPITAL-BASED NURSING HOMES: As expected, the Legislature declined to extend the special reimbursement status for these homes, and voted instead to phase them into the nursing home reimbursement system over a five-year period. This action marked an acknowledgement that these facilities had costs approximately 75% higher than free-standing facilities, despite their delivery of about the same level of care. In related action, the Legislature rejected a move by the Hebrew Home of Montgomery County for special reimbursement based upon the fact that it maintains a fulltime in-house medical staff.

GOVERNOR'S PACKAGE OF HEALTH COST CONTAINMENT MEASURES: As you know from our Newsletters, HFAM has been tracking this project since last August, and testified before the Governor's Commission last October, showing that it was poor economics and contrary to patients' interests to convert empty hospital facilities to nursing home care. As a result, the report of the Commission and the legislation to implement these recommendations omitted such recommendations. Instead, hospitals are encouraged to merge, consolidate or close unused facilities, or convert them to non-health uses.

Having won that argument, even before the Legislative session began, HFAM next turned to the unfavorable impact a proposed moratorium on new CON awards would have on our field. We found most legislators sympathetic to our pleas for more nursing home beds, based upon their experiences with constituents who cannot find a nursing home with vacancies to permit admissions. As a result, the temporary moratorium on CON awards, from now thru October 1st, 1985, exempts nursing homes. Further, the Legislature rejected the Governor's proposal for authority to impose moratoriums in the future, in cases of excess capacity.

The State's health planning agency, and its cumbersome and restrive Certificate-of-Need process, have come in for bitter Legislative criticism. The abrupt firing of its Executive Director early in the Session, and its inability to convince legislators of its validity, have compounded its problems. The Senate Finance Committee has scheduled a major review of the entire health planning law during

(Continued)

Annapolis Legislative Report

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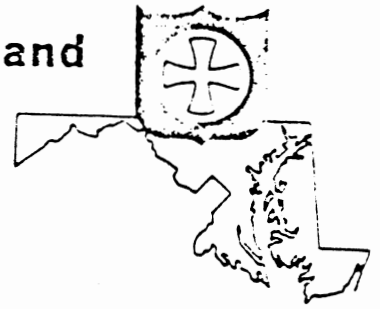
from the **Health Facilities Association of Maryland**



Background Report: December, 1984.

PREFERENTIAL REIMBURSEMENT FOR 6 HOSPITAL-BASED NURSING HOMES: SHOULD THIS AUTHORITY BE EXTENDED BY THE 1985 LEGISLATURE?

NO...is emphatic conclusion of state-commissioned Consultant, who recommends they be included in our Nursing Home Medicaid Reimbursement system with only "very slight modifications"...plus a 4-year phase-in to ease the financial shock.

The Maryland General Assembly, at its 1985 Session, must consider the issue of special Medicaid reimbursement for 6 hospital-based nursing homes. New legislation will be required to retain the system of paying these facilities the rates set by the Health Services Cost Review Commission.

Under mandate from the Legislature, the Dept. of Health & Mental Hygiene awarded a contract to the prestigeous Cambridge, Mass. consulting firm, Abt Associates, Inc. to compare hospital-based (HB) and free-standing (FS) comprehensive care facilities in Maryland, to enable the Department to advise the Legislature. The report of the consultant was made public on November 28, 1984.

Abt Associates, Inc. recommended that hospital-based facilities be included in a very slightly modified version of the free-standing system, even though this "will cause a drastic rate decrease for these facilities".

The consultant reviewed the patient mix of each of the HB facilities, and compared the data with a similar sample of 20 FS facilities. It also reviewed their cost reports and appraised their buildings. The state's patient classification instrument was modified to collect additional information on patient condition. The consultant found "enormous differences in costs" between HB and FS facilities -- with HB facilities experiencing costs about 75% higher than FS facilities.

Basis for the consultant's recommendation: "The basis of our recommendation is that the enormous differences in costs between HB and FS facilities are only slightly based on patient differences, and those differences are in fact addressed through the current FS system. Differences in costs between HB and FS facilities are primarily differences in philosophy, mission, and amenity level."

Abt Associates continued: "Maintaining a separate system for HB facilities is to maintain a separate system for them primarily because they are more expensive." It said "in the long run this is inequitable to facilities providing similar services and to patients who have similar conditions but did not have the good fortune to be in these more expensive facilities with a higher amenity level."

Turning to the question of a patient mix of heavier-care patients as justification for receiving higher rates, the consultant said: "With regard to patient mix, we found that, overall, the patient mix of these (HB) facilities was not materially different from that found in FS facilities. It noted that the existing FS reimbursement formula, based on an estimate of the amount of nursing time required by individual patients, would have taken care of the requirements of 4 of the 6 HB facilities reasonably accurately, with slight modifications.

The consultant noted that nursing hours for two of the HB facilities remained considerably higher than predicted by patient condition. The consultant found HB facilities to have wages rates generally higher than FS facilities, much higher employee benefit expenditures and higher supply costs. Additionally, it found HB costs increased by greater use than FS facilities of overtime, shift differentials and other salary costs not considered in the state's payment formula.

Regarding routine costs, HB facilities are more expensive in every respect, the consultant found. Further, the vast bulk of costs is related to non-patient conditions, such as higher housekeeping costs, higher benefit costs and higher plant operation. It found that HB facilities have 48% more square feet per bed than FS facilities. When compared on a equal, square foot basis, it costs 18% more to heat HB facilities than FS ones.

Administrative costs are more than 60% higher than FS facilities. Although there is no overall difference in salary for administrators, other office salaries are 136 % higher than in FS facilities. Property costs are more than 100% greater.

Thus, the state-financed study reveals that "enormously more expensive" costs of hospital-based nursing homes are "only partially related to patient differences and those differences are predicted by the existing FS (reimbursement) system."

The consultant therefore felt "compelled to recommend" including hospital-based facilities be included in the current free-standing facility reimbursement system, with only slight modifications. Were this in effect this fiscal year, the report noted, the state would save about $4-million. However, were it in effect, the hospital-based facilities would experience decreased rates by an average of more 25%, with even larger decreases in some facilities.

Because of the severity of these potential rate decreases to the 6 affected facilities, the state's consultant has recommended a four-year phase-in of major changes. Had such a phase-in process started this year, the consultant said, it would have reduced rates in hospital-based facilities an average of 7%, with resultant savings to the state Medicaid budget of about $1.2-million.

What Happens Now?

Since the Abt Associates, Inc. report has just been delivered to the Dept. of Health & Mental Hygiene...it is still under study by that agency, prior to being forwarded to the Legislature. In view of the emphatic nature of Abt Associates, Inc.'s conclusions, we believe the Department will have no option but to endorse it.

Likewise, leaders in the Legislature who have championed special treatment for the six hospital-based nursing homes will be hard pressed to defend an extension of their preferential treatment, in the face of the Abt Associates' study. High-cost free-standing nursing facilities, which in past sessions have clamored for special rates, will have new justification to renew their claims.

However the issue resolves itself for the hospital-based facilities, the Abt Associates' study gives HFAM, and the free-standing facilities we represent, new proof that our payment system is working...we are providing quality care under that system...and that creating more hospital-based nursing homes is contrary to the public interest.

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Maryland Medical Assistance Nursing Home Reimbursement Study

A COMPARISON OF HOSPITAL-BASED AND FREE-STANDING COMPREHENSIVE CARE FACILITIES

November 28, 1984

Prepared under Contract with the Maryland Department of Health and Mental Hygiene, Medical Assistance Policy Administration

Authors: Abt Associates Inc.:

Michael Koetting, Ph.D.
Margot A. Cella, M.S.
Douglas Staiger, M.A.

Bishop and Co.:

David Bishop, CPA

EXECUTIVE SUMMARY

Medical Assistance reimbursement for Maryland's six hospital-based nursing homes is on a different basis than reimbursement for other Maryland nursing homes. This report has been undertaken because the Secretary of Health and Mental Hygiene has been mandated by the General Assembly to recommend on or bfore February 1, 1985 whether these facilities should remain in that separate system, should be included in the FS system, or should be included in a modified version of the FS system. These six hospital-based (HB) nursing homes experience costs approximately 75 per cent greater than those experienced by free-standing (FS) facilities. (Exhibit 1.1)

In compiling this report, we reviewed the patient mix of each of HB facility (and a similar sample of twenty FS facilities), we reviewed their cost reports and we appraised their buildings. Because of the importance of the patient appraisal to this study, the existing instrument for measuring patient differences in Maryland nursing homes was modified to collect additional information on patient condition. These modifications were made at the suggestion of and after consultation with HB facilities.

After data collection, cost comparisons were made between FS and HB facilities in each major cost areas. Our recommendation is that HB facilities be included in a very slightly modified version of the FS system, even though this will cause a drastic rate decrease for these facilities. The basis of our recommendation is that the enormous differences in costs between HB and FS facilities are only slightly based on patient differences, and those differences are in fact addressed through the current FS system. Differences in costs between HB and FS facilities are primarily differences in philosophy, mission, and amenity level.

With regard to patient mix, we found that, overall, the patient mix of these facilities was not materially different from that found in FS facilities. (Exhibit 2.3) Three of the six HB facilities did indeed have a more severe patient population than most FS facilities, but the existing FS formula--which is based on estimating the amount of nursing time required by individual patients--was able to estimate, and include in reimbursement, the additional time required by patients in these facilities. In fact, with slight modifications, the existing formula estimated time required in four of the six facilities reasonably accurately. (Exhibit 2.9) Nursing hours for the other two facilities remained considerably higher than predicted by patient condition.

The more significant factors in predicting nursing costs were wage rates generally higher than FS facilities (Exhibit 2.13), much higher employee benefit expenditures (Exhibit 2.17), and higher supply costs (Exhibit 2.19). Additionally, HB costs are increased by greater use than FS facilities of overtime, shift differentials, and other salary costs which are not considered in the state's reimbursement formula.

With regard to routine costs, HB facilities are more expensive in every aspect. (Exhibit 4.1) It is possible that a small amount of this is related to patient condition, but the vast bulk is related to non-patient conditions, such as higher housekeeping costs, higher benefit costs, and higher plant operation. Higher maintenance and operation, particularly

utility costs, is directly related to the larger building size: HB facilities have 48 percent more square feet per bed than FS facilities. Even so, the cost of heating in these facilities is 18 per cent greater per square foot. (Exhibit 4.4)

Administrative costs are more than 60 per cent higher than FS facilities. Although there is no overall difference in salary for the administrator, other office salaries are 136 per cent higher than FS facilities. (Exhibit 4.5). Property costs are also more than 100 per cent higher for HB facilities than for FS facilities. (Exhibit 5.1)

From our review of patients and costs, we conclude that while HB are enormously more expensive, those costs are only partially related to patient diferences and those differences are predicted by the existing FS system. If, in fact, HB facilities were included under the current reimbursement, they would have reimbursements which range from six to thirty-one percent higher than the average FS facility, and the differences are clearly related to differences in patient case mix. We believe that the existing FS system generally compensates for case mix differences, per se.

We therefore feel compelled to recommend that HB facilities be included in the current FS standing--with the slight modifications which we have proposed. Maintaining a separate system for HB facilities is to maintain a separate system for them primarily because they are more expensive. In the long run this is inequitable to facilities providing similar services and to patients who have similar conditions but did not have the good fortune to be in these more expensive facilities with a higher ammenity levl.

Placing the HB facilities under the FS system, however, is a very difficult recommendation since the resulting rates would be dramatically less than rates currently being received by HB facilities. If our recommendation were in place for the current fiscal year, it would decrease rates by an average of more than 25 per cent, with even larger decreases for some facilities. (Exhibit 6.1). These decreases would, however, have reduced state expenditures by about $4 million had they been in place during the current year. (Exhibit 6.2) Because of the severity of these decreases, we believe it will be necessary to phase-in gradually any major changes. We have shown the impact on facilities and on state spending of phasing-in HB facilities over four years. Had such a phase-in process started this year, it would have reduced facility rates an average of seven percent, but resulted in state savings of about $1.2 million. (Exhibit 6.7)

COMPARISON OF OPERATINAG COST
AVERAGE FREE STANDING NURSING HOME VERSUS
LOWEST COST HOSPITAL BASED
Source - ABT Study

Cost Center	Free Standing Mean Cost	Lowest Cost Hospital	Difference	Hospital	Schedule
Nursing Costs:					
Supplies	.53	1.08	(.55)	Keswick	2.4
Other	.23	.01	.22	PG	2.4
Nursing Hours	2.56	2.67	(.11)	Mason Lord	2.5
Pt. Predicted Hours	2.46	2.35	.11	Levindale	2.9
Average		2.69	(.23)		
Average Hourly Wage					
DON	10.44	13.25	(2.81)	Deaton	2.22
RN	8.41	8.15[1]	.26	Deaton	2.22
LPN	7.23	6.89[1]	.34	Easton	2.22
Aide	4.32	4.76[1]	(.34)	Keswick	2.22
Employee Benefit Ratio	21.8%[2]	32.4%	(10.6%)	Easton	2.31
Nursing Supplies	.66	1.18	(.52)	Keswick	2.35
Pharmacy	.29	.06	.23	Deaton	3.20
Raw Food	2.79	3.03	(.24)	Levindale	3.20
Social Services	.19	.24[3]	.05	Deaton	3.20
Various (recreation etc)	1.14	1.21	.07	PG	3.20
Dietary	3.30	3.97	(.67)	Keswick	4.20
Laundry	.98	.88	.10	Levindale	4.20
Housekeeping	2.05	1.68	.37	Easton	4.20
Operations	2.99	3.91	(.92)	Easton	4.20
Benefits	.98	.83	.15	Mason Lord	4.20
Housekeeping @ Cost	1.98	1.08	.90	Mason Lord	4.80
Housekeeping @ Cost	1.73	1.85	(.15)	Mason Lord	4.90
Adm. Salaries	1.01	1.10[4]	(.09)	Mason Lord	4.11
Office & Other Salaries	1.16	1.38	(.22)	Mason Lord	4.11
Benefits	.43	.58	(.15)	Mason Lord	4.11
Other	2.33	1.25	1.08	Mason Lord	4.11
Interest	.46	1.02[4]	(.56)	Mason Lord	5.20
Insurance	.05	.03	.02	Mason Lord	5.20
Depreciation RE	2.19	2.94[4]	(.75)	Mason Lord	5.20

[1]Below 75th percentile reimbursement level

[2]Statistic too low

[3]Might be high

[4]Median used

Consultant finds Pines in disarray

By Michele Fuetsch
Staff Writer

Bergen Pines County Hospital is dirty, mismanaged, overstaffed with nurses, and wastes millions of dollars, says a report produced by the private management firm that county officials have picked to operate the public facility.

The grim profile of the hospital emerges from a 140-page study done by National Medical Enterprises Inc. (NME), a California-based health-care conglomerate that is promising, for a fee of about $1 million a year, to turn over a new leaf at Bergen Pines.

In February, as part of its effort to win the management contract, NME sent 18 persons to spend three days appraising day-to-day operations at the Paramus medical center. The study team — which included dietary, nursing, finance, architectural, and information-systems experts — poked into closets and pored over records, evaluating hospital services and management.

Among the findings:

- There has been virtually no preventive maintenance by the hospital's 98-member maintenance department.
- The housekeeping department is not only top-heavy with supervisors, it does a poor job. Almost all the public areas and many of the patient areas throughout the hospital were "frankly dirty."
- The hospital's operating deficit, which is covered by funds from county taxpayers, rose from $3 million in 1977 to a projected $24 million in 1985. Millions of dollars can be saved with such basic measures as keeping track of portions of food intended for patients and using computers for billing, which is still being done manually, sometimes with as many as six bills typed for one patient.
- Millions more can be saved by applying management systems that capture revenues the hospital is currently losing. Nurses and doctors, for instance, are making code errors in diagnostic information that goes on patient charts. The errors cost money because diagnosis determines how much private insurance companies and government programs pay the hospital.
- All the files on doctors lacked evaluations of their performance during their provisional period. Many files lacked documentation regarding reappointment and licenses.

What may be the most controversial finding put forth in the NME study is that the hospital's nursing staff is too expensive because of overstaffing. The information came as a surprise to county officials who have agreed in recent years to increase the nursing ranks as a way of improving the hospital.

In the hospital's general-medicine unit, says the report, "nursing hours per patient day in 1983 were 6.3, compared to the industry norm of 3.5 to 4.8 for hospitals of similar size and complexity." In the long-term care unit, says NME, nursing staff hours per patient day are 3.5, even though the state code calls for a range between 1.25 and 2.75, depending on the level of care required by the nursing-home patients.

Besides pointing out problem areas, the NME report makes a series of recommendations, the most dramatic of which is to close the hospital's 209-bed general-medical unit, which offers acute medical care and surgery.

The unit has a deficit of about $5 million this year and an occupancy rate of 54 percent, much lower than the 73-percent rate quoted recently by hospital officials, or the 90-percent rate considered efficient by hospital planners. In addition, some two thirds of the patients in the unit belong in nursing homes, not in an expensive hospital setting, the report said.

In the current competitive and regulatory climate, the unit can never reach optimal efficiency and quality of care, says NME's report, which recommends the unit be phased out and talks begun with area hospitals to develop contracts to provide acute care for the patients who would have been treated at Bergen Pines.

With the closing of the acute-care unit, the report says, the hospital ought to cut back its teaching function, reducing a staff of 55 interns and residents in various specialities to 12 residents in psychiatry.

The NME report portrays the present management at the hospital, both overall and in specific departments, as a piecemeal, bureaucratic labyrinth in which follow-up and accountability disappear and hospital needs go unmet.

The maintenance department, for example, is generally regarded throughout the hospital as being "incapable of providing basic services," the report says.

As a result of the maintenance department's ineptitude, NME points out, the hospital has not yet flagged as a significant problem the asbestos in ceiling materials and in much of the insulation in pipe tunnels.

The report cited the billing department and the credit and collection department as an example of piecemeal management. The billing department makes up patient bills and also is responsible for collecting payments from those patients who have insurance, the report said. The credit and collection department, meanwhile, is responsible for collecting money from patients who are considered self-paying.

NME findings also indicate that sometimes the hospital's left hand doesn't know what its right hand is doing.

For example, more and more attention is being focused publicly and privately on the possibility of closing the hospital's half-empty acute-care unit. Yet the hospital is about to purchase a $1.3-million computer system that, NME says, is "heavily oriented toward an acute-care hospital environment and is, as such, exceedingly expensive."

In some cases, NME found management tripping over itself. The housekeeping department, the report says, has "an associate director under the daily control of a director operating through an assistant director, who directs three building supervisors, who oversee the work of nine assistant building supervisors, who are directing 25 senior team leaders, each of whom supervises two or three housekeepers."

At top administrative levels of the hospital, the NME report says, no management systems are in place, meaning there's little accountability.

"A management plan, with priority objectives, tasks, staff responsibility, intermediate products, target dates, and evaluation process was not in evidence."

Some documents showing the status of a project or an assignment could be found, said the report, but evidence of follow-up and completion of assignments was not there.

The NME report noted another management problem at the top. It said that "a review of minutes of the board of managers [meetings] reveals an unusual degree of involvement by the board in the day-to-day operations of the hospital. Authority to administer and manage the hospital is not fully delegated to the executive director."

At least one area of the hospital — its medical department — appears to have been left to operate independently, or at least without much integration into overall hospital operations, the NME report indicates. NME counted 265 medical staff members, divided into various disciplines from 26 in podiatry to 21 active staff members and 17 "courtesy" staff members for psychiatry.

"In reviewing the specific membership in the medical staff with the medical staff secretary, it was apparent that many of the staff members have never really been active either as a source of patients or as contributors to the medical education programs," says the report.

Although the report dwells on management problems, it does not cite any instances in which patients directly suffered because of them. The impact on patients is indirect instead. For example, the report says the laundry department is only just beginning to get the right amount of linen to each patient; some wards lack good bathing facilities, a deficiency that can lead to skin problems; and patient-care evaluations are deficient in such areas as surgical review, antibiotic use, and infection control.

NME does recommend two major innovations in patient care: Within long-term care, it says that special units should be established for 80 to 100 multiple sclerosis patients and for victims of Alzheimer's disease.

9X

Firm to present operating plan for Homestead

3870

By MARGARET McGARRITY
Staff Writer

FRANKFORD — The Sussex County Welfare Board is not "pushing" privatization of the county's Homestead nursing home but will invite interested firms to propose taking over the management or full operation of the 98-bed Medicaid facility.

Although officials at several local hospitals and nursing homes say they were unaware such proposals would be sought, Freeholder Director Edmund Zukowski reported that at least two other companies have shown an interest.

Townco Management Associates of Lakewood, which submitted a partial efficiency study on The Homestead to the Welfare Board on Wednesday, will make a proposal.

AND ZUKOWSKI said he had "been contacted at a social function" by the owner of the Andover Nursing Center about possibly building a wing there to take The Homestead's patients.

The Andover facility's owner, Jerry Turco, could not be reached for comment.

Whether The Homestead is run efficiently and whether the county-funded share of its operating costs, now about $800,000 annually, is excessive are perennial questions at Welfare Board meetings.

Zukowski said that 1986 cuts in federal revenue sharing, which may cost the county about $1 million, make the questions even more pressing. "Revenue sharing is down the drain," he said, "and we have to start looking as to where we can conserve and cut back. I think the operation of The Homestead has got a lot of deficiencies."

The Townco study is one of several recent attempts to find answers to those questions, and the idea of turning over the home to private management is not a new one.

Officials at Newton Memorial Hospital, which was mentioned last year as a possible private operator or purchaser of the home, as well as at Wallkill Valley Hospital and the Barnhill Nursing Home in Newton said they will have to give the idea more thought.

Zukowski and Welfare Board Vice Chairman William Nestor both said privatization is still only an option and whether the county would still have to fund a share of Homestead costs would depend on what specific proposals are received.

Nestor said, "No one is pushing this. It's just an obligation the board feels it has. It's just one more alternative." He said it is "not the intent to close the home. What we're looking at is, is it more appropriate to get the county out of the health care business."

WELFARE BOARD member Nicholas Masi, the GOP candidate in the November freeholder race, said the board is just "looking to streamline our operation dollarwise ... If the options don't show us any great difference, I would as soon stay as we are."

According to Townco Administrative Consultant Steven A. Goldberg, Townco runs about 10 other nursing homes and is "expert" in long-term care. "I don't imagine the people who control The Homestead are experts to the extent we are," he said.

Townco plans to submit various alternatives to the Welfare Board, he said, including a "management contract where we would rent (The Homestead) and they would pay us a fixed fee" or a fee based on what savings the company can generate.

Although Townco has done only a brief study centering largely on nursing costs, Goldberg said he is "confident we can save them between $300,000 and $500,000 ... without harming patient care."

The Townco report submitted Wednesday applauds The Homestead for providing "excellent" nursing care and an "outstanding" quality of life for its patients.

But the report contends nursing hours could be cut from the current 3.9 hours per patient to 2.85 hours, creating a savings county auditors have estimated at $111,263.

ALSO ACCORDING to the study, which Masi said was based on a "one-day very superficial analysis," the number of nurses varies markedly on each shift; there appears to be overstaffing in the office, in housekeeping, and in nursing administration, and nursing wages are inconsistent or inadequate.

Goldberg said those wages are "very cockeyed — aides are making too much, LPN's (licensed practical nurses) are in the middle and RN's (registered nurses) are getting too little."

He said there are also two beds kept unnecessarily empty to provide emergency isolation, which figures show could represent an about $37,000 annual loss of revenue.

The Townco report also disagrees with the argument made by Homestead administrators that the home's costs are higher than private nursing home's costs because county Medicaid facilities tend to get patients needing more care.

Goldberg said Townco will submit its proposals within a month, but that in all instances it would reserve admissions decisions to the county, including whether to have the facility remain only for in-county Medicaid patients.

1C X

Firms show interest in running facility

By P.L. WYCKOFF
Advance Staff Writer

Two area firms have expressed an interest in taking over the job done by the Sussex County nursing home, Freeholder Director Edmund Zukowski said Wednesday.

Newton Memorial Hospital has indicated it might want to run the 98-bed Homestead, while the Andover Nursing Center has said it would be willing to build a 120-bed addition to its facility, and take all of the Homestead's patients, Zukowski said.

Zukowski made the statement at Wednesday's county Welfare Board meeting. Officials at the two institutions could not be reached for comment, but Zukowski and other board members said they are interested in exploring any avenues which might reduce the yearly $800,000 cost to the county of running the home.

Officials of a Lakewood management consulting firm also expressed an interest at the meeting in running the Homestead for the county.

Stephen Goldberg of Townco Management Associates said his firm would lease the facility from the county for one dollar a year, and would charge a fee which would be low enough to allow the county to cut its present costs.

The leaseback arrangement would allow Townco to run the home as a private business not covered by the Homestead workers' present civil service contract, he said.

Zukowski said the county is interested in exploring any way of economizing at the facility. The county expects to lose about $1 million in federal revenue sharing funds next year, which now help pay for the county's subsidy.

Board members asked Townco to submit a formal proposal for a study of the home's management, and also to seek management study proposals from other consulting firms.

Goldberg also used the meeting to explain the conclusions of a "cursory" one-day study of the Homestead which Townco conducted in February.

The nursing home is overstaffed, which helps keep the county subsidy of the facility high, he said. The home also keeps two of its 98 beds empty at all times, resulting in a yearly revenue loss of about $30,000, he said.

Goldberg and an assistant, Nancy Lessard, told members of the board that the quality of care at the home is "outstanding," but that inconsistent staffing of nurses and aides results in more workers than necessary during the week and fewer on weekends.

Lessard said the staff could be trimmed without lowering the quality of care. She said that the Homestead has a four-member office staff, one more than is usual for nursing homes with 120 beds.

"There is an inordinate amount of employees of all types," she said. "A bit of economizing could be done" which would help lower the $800,000 yearly county subsidy of the home.

Board members Nicholas Masi and Joseph Zidek expressed concern that no cuts be made unless it is certain the quality of care will not be jeopardized.

Zukowski and the other board members stressed that no changes in management or procedure would be made for quite some time, and that all suggestions so far are "preliminary."

APPENDIX "B"

APPENDIX

DRAFT

REPORT ON STUDY CONCERNING THE FEASIBILITY OF CONSOLIDATING THE TWO EXISTING LEVELS OF INTERMEDIATE CARE UNDER THE MEDICAID PROGRAM

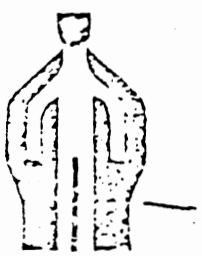
TO

THE HONORABLE LAURENCE S. WEISS, CHAIRMAN
JOINT APPROPRIATIONS COMMITTEE

FROM

GEORGE J. ALBANESE, COMMISSIONER
DEPARTMENT OF HUMAN SERVICES

MARCH, 1983



State of New Jersey
DEPARTMENT OF HUMAN SERVICES
CAPITAL PLACE ONE
222 SOUTH WARREN STREET
TRENTON, NEW JERSEY 08625

GEORGE J. ALBANESE
Commissioner

DRAFT

The Honorable Laurence S. Weiss, Chairman
Joint Appropriations Committee
State House
Trenton, New Jersey 08625

Dear Mr. Weiss:

I am pleased to present this report, which has been prepared by the Division of Medical Assistance and Health Services, Department of Human Services, in keeping with Resolution #3, P.L. 1982, C. 49, the State Appropriations Act for FY 1983. As you will recall, Resolution #3 stated:

> "The Division of Medical Assistance and Health Services shall by January 1, 1983 prepare and submit a report to the Joint Appropriations Committee concerning the feasibility of consolidating the two existing levels of intermediate care into a new, single level of intermediate care. The report shall indicate the number of nursing hours per day the new level will require and shall also estimate any savings to be realized in the inspections, rate setting and assessment process."

As you will also recall, an extension on the submission of the report was previously requested (Appendix 1) and approved. I hope the information contained in this report will be helpful to the Joint Appropriations Committee.

Sincerely yours,

George J. Albanese
Commissioner

GJA:2

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Thomas M. Russo, Director
Division of Medical Assistance and Health Services
Department of Human Services

INTRODUCTION

At present, there is an Intermediate Care level A which requires 2.50 nursing hours of patient care per day and an Intermediate Care level B which requires 1.25 nursing hours of patient care per day. Different Medicaid per diem rates are established for each level at each long term care facility participating in the State Medicaid program.

The initial meetings to consider the feasibility of consolidating the two existing levels of intermediate care services in long term care facilities were held with various members of the Division of Medical Assistance and Health Services. This included administrative, fiscal, medical and nursing staff.

Following the initial meetings, it was decided that it would be necessary to involve representatives of the New Jersey State Department of Health and the long term care industry, i.e., The New Jersey Association of Health Care Facilities and the New Jersey Association of Homes for the Aged.

Several combined meetings of this work group followed. The Department of Health representatives indicated little concern with the proposed consolidation from their perspective and expressed a desire to have only one level of care combining both the skilled and intermediate levels. The Department of Health did not attend further meetings.

During the course of further meetings, the Executive Directors of the two long term care industry Associations proposed that a survey be done in the form of a time/motion study in order to have a more accurate and scientific basis upon which to set hours and rates for a merged intermediate level of care. Several states had conducted such studies, including Illinois, Ohio and Maryland. These studies were used to establish a basis for reimbursement in those states. This approach was agreed upon.

For use in the New Jersey program, the work group considered the Maryland study to be the most appropriate and was the most recent of the three State studies (Appendix 2). The consulting firm was Applied Management Sciences, Inc., of Silver Springs, Md., and, with the agreement of the Division, was engaged by the industry to conduct a study in New Jersey.

METHODOLOGY

The procedure used in the Maryland study by Applied Management Sciences was that their staff, with a team of nurses, recorded time worked by the nursing staff at selected facilities during the 7 A.M. - 3 P.M. and the 3 P.M. - 11 P.M. shifts. In order to time nursing care, the final result was weighted to cover care provided to patients on a 24-hour basis.

A nursing procedure was considered to include four aspects - preparation, travel, clean-up and administration. The administration portion of the nursing function was categorized as procedure and the non-administration portion was categorized as non-procedure.

A ratio of 60% of the time for each specific nursing function was allotted for actual hands on care, and 40% of the time was allotted for non-procedural functions, such as charting, meetings, planning, making schedules, clean-ups, talking to patients and coffee breaks. As a result of the study, average time allottments were set for nursing functions.

For the study in New Jersey, elements of the Maryland study method were adapted. Since time/motion studies had already been completed across the county and were fairly consistent (i.e., the time needed to give an enema or bathe different types of patients were the same wherever it was observed), it was felt that to do another time/motion study of these elements would be unnecessary.

Therefore, for the New Jersey study, it was only necessary to observe and report the procedures being given to patients and to then apply the times to the recorded procedures. The form used in Maryland was modified for use by a team of regional staff nurses from the Division (Appendix 3). A random sample of facilities across the State was selected by the Division's statistical section (Appendix 4) and included proprietary, non-profit and governmental representation.

Within the selected facilities, the sampling of intermediate care patients (levels A and B) was completed by the regional staff nurses as instructed by Applied Management Sciences and the statistical section of the Division. The entire sampling procedure was established by the Division with consultation from Applied Management Sciences.

A Patient Assessment Form was checked relative to dependency and independency as applied to patient capabilities, such as bathing, dressing, feeding and ambulation. Other areas were checked "Yes" or "No" regarding the need for injections, medication, restraints, positioning, decubitus care, suctioning, feeding needs, etc.

The collected data was then submitted to Applied Management Sciences where the actual time for nursing functions was decoded and applied to the care requirements noted by the regional staff nurses (Appendix 5). It must be noted that the New Jersey State Department of Health licensing Manual of Standards for Long Term Care Facilities was adhered to regarding the categorization of patient levels and need for all aspects of care.

APPLIED MANAGEMENT SCIENCES REPORT

The report submitted to the Division by Applied Management Sciences contained raw data on the length of time required for each patient that was selected in a statistically valid sample. The average hours of nursing care required for an ICF patient was determined to be 2.39 hours. The time study developed by Applied Management Sciences specified the amount of nursing care that appeared to be needed to satisfy all patient care needs as set forth by the State of New Jersey, based upon research at nursing homes throughout the country.

It should be noted that, according to this study, the minimum amount of time felt necessary to service the most independent patient is 86.39 minutes, or 1.44 hours. This is over the present State standard of 1.25 hours for ICF-B level patients.

DIVISION EVALUATION

Utilizing the Applied Management Sciences data, the combined time for the care of Intermediate Level A and B patients was analyzed by the Division's statistical section. Based on this analysis, the amount of time required per patient per day is 2.39 hours (2 hours, 23 minutes) (Appendix 6).

The Division also conducted an analysis of time utilizing current Medicaid and State licensing standards. This analysis was based upon a weighted average of the existing minimum number of hours required for both the Intermediate A and B levels of care. The findings of this analysis indicate that under a consolidation, the minimum hours required would be 2.14 hours (2 hours, 8.4 minutes) per patient per day (Appendix 7).

The 2.39 hours of care as determined by the Applied Management Sciences data represents a 12% increase over the 2.14 weighted average number of hours which the Division currently utilizes for reimbursement purposes.

ADVANTAGES OF CONSOLIDATION

The Division, in its evaluation, has identified a significant number of advantages for the consolidation of the existing two levels of intermediate care into one level of Intermediate Care. These advantages are applicable to the Department of Human Services, the Department of Health, and the long term care facilities which provide Intermediate Care services under the Medicaid program.

The advantages listed below affect staff time, effort, processes and procedures. Moreover, the advantages do not detract from the adequacy of patient care. It is difficult to quantify the dollar amount of administrative savings that would be realized because of the impact on many different segments of the program. The advantages are:

1. Savings would be realized through the reduction of administrative appeals and hearings before an Administrative Law Judge on intermediate level of care assessments and the establishment of per diem rates.

2. One intermediate level of care would facilitate the authorization and reauthorization of care by Division nursing staff and would result in increased administrative savings and in professional staff time since team conference time would be limited to skilled cases, possible denials or problem cases.

3. The rate setting process by the Health Economics section of the Department of Health would be simplified with inherent savings of staff time.

4. The payment and adjustment of per diem rates to facilities by the Division's Bureau of Claims and Accounts would be expedited.

5. There would be a decrease in the Division's administrative and professional staff time regarding changes of level requests within the Intermediate Care range.

6. The inspection and evaluation process by the Department of Health licensing unit would be less cumbersome because of the consolidation of licensure requirements.

7. There would be a decrease in administrative time involving the change of levels of care on the MCNH 7 form in the Medicaid District Offices.

8. Administrative time in preparation of cases for conferencing and scheduling would be minimized and professional staff would be able to devote more time to areas requiring increased attention, such as transportation, medical equipment, home health care and other community health services.

9. The process of post audit recalculation of rates as a result of audit findings and the computation of overpayments for recovery of funds would be simplified and expedited.

10. The reporting of data and expenditures for fiscal and budgetary purposes would be less cumbersome.

11. The problem of classifying the Intermediate Care level private patient days would be eliminated.

12. The entire audit process would be facilitated since intermediate levels of care would not have to be tested.

13. The review of proposed per diem rates recommended to the Division by the Department of Health would be simplified.

DISADVANTAGES OF CONSOLIDATION

The disadvantages of consolidation are outweighed by the advantages and are listed below:

1. Administrative time and effort would be required by the Department of Health and the Division to prepare and implement the various regulatory changes needed, such as standards, licensing, inspection, patient assessment, cost reporting, rate setting, etc.

2. A Medicaid State Plan Amendment would need to be submitted to and approved by the Federal Health Care Financing Administration prior to implementation.

3. Long term care facilities in the State that provide Intermediate Care services would need to be informed of the changes and provided with a period to adjust to the revised nurse staffing patterns.

4. There may be an incentive provided to long term care facilities to gradually adjust their case mix to maximize the number of patients who need the least amount of intermediate level care and to avoid the more intensive intermediate care patient in order to increase income from the one level per diem rate. This could make placement of the patient requiring a higher level of intermediate care more difficult.

SAVINGS FOR LONG TERM CARE FACILITIES

1. Administrative time for the discharge and re-admission of patients from one Intermediate Care level to another would be eliminated.

2. Recordkeeping and statistical reporting would both be simplified.

3. The Medical Director would be required to consider only two levels of care upon admission - skilled or intermediate.

4. It would be easier for facilities to staff for one level because of a simplified staffing pattern.

5. A facility would have more flexibility in adjusting nursing care hours to the facility's case mix.

6. The submission of annual cost reports would be simplified concerning nursing hours.

SAVINGS FOR STATE

The Division is of the opinion that definite administrative staff and dollar savings in all areas would accrue to the State with the adoption of one level of intermediate care, but that such savings will not be identifiable until the change has been operational for a period of time. For example, the simplification of audit rate recalculations and the acceleration of money recoveries would be realized in gradual future increments.

As a result, no specific dollar or staff savings are able to be identified at this time. It is suggested that, if the change is adopted, a follow-up study be conducted one year following its implementation for the specific purpose of identifying and quantifying both staff and dollar savings.

EFFECT ON STATE LICENSING

The minimum hours of care for the licensing of long term care facilities are a responsibility under the jurisdiction of the State Department of Health. The per patient per day hours required for Intermediate Care levels A and B are currently contained in the State Administrative Code as a licensing standard. Therefore, in order to consolidate and utilize one level of intermediate care, it will be necessary for the State Department of Health to consider and promulgate a change in the licensing standards as a requirement for all long term care facilities in the State, irrespective of whether or not they participate in the Medicaid program. This would require review by the Health Care Administration Board in the Health Department and the publication and adoption of a revised rule in the New Jersey Register.

EFFECT ON MEDICAID PROGRAM

The consolidation of intermediate care into one level would also require the publication and adoption of a rule change in the New Jersey Register along with a change in the Medicaid State Plan. Any change in the State Plan for this purpose would require the approval of the Federal Health Care Financing Administration prior to implementation.

SUMMARY

Based upon the information contained in this study, the Division is of the opinion that the consolidation of the intermediate levels of care into one level is feasible using a standard of 2.39 hours of care per patient day and will save money administratively, but is estimated to incur a cost of approximately $7.2 million (State and Federal share).

APPENDIX INDEX

APPENDIX 1

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
CAPITAL PLACE ONE
222 SOUTH WARREN STREET
TRENTON, NEW JERSEY 08625

GEORGE J. ALBANESE
Commissioner

M E M O R A N D U M

November 8, 1982

TO: Honorable Laurence S. Weiss
Chairman, Joint Appropriations Committee

SUBJECT: Joint Appropriations Committee Resolution #3
on Single Intermediate Care Facility Level

As you know, the above Resolution requires the Division of Medical Assistance and Health Services to prepare and submit a report to the Joint Appropriations Committee by January 1, 1983 concerning the feasibility of consolidating the two existing levels of intermediate care into a new single level of intermediate care.

The Resolution further requires that the report indicate the number of nursing hours per day for the new level, along with an estimate of any savings to be realized in the inspections, rate setting and assessment process.

The Division is working closely with the New Jersey Association of Health Care Facilities on the study and is currently engaged in a detailed analysis of nursing tasks and the time required to perform the task for ICF patients in such facilities.

It is possible that this study may not be fully completed for submission by January 1, 1983 and I am, therefore, requesting a two-month extension for the submission of the report to the Joint Appropriations Committee. Your favorable consideration of this request will be most appreciated.

George J. Albanese
Commissioner

GJA:2
c.c. Larry J. Lockhart
Thomas M. Russo
James E. Cunningham

APPENDIX 2

HANDBOOK
ON
PATIENT ASSESSMENT

July 8, 1982

Medical Assistance Compliance Administration
Department of Health and Mental Hygiene
State of Maryland

The Patient Assessment Form

The patient assessment form has been designed to abstract a finite set of patient-specific characteristics for which Maryland nursing home providers will be reimbursed. This assessment form provides the State with the requisite data to determine reimbursement rates for nursing costs based on a patient's dependency in the Activities of Daily Living, the need for three specific special services (i.e., tube feeding, necrotic ulcer care, turning and positioning), and seven other categories of additional services.

Assessments will periodically be performed on all Medical Assistance patients so the instrument has been designed to capture data for each month between assessments. In addition to multiple month retrospective assessments, the form is also used to record either an initial admission or a conversion (i.e., from Medicare or private pay) assessment. All data items required to complete this form may be found in the patient's medical record. Instructions are provided to define ADL dependency and to count days of service. A cross-reference to the MAPP is also provided in the data sources.

PATIENT ASSESSMENT FORM

PATIENT NAME [ ] ASSESSMENT DATE [ ][ ][ ]
LAST FIRST

FACILITY ID [ ][ ][ ][ ][ ] MEDICAID ID [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] ASSESSOR ID [ ][ ]

PERIOD COVERING: MONTH 1 [ ][ ] MONTH 2 [ ][ ] MONTH 3 [ ][ ]
MO. YR. MO. YR. MO. YR.

I. ADMINISTRATIVE DATA

1. Initial Assessment 0=No 1=Yes [ ]

2. Date of Admission or Conversion to Medicaid [ ][ ][ ] MO. DAY YR.

3. Date of Discharge, Transfer, Death, or Medicaid Lost or Denied [ ][ ][ ] MO. DAY YR.

4. Days of Home Leave Taken [ ][ ][ ] 1 2 3

II. ACTIVITIES OF DAILY LIVING
(Enter one code for each month)

5. Bathing 0=Independent 1=Dependent [ ][ ][ ] 1 2 3

6. Dressing 0=Independent 1=Dependent [ ][ ][ ] 1 2 3

7. Mobility 0=Independent 1=Dependent 2=Bed/Chair Confined [ ][ ][ ] 1 2 3

8. Continence 0=Independent 1=Dependent [ ][ ][ ] 1 2 3

9. Eating 0=Independent 1=Requires Help [ ][ ][ ]

III. SPECIAL SERVICES
(Enter number of days services are received for each month.)

10. a. Necrotic Ulcer Care [ ][ ][ ] 1 2 3

b. 0=Not present at admission 1=Present at admission [ ]

11. Turning and Positioning For a 24 Hour Period [ ][ ][ ] 1 2 3

12. Tubefeeding [ ][ ][ ] 1 2 3

IV. ADDITIONAL SERVICES
(Enter number of days services were received for each month.)

13. Restraints [ ][ ][ ] 1 2 3

14. a. Single Injections [ ][ ][ ] 1 2 3

b. Multiple Injections [ ][ ][ ] 1 2 3

15. Ostomy Care [ ][ ][ ] 1 2 3

16. Oxygen/Aerosol [ ][ ][ ] 1 2 3

17. IV/Subcutaneous [ ][ ][ ] 1 2 3

29X

FORM IDENTIFIERS

A. Patient Name - Print the patient's name in the box provided. Record the last name first and then continue with the first and middle names as space allows. It is extremely important that the name appears correctly spelled since this field will be used to match the assessment form with the payment voucher when errors are present in the patient ID..

B. Assessment Date - The date that the form is completed by the interviewer. Record month, day, and last two digits of the year. Zero fill boxes (e.g., 01 = January).

C. Facility ID - Each nursing home has a six-digit unique provider code. If the assessment occurs in the hospital or in other circumstances where the nursing home facility is unknown, then code '000000' in this field and write the name of the hospital at the top of the form.

D. MEDICAID ID - This ID will appear in the patient's medical records or in the business office. This should be copied very carefully because this is the means by which this form can be linked back to a particular patient's payment record. The ID should consist of 11 digits. If less than 11 digits appear in the patient's records, ask the nursing home staff to check the number.

E. Assessor ID - This field is for the use of the assessment contractor and should be used to uniquely identify each assessor. Every assessment form should have this field completed.

F. Period Covering - If this is an initial assessment, record all zeros (i.e., '0000') in the boxes for each month and be sure to code item 1 in Section I properly. If not an initial assessment, then the continuing assessment recorded on this form can be for any period up to the three months in length. If more than three months have elapsed since a previous assessment (or admission), please use more than one form. Indicate for each month (or part thereof) the month number and last two digits of the year. By doing so, all responses in Sections I through IV will be properly keyed to the month of review.

I. ADMINISTRATIVE DATA

1. Initial Assessment

Item Definition: The first assessment performed on a patient after he/she has been determined to be eligible for Medical Assistance (MA) and has been classified as appropriate for nursing home placement. This assessment will generally be performed either in conjunction with a medical eligibility review in a hospital setting or in the facility in the case of a private pay nursing home resident who is converting to MA.

Data Source: Accompanying initial medical review.

Code Explanation

Code		Meaning
0	=	No
1	=	Yes

NOTE: If the form is being used for an initial assessment, Sections III and IV need not be filled out.

I. ADMINISTRATIVE DATA

2. Date of Admission or Conversion to MEDICAID

Item Definition: The date a patient on Medical Assistance enters the nursing home, OR the date that the patient's payment status changes to Medical Assistance from private pay or alternative sources.

Data Source: These data can be found in the facility's business office on the admittance forms or at the beginning of the patient's medical record.

Code Explanation:

Code		Meaning
00-00-00	=	Patient has not, as yet, been admitted to the nursing home
AA-BB-CC	=	Month patient admitted to the nursing home or converted to Medical Assistance. Code as follows in first two fields, indicated here as AA: 01 = January, 02 = February .... 12 = December.
AA-BB-CC	=	Day patient admitted or converted to MA. Code in second two fields, indicated here as BB: 01 = first day of month .... 28, 29, 30, or 31 = last day of month.
AA-BB-CC	=	Year patient admitted or converted to MA. Code last two digits of the year in the last two fields, indicated here as CC.

I. ADMINISTRATIVE DATA

3. Date of Discharge, Transfer, Death, or MEDICAID - Lost or Denied

Item Definition: When any of the above actions occur, the Medical Assistance reimbursement to that nursing home for the patient will be discontinued. It is imperative, therefore, to distinguish between an actual transfer/discharge and a patient who has, for example, left the facility for a brief hospital stay of, say, 72 hours, and for whom the facility is still holding their bed (the latter case should be regarded as the patient still being in the home). It is very important to get the exact date that the action occurred.

Data Source: Medical records; Business office

Code Explanation

Code		Meaning
00-00-00	=	Patient is still in the nursing home and is still receiving MA benefits.
AA-BB-CC	=	Month action occurred. Code in the first two fields, indicated here as AA: 01 = January, 02 = February .... 12 = December.
AA-BB-CC	=	Day action occurred. Code in the second two fields indicated here as BB: 01 = first day of month .... 31 = last day of month.
AA-BB-CC	=	Year action occurred. Code in the last two fields indicated here as CC the last two digits of the year.

I. ADMINISTRATIVE DATA

4. Days of Home Leave Taken

Item Definition: Patients are allowed up to 18 days of accumulated home leave each calendar year. During these visits, the nursing home will keep the bed available and Medical Assistance will continue to be paid.

Data Source: Medical records; Business office

Code Explanation

Code		Meaning
00	=	Home visits were not taken during the review month(s)
01-31	=	Code the number of days of home visits taken in each of the review month(s).

34 x

II. ACTIVITIES OF DAILY LIVING

5. Bathing

Item Definition: Refers to the description which best typifies the patient's overall performance of bathing or showering activities in a given month.

Data Source: Medical records; MAPP form - Category II Functioning Status - Section 4, Personal Hygiene items 4, 5, and 6; Charge Nurse; Nurse's Aide.

Code Explanation

Code		Meaning
0	=	Independent - a resident is classified as independent if no other person is involved in any part of the process of taking a sponge bath, shower or tub bath to wash the whole body. This category may be applied however to the patient who requires supervision for safety reasons though he washes himself, and the patient who is only unable to wash one extremity. A patient is also classified under this category if he/she uses only mechanical aids to assist in the bathing process, e.g., shower/tub chair, grabrails, pedal/knee controlled faucets, long handle brush or mecnanical lift.
1	=	Dependent - pertains to the individual who is assisted in washing; this includes the patient to whom water is brought even though he washes himself, and patient who is helped in or out of a tub as regularly as once a week. This category also includes the individual who is completely bathed by another person(s) and does not participate in the activity.

Put one code in each box for each review month by choosing the code which best describes the patient's overall abilities for the month.

II. ACTIVITIES OF DAILY LIVING

6. Dressing

Item Definition: The process of putting on, fastening, or taking off all items of clothing, braces, or artificial limbs that are worn daily by the individual, including obtaining and replacing the items from their storage area in the immediate environment. Clothing refers to the clothing usually worn daily by the individual. Individuals who wear pajamas or gown with robe and slippers as their usual attire are considered dressed.

Data Source: Medical records; MAPP-Category II Functioning Status, Section 5, Dress/Undress items 1-3; Charge Nurse; Nurse's Aide.

Code Explanation

Code		Meaning
0	=	Independent - pertains to the patient who does not receive personal help or supervision in getting clothes from the closets and drawers and in putting on the clothes, including brace (if usually worn) and including outer garments and footwear. Fasteners must also be managed without assistance, although, a resident who receives help in tying shoes only is included in this category. This class also includes the individual who uses mechanical help only to complete the dressing process. Such equipment or devices may include long-handled shoe horns, zipper pulls, velcro fasteners, adapted clothing, and walker with attached basket or some other device used to obtain clothing.
1	=	Dependent - includes patients who usually receive assistance from another person(s) in obtaining clothes, fastening hooks, putting on clothes, braces, artificial limbs or who require supervision or instruction in order to dress one's self. Also included in this category is the resident who receives human assistance (as specified above) and who uses the aid of mechical devices. Finally, this code includes patients who are completely dressed by another person(s) or who are bedfast and therefore remain partially or completely undressed.

Put one code in each box for each review month by choosing the code which best describes the patient's overall abilities for the month.

36 x

II. ACTIVITIES OF DAILY LIVING

7. Mobility

Item Definition: The patient's current performance, assessed with mechanical aids if customarily used, of moving from bed to chair or wheelchair, and from bed or chair to standing position. Exclude effort required to apply a brace or prosthesis (included in dressing).

Data Source: Medical records; MAPP-Category II Functional Status, Section 1 - Ambulation items 1-4, and Section 3 - Transferring items 1-4; Charge Nurses; Nurse Aides.

Code Explanation

Code		Meaning
0	=	Independent - requires no assistance in transferring and walking and/or wheeling.
1	=	Dependent - refers to the patient who is able to ambulate with or without mechanical assistance, but must be personally assisted getting in or out of bed or chair. This category also includes the patient who is unable to ambulate without human assistance or supervision, is wheeled, or is bed/chair confined. Patient cannot participate significantly in the process of walking/ wheeling or transfer, but is able to reposition self in bed or in chair.
2	=	Bed/Chair Confined/Unable to Reposition Self - refers to the patient who requires a daily maintenance schedule for positioning and turning by nursing staff to relieve areas of pressure and to prevent skin breakdown.

Put one code in each box for each review month by choosing the code which best describes the patient's overall abilities for the month.

II. ACTIVITIES OF DAILY LIVING

8. Continence

Item Definition: Continence refers to the physiological process of elimination from the bowels and bladder where incontinence is the involuntary loss of control. This item only refers to the function of control and does not include hygiene, toileting, adjusting clothes, etc.

Date Source: Medical records; MAPP-Category II Functioning Status, Section 6 - Toileting items 4 and 7; Charge Nurse; Nurse's Aide.

Code Explanation:

Code		Meaning
0	=	Independent - pertains to the patient who is continent of bowel and bladder and the patient who can completely care for their own ostomy. Also includes patient who has accidents only 1 or 2 times per week and is not catheterized. Does not include patient whose continence is maintained only through regularly scheduled and documented staff assistance in advance of need.
1	=	Dependent - Includes patient who has accidents 3 or more times per week includes patient who has accidents at night only. Also includes patient needing regular, daily continence care due to patient's inability to control micturition or bowels, or to notify staff in advance of need. Includes patient whose continence is maintained through regularly scheduled and documented staff assistance in advance of need. Patients with indwelling catheters, suprabubic catheters, and Texas catheters should be regarded as incontinent.

Put one code in each box for each review month by choosing the code which best describes the patient's overall abilities for the month.

II. ACTIVITIES OF DAILY LIVING

9. Eating

Item Definition: Eating and feeding refers to the process of getting food by any means from the receptacle into the body. This item describes the function of eating after food is placed in front of the individual. This standard includes N-G tube feeding or gastrostomy feedings, but excludes patient being maintained solely by IV or being taught self-care of gastrostomy.

Data Source: Medical records; MAPP-Category II Functioning Status, Section 2 - Muscle Strength, Items 5 and 6; MAPP-Category III Nutritional Status, item 1; Charge Nurse or Nurse's Aide.

Code Explanation

Code		Meaning
0	=	Independent - no service. Patient may receive assistance in cutting meat, buttering bread, opening containers of milk, pouring milk or cereal, or cream in coffee, or in clearing up after accidents.
1	=	Receives personal help or supervision - refers to patient who receives some assistance or direct supervision in eating in order to achieve adequate nutrition on a daily basis or to guard against life-threatening incidents (e.g., choking).
2	=	Spoonfed - refers to patient who is routinely fed by a staff member because the patient is usually unable to bring food to his mouth. Patient may occasionally bring food to his mouth in an effective manner for one feeding or during two or more feedings.
3	=	Gastric tube/gastrostomy feedings - Patient is fed a prescribed diet via a naso-oral-gavage tube or gastro-gavage tube. Activity includes insertion of tube, care of the opening, and feeding through the tube.

Put one code in each box for each review month by choosing the code which best describes the patient's overall abilities for the month.

III. SPECIAL SERVICES

10a. Decubitus Care

Item Definition: Refers to the days of care given to patients with Stage III and Stage IV decubitus ulcers. A Stage III decubitus ulcer is defined as a skin break with redness and significant or extensive tissue involvement; a full thickness of skin is lost, possibly including subcutaneous tissue, producing serosanguineous drainage. A Stage IV decubitus ulcer is defined as a skin break with deep tissue involvement, necrotic tissue may be present. A skin break must be present in both types of ulcers; blisters only would not be considered a Stage III/IV ulcer.

Data Source: Patient observation; medical records; nursing notes.

Code Explanation

Code		Meaning
00	=	Care for a necrotic ulcer was not administered during that month
01-31	=	Number of days that necrotic ulcer care was administered each month. Care is defined as treatment ordered more often than daily for decubitus ulcers, stasis ulcers, or similar conditions by a physician of one or more of the following treatments: sterile dressing, moist packs, soaks, irrigations, heat lamp, oxygen, or other recognized therapy.

Note: A Stage I ulcer is defined as inflamation or reddening of the skin which does not clear with gentle hand massage and repositioning of the patient. A Stage II ulcer is a skin break with inflamation of surrounding skin which does not clear with gentle hand massage and repositioning of patient.

III. SPECIAL SERVICES

10b. Decubitus present at admission

Item Definition: Indicate if the necrotic ulcer was present upon admission to the nursing home. If a private pay patient converts to Medical Assistance, the assessor would still indicate if the ulcer was present at the time the patient admitted to the nursing home as a private pay patient. This field need only be completed on the patient's initial assessment and his/her first Continued Stay Review.

Data Source: Resident observation; medical records.

Code Explanation:

Code		Meaning
0	=	Ulcer not present at admission
1	=	Ulcer present at admission

III. SPECIAL SERVICES

11. Turning and Positioning

Item Definition: The number of days for which the patient requires 24 hour turning and positioning. This does not include those patients who can sit in a chair during the day but need turning and positioning at night only. (If resident is turned and positioned, Item 7, Mobility, should indicate resident is bed/chair confined.)

Data Source: Medical records; Patient observation

Code Explanation:

Code		Meaning
00	=	24 hour turning and position was not required this month
01-31	=	Number of days patients required 24 hour turning and positioning each review month.

III. SPECIAL SERVICES

12. Tubefeeding

Item Definition: Refers to the use of a naso-gastric or gastric tube as the primary method of feeding the patient. (If resident is tubefed, Item 9, Eating, should indicate such.)

Data Source: Medical records; MAPP Category III Nutritional Status, Item 6 - Footnote; Patient observation.

Code Explanation

Code		Meaning
00	=	Patient was not tubefed during the review month
01-31	=	Number of days the patient was tubefed during each review month.

43 X

IV. ADDITIONAL SERVICES

13. Restraints

Item Definition: Number of days that physician ordered and patient was administered physical restraints, and/or the following protective devices: posey belt, geriatric chair. Restraints must be removed at regular intervals. Patients in protective devices must be repositioned at least every two hours. Protective devices such as mitts, elbow pads, knee pads, and heel pads are included as part of the dressing function and, therefore, are excluded here. Restraints can only be ordered for a 24-hour period; protective devices can be ordered for up to 30 days for skilled patient, and a maximum of 60 days for an ICF-level resident.

Data Source: Medical records; MAPP Category II Functioning Status, Section 3 Transferring - item 5; Patient observation.

Code Explanation

Code		Meaning
00	=	Restraints/protective devices were not used during the review month
01-31	=	Number of days that restraint/protective devices were used each review month.

44 x

IV. ADDITIONAL SERVICES

14a. Single Injections

Item Definition: The number of days the patient was administered only one injection each day. Excludes resident who self-administers injections.

Data Source: Medical records; medication records/sheets.

Code Explanation

Code		Meaning
00	=	No single injections were received during the review month
01-31	=	Number of days patient received only single injections during review month.

IV. ADDITIONAL SERVICES

14b. Multiple Injections

Item Definition: The number of days that the patient receives two or more injections per day. Excludes patient who administers own injections.

Data Source: Medical records; medication records/sheets.

Code Explanation

Code		Meaning
00	=	No multiple injections were received during the review month
01-31	=	Number of days that the patient received multiple injections each review month.

IV. ADDITIONAL SERVICES

15. Ostomy Care

Item Definition: The number of days of care and/or irrigation of all ostomies including colostomies, ileostomies, ureterostomies; as ordered by a physician and care provided under supervision of a licensed nurse. Excludes the resident who is self-care.

Data Source: Medical record; Treatment records; Category II Functioning Status Section 6 - items 6, 8; Patient Observation.

Code Explanation

Code		Meaning
00	=	No care was given during review month
01-31	=	Number of days during review month the patient received care for the ostomy.

IV. ADDITIONAL SERVICES

15. Oxygen/Aerosol

Item Definition: Administration of oxygen and/or aerosol therapy (IPPB) respiratory care only as ordered by a physician and administered by a licensed nurse or a registered respiratory therapist. Self-administered oxygen nebulizers, vaporizers, or atomizers are not included in this category.

Data Source: Medical records; Treatment record; Charge nurse; Nurse's Aide; Patient observation.

Code Explanation

Code		Meaning
00	=	Oxygen/Aerosol Therapy was not administered during review month
01-31	=	Number of days that the patient received Oxygen/Aerosol treatments each review month.

IV. ADDITIONAL SERVICES

17. IV/Subcutaneous

Item Definition: Parenteral solutions, with or without medication, ordered by a physician and administered under the supervision of a registered nurse who is available on a 24-hour basis, in compliance with licensure requirements. Resident who receives IV/Subcutaneous treatments for any part of a day is considered to have received treatment for a full day.

Data Source: The medication sheet must specify the solution, the date, the time administered, and the signature of the person administering the fluid. The patient's plan of care must be reevaluated by the physician after four days' administration.

Code Explanation

Code		Meaning
00	=	Patient did not require this type of care during the review month
01-31	=	Number of days the patient received this service each review month.

IV. ADDITIONAL SERVICES

1S. Suctioning/Tracheostomy

Item Definition: Maintenance of patient airway ordered by a physician and performed by a licensed nurse, including the cleaning of inner and outer cannula and sterilization of needed equipment. The suctioning equipment must be located in the patient's room.

Data Source: Medical record; treatment records.

Code Explanation

Code		Meaning
00	=	Patient did not require suctioning or tracheostomy care during the review month
01-31	=	Number of days that patient received these services each review month.

5c X

APPENDIX 3

PATIENT ASSESSMENT FORM

PATIENT NAME [ ] ASSESSMENT DATE [ ][ ][ ]
LAST FIRST

FACILITY ID [ ][ ][ ][ ][ ][ ] MEDICAID ID [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] ASSESSOR ID [ ][ ][ ]

PERIOD COVERING: MONTH 1 [ ][ ] MONTH 2 [ ][ ] MONTH 3 [ ][ ]
MO. YR. MO. YR. MO. YR.

I. ADMINISTRATIVE DATA

1. Initial Assessment 0=No 1=Yes [ ]

2. Date of Admission or Conversion to Medicaid [ ][ ][ ] MO. DAY YR.

3. Date of Discharge, Transfer, Death, or Medicaid Lost or Denied [ ][ ][ ] MO. DAY YR.

4. Days of Home Leave Taken [ ][ ][ ] 1 2 3

II. ACTIVITIES OF DAILY LIVING
(Enter one code for each month)

5. Bathing 0=Independent 1=Dependent [ ][ ][ ] 1 2 3

6. Dressing 0=Independent 1=Dependent [ ][ ][ ] 1 2 3

7. Mobility 0=Independent 1=Dependent 2=Bed/Chair Confined [ ][ ][ ] 1 2 3

8. Continence 0=Independent 1=Dependent [ ][ ][ ] 1 2 3

9. Eating 0=Independent 1=Receives Help [ ][ ][ ]

III. SPECIAL SERVICES
(Enter number of days services are received for each month.)

10. a. Necrotic Ulcer Care [ ][ ][ ] 1 2 3

b. 0=Not present at admission 1=Present at admission [ ]

11. Turning and Positioning For a 24 Hour Period [ ][ ][ ] 1 2 3

12. Tubefeeding [ ][ ][ ] 1 2 3

IV. ADDITIONAL SERVICES
(Enter number of days services were received for each month.)

13. Restraints [ ][ ][ ] 1 2 3

14. a. Single Injections [ ][ ][ ] 1 2 3

b. Multiple Injections [ ][ ][ ] 1 2 3

15. Ostomy Care [ ][ ][ ] 1 2 3

16. Oxygen/Aerosol [ ][ ][ ] 1 2 3

17. IV/Subcutaneous [ ][ ][ ] 1 2 3

APPENDIX 4

DEPARTMENT OF HUMAN SERVICES

INTER-OFFICE COMMUNICATION

THROUGH Ann Kohler

DATE December 3, 1982

TO Jed Spector
James Cunningham

FROM James Bohan

SUBJECT Revised Sample of Long Term Care Patients

As requested, the sample of long term care patients has been revised to include a minimum number of facilities according to type; Proprietary (10 sample facilities), Governmental and Non-Profit which received Medicaid funds (5 sample facilities each). This remains a two stage sample and the instructions provided with the original sample still apply (copy attached). The lists of random numbers which correspond to the beds to be sampled are attached and grouped according to type of facility. A face sheet for each group identifies the facilities selected for review. In keeping with your cost and time constraints, the total sample size remains essentially the same. A total of 20 facilities will be selected each having 30 beds to review, with the exception of two small facilities in which all beds are to be reviewed (see face sheet).

The total number of facilities that were subject to sampling was revised from 242 to 238 facilities. Facilities are defined as units with discrete Medicaid provider numbers. As had been agreed and stated in the original memo, the sample frame excludes facilities which did not receive Medicaid funds for the report month of August 1982 (CP08). Statistically, inferences cannot be made relevant to these facilities. Also, this sample was not constructed to facilitate comparisons between level A and level B care. The new stratified format is likely to increase the sampling error from the previous target of ± 20 minutes. Sampling error can only be reduced by increasing the sample size. Again, the estimated sampling error is subject to the assumptions you provided.

If you have any questions regarding the above or experience problems selecting random samples at the facilities, please call me at 292-7341.

JB:jh

attachments

APPROVED: Jed Spector, Chief, Bureau of Nursing Services
James Cunningham, President, New Jersey Association of Health Care Facilities
Dennis Hett, Executive Director, N.J. Association of Non-Profit Homes for the Aging, Inc.

DEPARTMENT OF HUMAN SERVICES

INTER-OFFICE COMMUNICATION

To: Jed Spector

Date: November 5, 1982

From: Jim Bohan

Subject: Random Sample of Long Term Care Patients Level A & B

As requested, please find attached a statistically random sample of numbers which identify the nursing home beds to be used in your study of long term care. The sample is divided into two stages. The first identifies the 20 facilities to be visited out of the 242 facilities that received Medicaid payments during August 1982. The second stage identifies the 30 beds to be reviewed in each facility selected by listing 30 random numbers between one and the total number of beds in each respective facility (Mi.) For example if the first selected facility had 100 beds, thirty random numbers will be listed which could range from one to 100. In addition, each facility has five reserve pool numbers. These are to be used only if one or more of the first 30 beds selected has a patient requiring skilled nursing care (which are not subject to review) or are empty during the time of review. An empty bed should be narrowly defined as 'empty for the duration of review time spent at the facility'. Reserve pool cases should not replace other beds for administrative convenience. Also, they must be used in the order given.

Because of the uncertainty of the physical layout or available records of each facility, the procedure for matching the sample of random numbers of actual beds in the facility has yet to be defined. If a facility has all rooms numbered in consecutive order from one to Mi and there are two beds to a room, the bed to be reviewed can be derived directly from the random numbers. An odd random number means you will review bed A, an even number equals bed B. The room number is derived by dividing the random number by 2 and rounding up to the nearest integer. An example, the random number 29 would correspond to bed A in room number 15 (29÷2=14.5,Rd=15). If room numbers are numbered consecutively but begin with multiple digits, eg., 101, 201, 1001, etc., disregard all digits to the left of 1-Mi. If rooms are not ordered consecutively, you can create a contiguous list by listing all beds according to hierarcy of room numbers (eg., 1A, 1B, 12A, 12B,... MiA MiB). Then the bed to be reviewed would correspond to the ordered position of the random number (eg., Random #3 corresponds to bed 12A in prior example). Other lists are also suitable, such as, a file with one card for each bed, a ledger sheet listing all beds, etc. Again the bed selected for review would be according to its position in the files or list. However, any source for selection of sample beds must be complete (all occupied level A & B beds) and randomly ordered. The procedure used for each facility should be documented so that sample selected could theoretically be duplicated.

Per the instructionsof yourself and Jim Cunningham, this sample is constructed to provide an estimate of the average length of time required per day to service all level A and B patients in LTC facilities which received Medicaid funds. Statistically, inferences cannot be made relevant to private facilities, nor will this sample facilitate comparisons between level A and level B care. The amount of error of the estimate is expected to be ± 20 minutes at a 95% level of confidence. However, factors which determine sample sizes and distribution between stages were derived intuitivel Samples of this type are extremely sensitive to such assumptions and sampling error may be adversely affected.

In order to make the necessary calculations after the sample is completed, the length of time of service per day for each patient sampled must be provided and grouped by pertinent facility. In otherwords, we will receive 20 groups of 30 numbers each.

If you have any questions regarding the above or experience problems selecting random samples at the facilities, please call me @ 292-7341.

JB:es

Attachments

SAMPLE FOR PROPRIETARY FACILITIES

FACILITIES SELECTED	PROVIDER NUMBER	NUMBER OF BEDS
Beachview Nursing Home	0102	104
Bel Air Nursing Care	0230	250
Lakewood of Voorhees	0410	240
Greenbriar Nursing & Convalescent Home	0801	220
Emery Manor Nursing Home	1206	100
H & H Nursing Home, Inc.	1311	115
The Grove Health C.C.	1366	121
Bayview Conva. Center	1505	323
Dolly Mt. Nursing Home	1609	32 (ALL)
Bridgeway Conva. Center	1816	120

BEACHVIEW NURSING HOME (0102)

NO. OF BEDS 104

SAMPLE NO.

1	62
6	63
7	67
11	68
12	71
22	72
23	73
24	81
34	82
36	89
39	90
42	98
50	99
58	100
59	101

RESERVE POOL

40
21
54
55
44

BEL AIR NURSING CARE (0230)
NO. OF BEDS 250
SAMPLE NO.

6	117
15	126
31	129
32	136
36	140
42	141
45	148
47	151
81	177
91	196
98	208
100	223
101	232
103	235
107	238

RESERVE POOL

34
156
172
192
194

LAKEWOOD OF VOORHEES (0410)
NO. OF BEDS 240
SAMPLE NO.

18	150
20	154
27	165
49	172
60	174
67	178
70	190
77	192
92	208
95	220
100	221
103	224
118	225
137	233
146	236

RESERVE POOL

34
35
53
109
205

GREENBRIAR N&C HOME (0801)

NO. OF BEDS 220

SAMPLE NO.

5	120
26	121
36	127
45	135
48	138
59	161
60	162
61	174
76	175
79	178
89	184
94	185
108	189
111	191
117	215

RESERVE POOL

67

122

62

158

136

EMERY MANOR NURSING HOME (1206)

NO. OF BEDS 100

SAMPLE NO.

2	59
3	60
5	61
6	62
15	63
21	65
22	67
26	68
28	69
32	73
35	78
42	83
45	85
51	89
52	92

RESERVE POOL

39
17
34
97
9

H & H NURSING HOME, INC. (1311)

NO. OF BEDS 115

SAMPLE NO.

2	51
8	55
10	56
12	57
19	59
21	62
24	63
29	65
34	67
35	73
36	85
37	103
45	104
47	107
49	114

RESERVE POOL

78
87
94
72
31

THE GROVE HEALTH C.C. (1966)

NO. OF BEDS 121

SAMPLE NO.

1	47
2	49
3	57
6	59
8	62
10	67
11	68
13	80
15	84
18	87
24	104
32	105
38	108
42	115
45	120

RESERVE POOL

19

28

43

63

69

BAYVIEW CONV. CTR. (1513)

NO. OF BEDS 323

SAMPLE NO.

1	200
14	203
17	208
20	224
33	235
35	245
76	251
92	256
111	261
123	270
142	273
159	287
167	297
188	304
190	309

RESERVE POOL

31
119
126
194
253

BRIDGEWAY CONVA. CENTER (1816)

NO. OF BEDS 120

SAMPLE NO.

1	62
2	63
6	67
10	68
12	71
18	73
22	75
27	86
29	91
32	99
37	101
42	106
45	108
59	111
60	120

RESERVE POOL

93
3
80
61
38

SAMPLE FOR NON-PROFIT FACILITIES

FACILITIES SELECTED	PROVIDER NUMBER	NUMBER OF BEDS
Masonic Home	0313	239
Wesley Manor Methodist Home	0561	32 (ALL)
Lutheran Home, Jersey City	0964	81
Francis Asbury Manor	1362	67
Workman's Circle Home	2063	78

MASONIC HOME (0313)
NO. OF BEDS 239
SAMPLE NO.

13	150
15	154
48	157
52	158
72	159
82	169
95	177
96	189
102	192
111	194
125	195
127	197
135	217
141	225
149	232

RESERVE POOL

71
75
117
124
160

LUTHERAN HOME, JERSEY CITY (0984)

NO. OF BEDS 81

SAMPLE NO.

1	48
4	51
5	53
6	56
8	57
11	58
13	59
16	63
22	64
23	71
27	73
29	75
31	78
39	80
47	81

RESERVE POOL

36

2

24

37

72

FRANCIS ASBURY MANOR (1982)

NO. OF BEDS 67

SAMPLE NO.

3	32
4	36
5	37
6	42
10	45
12	49
13	52
18	55
19	58
20	59
22	61
23	62
25	63
27	64
31	65

RESERVE POOL

2

8

9

48

56

70 x

WOMAN'S CIRCLE HOME (2063)

NO. OF BEDS 78

SAMPLE NO.

1	25
3	27
5	29
7	30
9	32
11	38
12	40
14	47
15	52
16	58
17	61
18	65
20	68
22	76
23	78

RESERVE POOL

53
77
21
60
69

SAMPLE FOR GOVERNMENTAL FACILITIES

FACILITIES SELECTED	PROVIDER NUMBER	NUMBER OF BEDS
Bergen Pines County Hospital	0281	651
Cumberland Manor	0651	196
Meadowview Hudson County	0903	440
Roosevelt Hospital	1252	290
Preakness Hospital	1651	432

BERGEN PINES (0281)

NO. OF BEDS 651

SAMPLE NO.

10	268
20	350
60	391
76	394
86	462
93	463
104	480
123	488
132	511
188	568
219	571
223	578
235	583
237	585
263	651

RESERVE POOL

155

194

400

575

609

CUMBERLAND MANOR (0651)

NO. OF BEDS 196

SAMPLE NO.

1	124
6	126
13	129
37	134
56	144
59	147
63	150
64	153
65	164
67	172
81	177
89	187
98	191
109	195
111	196

RESERVE POOL

132
44
167
158
26

MEADOWVIEW HUDSON CO. (9909)

NO. OF BEDS 440

SAMPLE NO.

4	183
8	213
11	227
42	240
52	257
59	282
63	321
70	324
92	353
100	367
107	368
127	369
156	391
161	408
164	422

RESERVE POOL

285

361

132

235

265

ROOSEVELT HOSPITAL (1252)

NO. OF BEDS 290

SAMPLE NO.

1	145
13	161
14	173
36	182
39	187
60	189
62	199
63	203
81	234
85	246
88	263
101	264
106	265
133	267
140	284

RESERVE POOL

52
5
110
151
26

PREAKNESS HOSPITAL (1651)
NO. OF BEDS 432
SAMPLE NO.

13	275
15	278
33	281
35	285
45	289
60	292
102	334
103	349
110	353
115	367
134	372
139	391
203	409
253	413
273	429

RESERVE POOL

249
339
417
64
161

APPENDIX 5

CONVERSION TABLE OF CODES DESCRIBING PATIENT CARE NEEDS

All Patients	Assessment Item No.	Service			Minutes PPD
	-	Director of Nursing		4.20	
	-	Night Shift		30.51	
	-	Medications		14.70	86.39
	5.	Personal Hygiene		11.59	
	6.	Dressing		16.03	
	-	Meal Preparation		8.89	
	-	Miscellaneous Services		0.47	
As required	7.	Mobility Asst.	= 1	add	26.75
	8.	Continence	= 1	add	4.89
			± 2	add	31.36
—	9.	Feeding	= 1	add	20.42
			= 2	add	57.17
			= 3	add	57.17
	10.	Necrotic Ulcer Care = Y		add	51.85
	11.	Turning & Positioning = Y		add	26.23
	12.	Tubefeeding = Y		add	57.96
	13.	Restraints = Y		add	21.60
	14.	Single Injections = Y		add	4.80
		Multiple Injections = Y		add	9.60
	15.	Ostomy Care = Y		add	7.04
	16.	Oxygen/Aerosol = Y		add	6.25
	17.	IV/Subcutaneous = Y		add	20.00
	18.	Suctioning/Trach = Y		add	14.82

PATIENT ASSESSMENT FORM

PATIENT NAME [ ] ASSESSMENT DATE [ ]
LAST FIRST

FACILITY ID [ ] MEDICAID ID [ ] ASSESSOR ID [ ]

PERIOD COVERING: MONTH 1 [ ] MONTH 2 [ ] MONTH 3 [ ]
MO. YR. MO. YR. MO. YR.

I. ADMINISTRATIVE DATA

1. Initial Assessment 0=No 1=Yes [ ]

2. Date of Admission or Conversion to Medicaid [ ] [ ] [ ] MO. DAY YR.

3. Date of Discharge, Transfer, Death, or Medicaid Lost or Denied [ ] [ ] [ ] MO. DAY YR.

4. Days of Home Leave Taken [ ] [ ] [ ] 1 2 3

II. ACTIVITIES OF DAILY LIVING
(Enter one code for each month)

5. Bathing 0=Independent 1=Dependent [ ] [ ] [ ] 1 2 3

6. Dressing 0=Independent 1=Dependent [ ] [ ] [ ] 1 2 3

7. Mobility 0=Independent 1=Dependent 2=Bed/Chair Confined [ ] [ ] [ ] 1 2 3

8. Continence 0=Independent 1=Dependent [ ] [ ] [ ] 1 2 3

III. SPECIAL SERVICES
(Enter number of days services are received for each month.)

10. a. Necrotic Ulcer Care [ ] [ ] [ ] 1 2 3

b. 0=Not present at admission 1=Present at admission [ ]

11. Turning and Positioning For a 24 Hour Period [ ] [ ] [ ] 1 2 3

12. Tubefeeding [ ] [ ] [ ] 1 2 3

IV. ADDITIONAL SERVICES
(Enter number of days services were received for each month.)

13. Restraints [ ] [ ] [ ] 1 2 3

14. a. Single Injections [ ] [ ] [ ] 1 2 3

b. Multiple Injections [ ] [ ] [ ] 1 2 3

15. Ostomy Care [ ] [ ] [ ] 1 2 3

16. Oxygen/Aerosol [ ] [ ] [ ] 1 2 3

17. IV/Subcutaneous [ ] [ ] [ ] 1 2 3

APPENDIX 6

DEPARTMENT OF HUMAN SERVICES

INTER-OFFICE COMMUNICATION

THRU: Ann Kohler

To: Thomas M. Russo

Date: February 24, 1983

From: James Bohan

Subject: Hours of Nursing Home Care

Please find attached the technical notes describing the sample design and corresponding statistical formulas used for the sample which determined the combined hours of care provided to level A and B patients. This is to be included with the material sent on February 22, 1983.

JB:jh

attachment

cc: Jed Spector

SAMPLE DESIGN

Two-Stage Stratification Sampling With Systematic Selection of Primaries With Probability Proportionate to Size (PPS)

Define:

N_h = No. of units in population in h^{th} stratum

n_h = no. of units in sample in h^{th} stratum

Y_{ijh} = Observation for the j^{th} subunit within the i^{th} unit in population in h^{th} stratum

y_{ijh} = corresponding observation in sample.

$i = 1, 2, 3, \ldots, n_h$

$j = 1, 2, 3, \ldots, m_{hi}$

M_{hi} = No. of elements in the i^{th} subunit selected in h^{th} stratum

m_{hi} = No. of elements sampled out of M_{hi} subunits selected in the 2^{nd} stage from h^{th} stratum.

Population Mean for i^{th} subunit for h^{th} stratum $= \bar{Y}_{hi} = \frac{1}{M_{hi}} \sum_{j=1}^{M_{hi}} Y_{hij}$

Sample Mean for the i^{th} subunit for h^{th} stratum $= \bar{y}_{hi} = \frac{1}{m_{hi}} \sum_{j=1}^{m_{hi}} y_{hij}$

Let $M_{ho} = \sum_{i=1}^{N_h} M_{hi}$, $m_{ho} = \sum_{i=1}^{n_h} m_{hi}$, $m^*_{ho} = \sum_{i=1}^{n_h} M_{hi}$

$Y_h = \sum_{i=1}^{N_h} Y_{hi}$, $y_h = \sum_{i=1}^{n_h} y_{hi}$

Mean for subunit for h^{th} stratum

$\bar{Y}_h = \frac{Y_h}{M_{ho}}$, $\bar{y}_h = \frac{y_h}{m_{ho}}$, or $\bar{y}_{h(PPS)} = \frac{1}{n_h} \sum \bar{y}_{hi}$

(Over)

Mean Per Primary Unit for h^{th} stratum

$$\bar{Y}_h = Y_{h/N_h} \quad , \quad \bar{y}_h = y_{h/n_h}$$

$$M_o = \sum_{h=1}^{K} M_h = 31532, \quad k = \text{No. of strata} = 3$$

$$m_o = \sum_{h=1}^{K} m_h = 599, \qquad M_o^* = \sum_{h=1}^{K} \sum_{i=1}^{n_h} M_{hi} = 4131$$

$$E(\bar{\bar{y}}_h) = \bar{\bar{Y}}_h, \qquad s_{hi}^2 = \frac{1}{m_{h-1}} \sum_{j=1}^{m_h} (y_{ijh} - \bar{y}_{ih})^2, \; \bar{y}_{ih} = \frac{1}{m_h} \sum_{j=1}^{m_h} y_{i}$$

& $$\hat{V}(\bar{\bar{y}}_h) = \frac{1}{n_h m_{ho}^*} \sum_{i=1}^{n_h} (M_{hi} - m_{hi}) \frac{s_{hi}^2}{m_{hi}} + \sum_{i=1}^{n_h} M_{hi} \cdot (\bar{y}_{ih} - \bar{\bar{y}}_h)^2$$

To calculate

$$\bar{\bar{y}}_{st} = \frac{1}{M_o} \cdot \sum_{h=1}^{K} M_{ho} \bar{\bar{y}}_h$$

& $$\hat{V}(\bar{\bar{y}}_{st}) = \frac{1}{M_o^2} \cdot \sum_{h=1}^{K} M_{ho}^2 \, \hat{V}(\bar{\bar{y}}_h)$$

M_{ho} = Total no. of secondaries in stratum h

M_o = Total over all strata = $\sum_{h=1}^{K} M_{ho}$

and 95% confidence interval for $\bar{\bar{Y}}_{st}$ is

$$\bar{\bar{y}}_{st} \pm 1.96 \sqrt{\hat{V}(\bar{\bar{y}}_{st})}$$

CALCULATIONS:

NON-PROFIT	GOVERNMENTAL	PROPRIETARY
$\bar{\bar{y}}_h = 136.9522$	$\bar{\bar{y}}_h = 139.0849$	$\bar{\bar{y}}_h = 145.8412$
$\hat{V}(\bar{\bar{y}}_h) = 129.5075$	$\hat{V}(\bar{\bar{y}}_h) = 182.2596$	$\hat{V}(\bar{\bar{y}}_h) = 19.9154$

i) $$\bar{\bar{y}}_{st} = \frac{21174(145.8412) + 4869(136.9522) + 5490(139.0849)}{31532}$$

$$= 143.2926$$

= 2.39 hours = 2 hours 23 minutes

ii) $\hat{V}(\bar{\bar{y}}_{st}) = 17.5920$

iii) 95% confidence interval for $\bar{\bar{Y}}_{st}$ = Population Mean is

$$\bar{\bar{y}}_{st} \pm 1.96 \sqrt{\hat{V}(\bar{\bar{y}}_{st})}$$

(135.0718, 151.5134)

= (2 hours 15 minutes, 2 hours 32 minutes)

iv) 99% confidence interval for $\bar{\bar{Y}}_{st}$ is

$$\bar{\bar{y}}_{st} \pm 2.58 \sqrt{\hat{V}(\bar{\bar{y}}_{st})}$$

(2 hours 12 minutes, 2 hours 34 minutes)

DEPARTMENT OF HUMAN SERVICES

INTER-OFFICE COMMUNICATION

FROM: Ann Kohler

DATE: February 22, 1983

TO: Thomas M. Russo

FROM: James Bohan

SUBJECT: Results From Study on Hours of Nursing Home Care Provided

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The following is a synopsis of the results derived from the survey on nursing home care. The time study questionnaire was completed by Division staff. Design of the time study and the subsequent conversion of the completed questionnaire into hours of care for each sample patient was completed by Applied Management Sciences of Silver Spring, Maryland.

The combined average length of time for care administered to level A and B patients was determined to be 2.39 hours (2 hours 23 minutes). The period of time covered by the study was essentially December 1982. Under our present two-tiered payment system, the comparable average time for which we reimburse nursing homes was 2.14 hours (ie., during December, 1982). The hours of care as determined by the study represents a 12% increase over the average number of hours for which we presently reimburse nursing homes. This increase in hours of care does not mean there will be an equal increase in cost. Hours of care is only one component of the total per diem rate. The total rate or cost is comprised of other items such as administrative costs, fixed and variable costs, and type of nursing care provided.

Since this study is based upon a statistically valid sample, there is a sampling error associated with the estimated 2.39 hours of care. This sampling error was calculated to be 8.22 minutes, or 0.14 hours, at the 95% confidence limit. The sampling error is less than the difference between the hours of combined care estimated in the sample and the hours of combined care when determined under our current reimbursement system. The difference equals 15 minutes or 0.25 hours. This indicates that, statistically, there is a significant difference between the hourly rates of care aforementioned.

I have attached for your reference copies of the memos sent to Jed Spector which describe the sampling format, and a copy of the survey questionnaire developed by Applied Management Sciences. Technical notes on the sample design and statistical formulas will follow.

For your information, Applied Management Sciences has requested that they receive findings of this survey. I will initiate a letter for your signature upon your request.

APPENDIX 7

Division of Medical Assistance and Health Services
Department of Human Services

ANALYSIS OF TIME

The Division of Medical Assistance and Health Services' analysis of the statewide weighted average of the minimum number of hours worked required based on the present ICF-A and ICF-B hourly amounts is 2.14 hours. The statewide weighted minimum ICF hours per day has been determined as follows:

	% ICF At 6/30/82	X	Present Minimum Hours Work Required	=	Weighted ICF Hours
A	71.2%	X	2.5	=	1.78
B	28.8%	X	1.25	=	.36
TOTAL	100%				2.14

A breakdown of the 2.14 ICF standard hours per day is:

RN	.25
LPN	.12
Aide	1.77
TOTAL	2.14

APPENDIX "C"

APPENDIX CCC 75

Amendments

to

ASSEMBLY Bill No. 3494

Amend:

Page	Sec.	Line	
1	1	3	Delete "2.75" and insert "3"
1	1	4	After "patient" insert "and each heavy care patient"
1	1	9-11	Delete "have completed a training course approved by the Department of Health or are certified by that department and"
1	1	12-17	After "nursing personnel;" delete entirely.
1	1	18-19	Delete "registered professional nurse and at least one"
1	1	19	Delete "practical"
1	1	After 20	Insert new section. (provide necessary appropriation)
1	2	1	Delete "2." Insert "3."

STATEMENT

These amendments are designed to enhance the bill's objective of providing better nursing care by raising the requirement for "skilled" care which generally applies to convalescent Medicare patients to a more realistic three hours. The change also establishes a category of "heavy care" patients. The need for this category has been emphasized by the DRG system in hospitals which results in more seriously ill patients being discharged into nursing homes and requiring more care. These changes also could help relieve a backup of patients in hospitals who cannot be placed in nursing homes because of insufficient levels of nurse staffing. The heavy care level already has been establish in Maryland, Massachusetts and Utah.

9/X

Amend

Page	Sec.	Line

The removal of the requirement that all nursing personnel have completed a training course is necessary because it would destroy the present system which requires 75% of all unlicensed personnel to have completed the course, but allows the remainder to be uncertified because they either have been newly hired or are encountering difficulties with the English language. The 100% requirement in the bill would seriously threaten patient care and would place every operating facility in this state out of compliance. The other changes add unnecessarily to patient costs by requiring registered nurses for floor duties that can be and are performed as well by licensed practical nurses. The requirement that both an RN and LPN be on duty at the same time also is removed because this would be costly and impractical for smaller facilities. The existing law provides that nursing care in every facility must be supervised by a full-time registered nurse.

The amendments also provide for the Medicaid appropriation that is essential if the provisions are to be implemented.

917

PUBLIC HEARING

Consideration of Nursing Home Reimbursement Issues

Roosevelt Hospital, Menlo Park

June 25, 1985, 10:30 a.m.

Testimony presented by:

Mrs. Mary Kay Kirschman, RN, CNA, MSN, LNHA
Assistant Administrator - Nursing
Roosevelt Hospital

My name is Mary Kay Kirschman. I am Assistant Administrator for Nursing here at Roosevelt Hospital. I was pleased to be asked by the NJSNA to testify today concerning the concept of peer grouping. I plan to leave the issues of the adequacy of Medicaid rates to the financial people. I instead will concentrate on the result of reimbursement rates and the adequacy of nursing care hours which are reimbursed by the Medicaid program. My testimony will be brief.

Under the Medicaid program a patient with the greatest need for care in a nursing home is titled a skilled patient - Medicaid Level 3. If he were any sicker he would have to go to a general hospital for acute care. In a twenty-four hour period, Medicaid will pay for two (2) hours and forty-five (45) minutes of nursing care only. As a further example, on a fifty-patient skilled unit Medicaid would reimburse only 19.5 nursing staff members in twenty-four hours. That is 6.5 positions for each shift with no days off, no vacations, and no personal illness. To add to this nightmare, only two of these 19.5 people may be registered nurses.

The care of any skilled patient could include:

- his bathing (sometimes twice a day)
- getting dressed
- linen change
- three meals (patients can vary, but most need to be fed by the nurse or an aide
- all medicines
- tube feedings
- dressing and medications for decubitus ulcers (bedsores)
- hydration either by mouth, tube or IV
- tracheostomy care
- oxygen
- emotional support to patient

- counselling
- education and support of the family
- complex, voluminous documentation of care

Since much of this must be performed by nurses, the rate of unreimbursed care goes even higher.

Let us remind ourselves that:

- Patient care staffing is the only area of nursing home management linked to reimbursement. (SDOH adopted these rates to insure that profit-making nursing homes would be required by law to provide at least the number of patient care staff for which Medicaid is paying, not to prevent nursing homes from staffing according to their own needs.

Although patients who need all of this care on a twenty-four hour basis are not in the majority, I submit that when they do need this care, they get it in county nursing homes like Roosevelt Hospital. Families of this type of patient tell us that private nursing homes turn them down when the care is too complex. Understandably, these private homes will not be reimbursed for anything over two hours and forty-five minutes. So they choose not to provid it by not admitting the patient.

Long term care facilities under county government do admit these patients and do provide whatever nursing care is needed by the patient. If the concept of peer grouping would address this inequity our patients could only be helped to live safer and more peaceful lives. If peer grouping will reimburse us at a higher rate so we may provide this care in a fiscally responsible manner, I and my staff would welcome it overwhelmingly and support it actively.

Mary Kay Kirschman

Mary Kay Kirschman, RN,CNA,MSN,LN
Assistant Administrator - Nursing
Roosevelt Hospital

Doris Horenkamp RNC, MSN
Gerontological Nurse Practitioner
Assistant Director-Nursing Education
Roosevelt Hospital
Metuchen, New Jersey

This bill proposes a raise in the reimbursement for hours of nursing care for the Medicaid IV B patient. Reimbursement for this level of patient is currently 1.25 hours of nursing care in 24 hours. On a unit with 51 patients, if all were classified level IV B, this would provide three nursing staff members per shift: one licensed nurse and two nurses aides. The nurse would be responsible for administration of all medications and treatments, planning and documentation of nursing care, and supervision of the unlicensed nursing staff. Each aide would be responsible for the physical care of 25 or 26 patients. In each eight hour shift this amounts to a little more than six minutes of the nurse's time and 15 minutes of the nurses aides' time per patient.

The typical patient classified as level IV B at Roosevelt Hospital is:

-between 70 and 80 years old

-has multiple chronic illness (stroke, chronic obstructive airway disease, diabetes, beginning stages of dementia)

-wheelchair bound

-requires assistance or supervision in transferring from bed to chair or chair to toilet

-requires minimal assistance in bathing, dressing, grooming, and feeding

-has some behavioral, emotional or social problems such as agressive behavior, difficulty coping, withdrawal or depression, or problems with communication

Within this one level of care the patients can range from being almost independent in care to requiring assistance with every aspect of care.

If you are familiar with the Medicaid guidelines for nursing care and documentation, you will be aware of the scope of the nursing care nurses

are expected to provide which includes planning, evaluation, supervision, patient and family teaching and counseling, and follow-up of therapy in addition to meeting the basic physical needs. How is it humanly possible to meet the complex needs of these patients in just 21 minutes out of each eight hour shift? It takes more than 21 minutes just to accomplish three transfers. If a patient, upon awakening in the morning, is assisted in transferring from his bed to his wheelchair, then taken to the bathroom and transferred from the wheelchair to the toilet and then back again, he has received his hours of reimbursed nursing care for that eight hours. Where does the time come from to assist him in opening containers on his meal tray, bathing, buttoning buttons, grooming, and making his bed, not to mention any psychosocial interventions which are planned?

Even increasing the hours of reimbursed nursing care to 2.25 hours in 24 hours will not allow time to address all of the needs of these patients, but it is, at least, a step in the right direction. It would raise the number of nursing staff from nine to sixteen in 24 hours and would effectively double the amount of time actually spent with the patient.

NJANPHA
Founded 1971
New Jersey Association of Non-Profit Homes for the Aging
CENTER FOR HEALTH AFFAIRS 760 Alexander Road CN1 Princeton, New Jersey 08540
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COMMENTS OF DENNIS R. HETT, EXECUTIVE DIRECTOR

before the

ASSEMBLY CORRECTIONS, HEALTH AND HUMAN SERVICES COMMITTEE

JUNE 25, 1985

Medicaid reimbursement for nursing home care is based on minimum standards.

Minimum standards means:

- an RN present on the day shift •
- 2.5 hours daily of care from nurses and aides for about 60% of patients •

Nurses are responsible to ...

Supervise, direct and instruct nurse aides as they keep patients clean, dry and comfortable, assist residents who need help in eating;

Observe, evaluate, report to physician patients' symptoms, reactions and progress;

Document patients' symptoms, reactions and progress, as well as all procedures conducted, medications given, etc.;

Ensure patients receive treatments, medications and diets as prescribed;

Keep resident and relatives informed about the resident's condition;

Provide restorative care, encourage independence and assist with prosthetic devices.

Aides provide most direct care, and are responsible to ...

Assist residents with eating, dressing, bathing, grooming, ambulation and travel to activities, therapies, beauty/barber shop, etc.

Encourage socialization and independence;

Report observations to nurses.

Now, when Medicaid rates are set, they are based on homes' compliance with these minimum standards. This means that ...

• MAXIMUMS FOR MEDICAID REIMBURSEMENT ARE BASED ON MINIMUM STANDARDS - payment is based on what it costs your "average" voluntary or proprietary nursing home to provide the minimum amount of nursing care, as required by the Department of Health;

• as a result, the nursing home with a high Medicaid occupancy has a very small "window" (to use the space program term) through which to shoot for quality: there is no cushion between minimum acceptability and limits imposed by Medicaid's payment limitations;

• if a home opts for a higher standard of care [i.e., greater frequency of baths, elimination and prevention of bed sores, more assistance in eating, assistance whenever a resident needs help going to the bathroom (less reliance on diapers), time to deal with wanderers, etc.], Medicaid will not recognize the additional cost, which the home must finance through greater reliance on donations (in voluntary homes), higher rates for private patients or government appropriations (in county homes).

Discussion of minimum standards should address the following issues:

Do the minimum standards promote assistance in toileting and re-training over reliance on diapers and incontinence briefs? Is sufficient staff available to provide changes of clothing after accidents?

How much time spent encouraging residents instead of taking care of them? It takes more time to foster independence and self care than it does to take care of a dependent person. Is there time for training in self care? Do the standards permit time to encourage residents to dress and behave normally?

How many medication errors are the result of the existing minimum standards? Is sufficient time provided for full documentation?

How much extra time is there for nursing staff to help residents with initial adjustments and in crises?

How frequently should patients be bathed? Is staffing sufficient to assist individual residents to bathe in privacy?

The study submitted to the Joint Appropriations Committee on the consolidation of intermediate care into a single level documents the need for an increased staffing allowance to meet the current Manual of Standards. We think that its recommendations move the state in the right direction, and urge consolidation of intermediate care at 2.5 hours of nursing care per day, accompanied by an appropriation, as a means to upgrade nursing home care in New Jersey.

TESTIMONY OF VICTOR KATTAK, CHAIRMAN

COUNTY NURSING HOME ADMINISTRATORS ASSOCIATION

BEFORE THE ASSEMBLY CORRECTIONS, HEALTH AND HUMAN SERVICES COMMITTEE

JUNE 25, 1985

Mr. Chairman and members of the Committee, I am here on behalf of the County Nursing Home Administrators Association to testify on the major issues and merits of the "PEER" Grouping of Governmental Nursing Homes for Medicaid reimbursement purposes. Let me begin by noting that the County Nursing Home Administrators Association enthusiastically supports the implementation of PEER Grouping for governmental nursing homes in the Development of Cost Limitations, or screens of reasonable costs, related to the operations of our nursing homes. The development of new reasonable cost limitations will represent a gigantic step forward in the recognition that governmental nursing homes incur additional costs in the treatment of their patients, who on the whole require more intensive care than patients in non-governmental homes. In many cases we are the only facility which will provide care to the frail and elderly indigent population of the State.

The New Jersey Medicaid Program has instituted a system of cost-related reimbursement to all nursing homes in the State (known as the CARE system). Unfortunately, this system only utilizes costs reported from proprietary and voluntary nursing homes. These costs are then used to establish screens by which the "reasonableness" of expenditures are judged for all nursing homes in the State which participate in the Medicaid program.

County facilities, however, comprise the only nursing home group which has cost data excluded from the development of the reasonableness cost limitations. The State does not utilize the County cost data in the development of "reasonable" reimbursement rates, the County Nursing Homes being reimbursed for Medicaid patients based solely on the cost data from other nursing homes.

In October 1978 the State of New Jersey recognized the inequity to County Nursing Homes of the State's CARE system and initiated correspondence with the Federal Government requesting permission to establish PEER Grouping for County-operated long-term care facilities. As a result of a continuing dialogue through August 1980, the Federal Government indicated its willingness to accept the State's request, if the State would furnish data supporting its position. Unfortunately, the State abandoned its request.

Spearheaded by Jean Sickles of Warren County and supported by the New Jersey Association of Not-for-Profit Homes for the Aging, a group of New Jersey Nursing Home Administrators of County-operated long-term care facilities met in May 1982 with Thomas M. Russo, the Director of the New Jersey Division of Medical Assistance (Medicaid) and his key staff members, to request State support for PEER Grouping.

The Nursing Home Administrators subsequently retained the services of the firm of Samuel Klein and Company of Newark, New Jersey, to assist us in our efforts to obtain acceptance of the PEER Grouping concept. A Position Paper prepared by Samuel Klein and Company, entitled "The Indispensable Need of a PEER Grouping for County-Operated Nursing Homes in the State of New Jersey", was presented to the Department of Human Services in February of 1983. It is this Position Paper which formed the basis for the current support by the Administration for the PEER Grouping concept.

The implementation of PEER Grouping would reimburse the Counties for approximately $20,000,000 of costs which they currently incur, but for which they are not receiving reimbursement. This reimbursement would reduce, but not eliminate, the substantial subsidy that each of the 18 counties which operate a nursing home budgets for the care of indigent patients. As a matter of fact, the Counties would still be subsidizing far in excess of $20,000,000 a year to maintain the patients who would have great difficulty in obtaining, or could not obtain care elsewhere.

I wish to call to your attention that the Counties would be providing the non-federal match of Medicaid funds, so that the implementation of PEER Grouping would have no additional impact upon the budget or expenditures of the State of New Jersey. Adoption of PEER Grouping, however, would provide much needed relief for County taxpayers.

I appreciate the opportunity to make this presentation before the Committee.

TESTIMONY BEFORE THE ASSEMBLY COMMITTEE ON CORRECTIONS, HEALTH AND HUMAN SERVICES BY THE ESSEX COUNTY DEPARTMENT OF HEALTH AND REHABILITATION.

JAMES W. JORDAN, JR.

DEPARTMENT DIRECTOR

JUNE 25, 1985

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE, MY NAME IS JAMES JORDAN. I AM HERE TODAY IN MY CAPACITY AS DIRECTOR OF THE DEPARTMENT OF HEALTH AND REHABILITATION, COUNTY OF ESSEX. I WOULD LIKE TO THANK YOU FOR THE OPPORTUNITY TO SPEAK TO YOU IN SUPPORT OF THE CONCEPT OF PEER GROUPING AMONG GOVERNMENTAL NURSING HOMES FOR MEDICAID REIMBURSEMENT PURPOSES.

ESSEX COUNTY HAS A LONG HISTORY OF PROVIDING QUALITY AND ESSENTIAL HEALTH CARE SERVICES TO ITS RESIDENTS. OVER THE PAST TWO DECADES, THE ESSEX COUNTY GERIATRICS CENTER, A 100% MEDICAID FACILITY, HAS OPERATED AS A LICENSED, SKILLED LEVEL NURSING INSTITUTION IN A HOME-LIKE SETTING FOR THE ELDERLY AND DISABLED IN NEED OF ROUND THE CLOCK MEDICAL AND NURSING SERVICES. THE TOTAL COST OF THESE SERVICES HAS BEEN PROVIDED IN A PARTNERSHIP BETWEEN THE FEDERAL AND STATE MEDICAID PROGRAM AND THE TAXPAYERS OF ESSEX COUNTY. OVER THE YEARS, AS A RESULT OF DECLINING REIMBURSEMENT BY THE MEDICAID PROGRAM, AN INCREASING TAX BURDEN HAS BEEN PLACED ON OUR TAXPAYERS. HOWEVER, ESSEX COUNTY DID NOT COMPROMISE THE QUALITY OF HEALTH CARE IN ITS NURSING HOME AS THE COSTS BECAME GREATER. RATHER, THE COUNTY ACCEPTED ITS RESPONSIBILITY AND HAS LIVED UP TO ITS COMMITMENT.

THE PEER GROUPING CONCEPT RECOGNIZES THAT COUNTY OPERATED NURSING HOMES HAVE HIGHER OPERATING COST. IT PROVIDES SOME MEASURE OF FINANCIAL RELIEF TO COUNTIES OPERATING THESE HOMES. WE ACCEPT ALL PATIENTS AND THUS FOR

MANY, BECOME THE ONLY HOPE FOR QUALITY CARE WHEN THE NEED ARISES.

PEER GROUPING IS A REASONABLE AND FAIR APPROACH TO THE PROBLEM OF HIGHER OPERATING COST FOR COUNTIES. THIS CONCEPT WAS DEVELOPED WITH THE ASSISTANCE OF THE STATE DEPARTMENT OF HUMAN SERVICES, AND IS BASED UPON EQUITABLE FISCAL STANDARDS. BUT IN NO CASE WILL IT COVER THE ENTIRE COST OF MAINTAINING A RESIDENT IN OUR FACILITIES.

AT THE TIME OF DEVELOPMENT, OVER FOUR YEARS AGO, IT WAS MUTUALLY DECIDED NOT TO SEEK THE 50% STATE SHARE OF THE REIMBURSEMENT INCREASE. THE COUNTIES WERE WILLING TO ACCEPT THE ADDITIONAL FEDERAL DOLLARS AND FORGIVE THE STATE ITS SHARE FOR THE ADDITIONAL COST OF PEER GROUPING FOR EACH MEDICAID BED IN A GOVERNMENTAL NURSING HOME. CONSEQUENTLY IT IS ESSEX COUNTY'S POSITION THAT ANY REIMBURSEMENT MONIES GENERATED BY PEER GROUPING SHOULD BE ALLOCATED BY THE COUNTIES TO MEET THE SPECIFIC HEALTH CARE NEEDS WITHIN EACH COUNTY. NEEDS VARY FROM COUNTY TO COUNTY AND ARE BEST IDENTIFIED AT THE LOCAL LEVEL. IN ADDITION, SINCE THE STATE DEPARTMENT OF HUMAN SERVICES HAS AGREED TO THIS CONCEPT WHICH FORGIVES THE STATE ITS FISCAL RESPONSIBILITY, WE BELIEVE THE STATE SHOULD NOT THEN DICTATE A USE OF THE FEDERAL DOLLARS THAT DIFFERS FROM THE ORIGINAL INTENT.

ESSEX COUNTY HAS LONG RECOGNIZED THE IMPORTANCE OF COMMUNITY-BASED HEALTH CARE SYSTEMS, AND HAS BEEN AN ACTIVE PARTICIPANT IN THE DEVELOPMENT OF MANY PROGRAMS AND SERVICES THAT ADDRESS THE HEALTH CARE NEEDS OF OUR 850,000 RESIDENTS.

OUR PROGRAMS COVER THE FULL SPECTRUM OF SERVICES FROM PRENATAL CARE TO HOMEMAKER SERVICES FOR THE ELDERLY, AS WELL AS PSYCHIATRIC SERVICES IN AN INSTITUTIONAL AND COMMUNITY-BASED SETTING. WE RECOGNIZE THE NEED TO FURTHER EXPAND THESE SERVICES. HOWEVER, PEER GROUPING WAS INTENDED TO HELP COUNTIES MAINTAIN EXISTING SERVICES. WE ENCOURAGE THIS COMMITTEE TO HELP COUNTIES MAINTAIN THESE MUCH NEEDED SERVICES. WE BELIEVE THAT WE HAVE THE TRACK RECORD AND THE COMMITMENT TO CONTINUE TO ADDRESS THE HUMAN, SOCIAL AND HEALTH CARE NEEDS IN OUR COUNTY. ESSEX COUNTY IS ALSO CONFIDENT THAT ITS SISTER COUNTIES HAVE THE UNDERSTANDING OF THEIR NEEDS TO ALLOCATE THEIR FUNDS APPROPRIATELY. EACH COUNTY MUST HAVE THE FLEXIBILITY TO ADDRESS AND RESOLVE ISSUES AND CONCERNS CONTAINED WITHIN ITS BOUNDARIES.

AS IN THE PAST, ESSEX COUNTY WILL CONTINUE TO WORK WITH THE AGENCIES AND DEPARTMENTS OF THE STATE OF NEW JERSEY FOR THE BEST INTERESTS OF ITS COUNTY RESIDENTS. THE CONCEPT OF PEER GROUPING WOULD NOT BE AN ITEM FOR DISCUSSION TODAY IF THERE HAD NOT BEEN ACTIVE SUPPORT OF THE ORIGINAL CONCEPT BY THE STATE MEDICAID OFFICIALS. LET US CONTINUE TO SUPPORT PEER GROUPING AND RELIEVE THE TAXPAYERS OF AN ADDITIONAL UNNECESSARY TAX BURDEN BY INSURING THE ADOPTION OF LEGISLATION THAT ADHERES TO THE ORIGINAL CONCEPT.

TODAY, HOME RULE IS ALSO AN ISSUE HERE. YOU, AS LEGISLATORS, RECOGNIZE THE TALENTS OF COUNTY GOVERNMENTS TO

PROVIDE QUALITY MANDATED SERVICES FOR THEIR RESIDENTS. YOU ALSO RECOGNIZE THE NEED TO MAINTAIN A STABLE TAX BASE. PEER GROUPING REIMBURSEMENTS WILL BE A BENEFIT TO ALL IF THE COUNTIES ARE ALLOWED TO MANAGE THEIR MONIES. WE IN ESSEX COUNTY SUPPORT THE POSITION OF THE STATE DEPARTMENT OF HUMAN SERVICES TO INCREASE FUNDING TO COMMUNITY-BASED HEALTH CARE PROGRAMS, BUT WE CANNOT SUPPORT THE UTILIZATION OF PEER GROUPING REIMBURSEMENTS FOR THOSE INITIATIVES.

THANK YOU FOR THE OPPORTUNITY TO PRESENT OUR POSITION ON THE IMPORTANT ISSUE OF PEER GROUPING.

June 24, 1985

S T A T E M E N T

MY NAME IS ROBERT KNAPP AND I AM THE ASSISTANT TO WILLIAM J. JONES, DIRECTOR OF THE HUDSON COUNTY DEPARTMENT OF HEALTH AND SOCIAL SERVICES. I HAVE, IN THIS CAPACITY, BEEN REQUESTED TO TESTIFY HERE TODAY ON HIS BEHALF AND ALSO ON BEHALF OF EDWARD F. CLARK, HUDSON COUNTY EXECUTIVE.

IN HUDSON COUNTY, WE OPERATE TWO (2) FACILITIES WHICH ARE EFFECTED BY THE PROPOSED LEGISLATION. ONE, B.S. POLLAK HOSPITAL IS LOCATED IN JERSEY CITY. THE OTHER IS HUDSON COUNTY MEADOWVIEW HOSPITAL, LOCATED IN SECAUCUS, NEW JERSEY. B.S. POLLAK HOSPITAL IS A GERIATRIC FACILITY, OPERATING 460 BEDS. HUDSON COUNTY MEADOWVIEW HOSPITAL IS A SPECIAL HOSPITAL, OPERATING 550 LONG TERM NURSING AND INTERMEDIATE CARE BEDS AND ALSO OPERATING 70 PSYCHIATRIC HOSPITAL LEVEL BEDS. IN ADDITION, WE WILL SHORTLY BE OPENING 24 SUBSTANCE ABUSE DETOXIFICATION BEDS.

BOTH FACILITIES ARE ALMOST ENTIRELY DEDICATED TO SERVING THE MEDICAID ELEIGIBLE PATIENT. AS A CONSEQUENCE, BOTH FACILITIES HAVE RECEIVED REIMBURSEMENT FROM THE MEDICAID PROGRAM WHICH HAS NOT MET THE COST OF OPERATIONS, SINCE MEDICAID, UNDER ITS REIMBURSEABLE FORMULA, HAS NOT FULLY RECOGNIZED THE COST OF THE OPERATION OF THE FACILITIES. IN FACT, BOTH FACILITIES OPERATIONS HAVE BEEN SUBSIDIZED BY THE COUNTY TAXPAYERS TO APPROXIMATELY 30% OF THE COST OF PROVIDING THE SERVICE. THIS, IN EFFECT, IS SUBSIDIZING THE MEDICAID PROGRAM - OBVIOUSLY AN UNFAIR BURDEN TO BE PLACED ON THE SHOULDERS OF THE TAXPAYERS OF HUDSON COUNTY, SINCE THEIR TAXES ARE RAISED THROUGH THE REAL ESTATE TAX, WITH ALL THE SEQUENTIAL PROBLEMS ARISING THEREFROM.

OPPONENTS OF THE PEER GROUPING FOR COUNTY FACILITIES MIGHT SUGGEST THAT IT IS UNFAIR FOR THE COUNTY TAXPAYERS TO BE RECOGNIZED FOR PEER GROUPING AND REIMBURSEMENT. HOWEVER, AN OBJECTIVE AND ANALYTICAL LOOK AT FACILITIES SUCH AS THE HUDSON COUNTY OPERATIONS, WOULD CLEARLY DEMONSTRATE THE JUSTICE OF OUR POSITION.

FIRST AND FOREMOST IS THE PROVISION OF HIGH QUALITY MEDICAL SERVICES WHICH ARE NOT REIMBURSED BY MEDICAID. PARTICULAR REFERENCE IS MADE TO A FULL COMPLEMENT OF MEDICAL AND SPECIALTY PHYSICIANS' SERVICES. BOTH COUNTY FACILITIES EMPLOY A FULL STAFF OF SALARIED PHYSICIANS FOR WHOM NO FEE IS CHARGED. NOR IS ANY PAYMENT MADE BY THE MEDICAID PROGRAM. X-RAY AND, TO A LARGE EXTENT, CLINICAL LABORATORY SERVICES ARE PROVIDED BY THE FACILITIES. HERE AGAIN, NO CHARGE IS MADE, NOR ARE ANY MONIES PAID BY THE MEDICAID PROGRAM. COMPARED TO THE PRIVATE SECTOR FACILITY WHICH GENERALLY ONLY PROVIDE THE SERVICES OF A PART-TIME PHYSICIAN, THE PROVISION OF A FULL TIME, PAID MEDICAL STAFF CONSISTING OF SOME 22+ PHYSICIANS AND CONSULTANTS, IS NOT EVEN A DEBATABLE ISSUE IN OUR OPINION. IN MOST OTHER FACILITIES THE SERVICES OF THE SO-CALLED PROFESSIONAL COMPONENTS ARE PAID FOR BY AN ARRANGEMENT CALLED, "FEE FOR SERVICE" WHEREIN THE PHYSICIANS AND RADIOLOGISTS BILL FOR THAT SERVICE SO THAT THESE COSTS ARE ADDED ADDITIONALLY TO THE COST OF THE FACILITY AND DO NOT SHOW IN THE COST OF THE OPERATION OF THE SO-CALLED PRIVATE SECTOR FACILITY.

IT HAS BEEN RECOMMENDED THAT THE HUDSON COUNTY FACILITIES PROVIDE MEDICAL STAFF SERVICES THROUGH THE FEE FOR SERVICE ARRANGEMENT AND THEREBY REDUCE THE COST TO THE COUNTY. IN OUR OPINION, THIS REVERTS TO A "SUPERMARKET MEDICINE" APPROACH. THE FACT OF THE MATTER IS

THAT MOST FACILITIES CANNOT OBTAIN THE SERVICES OF A FULL COMPLEMENT OF PHYSICIANS TO CARRY OUT THE NECESSARY MEDICAL WORK ON A FEE FOR SERVICE BASIS. PART OF THE ABUSE ISSUE CAN BE TRACED DIRECTLY TO A LACK OF PHYSICIAN CARE IN LONG TERM CARE FACILITIES. WITH AN ONSET OF THE DRG REIMBURSEMENT, THE LONG TERM CARE FACILITIES ARE RECEIVING PATIENTS WHO ARE MUCH MORE ILL THAN IN THE PAST. IN EFFECT, MANY NURSING HOMES ARE BECOMING MORE HOSPITAL THAN NURSING HOMES. IN THIS ENVIRONMENT THE PHYSICIANS' SERVICES ARE MORE IMPORTANT NOW THAN IN THE PAST. A FEE FOR SERVICE ARRANGEMENT UNDER MEDICAID, AT SUCH A POOR LEVEL AND WITH THE ANTAGONISM OF THE MEDICAL FAMILY TOWARD MEDICAID, DOES NOT, CANNOT AND WILL NOT PROVIDE A RESPONSE TO THE NEEDS OF PATIENTS WITHIN LONG TERM CARE FACILITIES.

LOOK AT THE HISTORY - LOOK AT THE FACTS. IN HUDSON COUNTY WE HAVE NOTED AND WE ARE ASSURED THAT THE MEDICAID FEE FOR SERVICE REDUCES THE AVAILABILITY OF NEEDED PHYISICIAN CARE.

SECOND, THE TYPE OF PATIENT WHO IS THE USUAL GUEST OF THE COUNTY FACILITY IS THE PATIENT WHO, IN MANY INSTANCES, IS FOUND TO BE UNWELCOME IN MOST PRIVATE FACILITIES. TOO OFTEN THE PATIENT REQUIRING EXTENSIVE AND/OR INTENSIVE NURSING CARE OR STAFF ATTENTION IS AN UNDESIRABLE ADMISSION TO OTHER FACILITIES AND A COUNTY FACILITY IS THE PLACEMENT OF LAST RESOURCE. PATIENTS WHO REQUIRE BEHAVIORAL MODIFICATION TECHNIQUES BECAUSE OF THEIR ABBERATIONAL CONDUCT ARE MOST OFTEN SENT TO COUNTY FACILITIES BECAUSE ADMISSION TO PRIVATE SECTOR FACILITIES IS BARRED. OR, IF ADMITTED TO A PRIVATE FACILITY, THEY ARE SOON DISCHARGED TO GOVERNMENT CLASSIFIED UNITS.

THE STATE OF NEW JERSEY HAS TRIED DESPARATELY TO DISCHARGE PATIENTS FROM THE STATE PSYCHIATRIC HOSPITALS WHEN THESE PATIENTS WERE DETERMINED NO LONGER TO REQUIRE HOSPITALIZATION. HUNDREDS OF THESE PATIENTS WERE DETERMINED TO NEED INTERMEDIATE CARE OR SHELTERED BOARDING. THE LICENSING AUTHORITY FOR LONG TERM CARE FACILITIES REQUIRED THAT NURSING HOMES AND INTERMEDIATE CARE FACILITIES, AS A REQUIREMENT FOR LICENSING, TAKE CERTAIN NUMBERS OF FORMER PSYCHIATRIC HOSPITAL CASES. TO DATE, FEW - IF ANY - HAVE ACQUIESED TO ADMITTING PATIENTS FROM LARGE PSYCHIATRIC FACILITIES. HUDSON COUNTY HAS ADMITTED DOZENS OF OUR CITIZENS FROM BOTH TRENTON STATE PSYCHIATRIC HOSPITAL AND OTHER STATE HOSPITALS WHEN THE MEDICAL AND PSYCHIATRIC DETERMINATION WAS THEY NO LONGER NEEDED A PSYCHIATRIC HOSPITAL LEVEL OF CARE. THE PARADOX IN DOING THIS, HOWEVER, IS THAT MOST OF THESE PATIENTS REQUIRE INTENSIVE STAFF SUPERVISION AND BEHAVIORAL MODIFICATION AND, AS A RESULT, THE INSPECTORS FROM THE MEDICAID PROGRAM CRITICIZE US BECAUSE THE PATIENTS DO NOT CONFORM TO THE USUAL PATTERNS OF ACTIVITY. CONSEQUENTLY, WE IN GOVERNMENT FACILITIES FIND OURSELVES IN A CATCH 22 WHERE WE TRY TO TAKE IN THE MEDICALLY AND PSYCHOLOGICALLY HOMELESS IN NEED OF LONG TERM CARE AND TAKE IN THOSE WHO NO ONE ELSE WOULD CARE FOR AND YET, BECAUSE WE ARE GOVERNMENT, WE ARE NOT ACCEPTED TO RECEIVE RECOGNITION, NEITHER IN PROGRAM OR REIMBURSEMENT FROM OTHER THIRD PARTY PAYMENT PROGRAMS. WE FEEL THIS IS UNEQUIVOCABLY AND TOTALLY UNFAIR.

THIRD, THE COST OF OPERATING GOVERNMENT FACILITIES BECAUSE OF THE PARTICULAR CASE LOADS THEY ARE REQUIRED TO SERVE, IS INORDINATELY HIGHER THAN THE PRIVATE SECTOR, AS DEMONSTRATED BY THE REQUIRED SUPERVISION OF THE TYPE OF PATIENTS ADMITTED; AND,

FOURTH, THE GOVERNMENT FACILITIES ARE MORE COSTLY TO OPERATE BECAUSE INVARIABLY THE FACILITIES ARE UNIONIZED AND COME UNDER THE RULES AND REGULATIONS OF CIVIL SERVICE. THE COST OF EMPLOYEE BENEFITS GENERATED UNDER THESE DOUBLE EMPLOYEE ASSOCIATIONS IS AN ADMINISTRATION COST FACTOR OF APPROXIMATELY 20 TO 25% OVER AND ABOVE THE PRIVATE SECTOR OPERATIONS.

BECAUSE OF THE SHORT TIME THAT WAS AVAILABLE FROM THE POINT OF RECEIVING THE NOTICE OF THIS MEETING; i.e., JUNE 21, 1985, WE WERE UNABLE TO PREPARE A MORE DETAILED STATEMENT BUT WE FEEL IT IS IMPORTANT THAT WE EXPRESS OUR SUPPORT OF THE PEER REVIEW CONCEPT FOR THE FINANCING OF LONG TERM CARE FACILITIES.

HOWEVER, IT IS IMPORTANT THAT WE ALSO POINT OUT A CAVEAT IN THAT WE STRONGLY OBJECT TO THE METHOD THE STATE HAS CHOSEN TO PERMIT THE FUNDING OF PEET GROUPING AND MEDICAID PAYMENT. IT IS OUT UNDERSTANDING THAT, IN ORDER FOR THE PEER GROUPING PAYMENT TO BE MADE UNDER THE MEDICAID PROGRAM, THE COUNTIES WOULD BE REQUIRED TO PAY THE 50% STATE SHARE OF THE MEDICAID DOLLARS IN ORDER TO DRAW DOWN THE 50% FEDERAL DOLLARS. WE STRONGLY OBJECT TO THE STATE SUBTERFUGE AND THE EFFORT TO PUT THE COUNTIES INTO THE MEDICAID PAYMENT BUSINESS.

ONCE BEFORE, THE STATE DEPARTMENT OF HUMAN SERVICES IN THE ICF/MR PROGRAM MISLED THE STATE LEGISLATURE AND CREATED A PROGRAM WHEREBY THE ICF PROGRAM WAS CREATED UNDER THE SUBTERFUGE OF BRINGING IN FEDERAL DOLLARS. HOWEVER, A REVIEW OF THAT PROGRAM WILL CLEARLY SHOW THAT, WHILE SOME FEDERAL DOLLARS WERE BROUGHT INTO THE STATE OF NEW JERSEY, THE COUNTIES WERE STILL BILLED ADDITIONAL MONIES FOR THE

CARE OF THE PATIENTS AND THERE WAS NO REDUCTION IN THE COST OF OPERATIONS, MAKING IT APPEAR AS THOUGH NO FEDERAL MONIES WERE RECEIVED. IN EFFECT, EVEN WHILE SOME MONIES WERE BROUGHT INTO THE STATE, THESE MONIES DID NOT REDUCE THE COST OF OPERATIONS TO THE COUNTIES OR THE TAXPAYERS. CONSEQUENTLY, WE HAVE CONCERN THAT THE SUGGESTED METHOD OF PAYING FOR THE LEGISLATION THROUGH MEDICAID NOT BECOME ANOTHER "MONKEY TRAP" AND THAT THE COUNTIES, ONCE AGAIN, BE PUT IN A POSITION OF PAYING FOR MEDICAID WHEN CLEARLY THE ENABLING LEGISLATION FOR MEDICAID DEMANDED THAT MEDICAID BE A STATE/FEDERAL PROGRAM WITHOUT COUNTY PARTICIPATION.

IN REFERENCE TO THE ANNOUNCEMENT FOR THIS PUBLIC HEARING, REFERENCE WAS MADE TO OTHER STATE LEGISLATION.

AS A REPRESENTATIVE OF MR. CLARK AND DIRECTOR JONES, AND PERSONALLY, WE FEEL VERY STRONGLY ABOUT THE PROPOSED PIECE OF LEGISLATION CONCERNING DEFICIENCIES AND THE WITHHOLDING OF MEDICAID MONIES THAT HAD BEEN PUBLICIZED IN THE LOCAL PAPERS. WE OBJECT STRONGLY TO ANY LEGISLATION THAT WOULD WITHHOLD MEDICAID MONIES FOR A LITANY OF DEFICIENCIES AS PROMULGATED EITHER BY THE DEPARTMENT OF HEALTH OR MEDICAID PERSONNEL. WE FEEL THAT THERE IS A COMPLETE MISUNDERSTANDING AS TO THE USE OF DEFICIENCY REPORTS AND THE MEANING OF DEFICIENCIES OR, IN FACT, THE FAIRNESS OF DEFICIENCIES. MANY DEFICIENCIES HAVE TO DO WITH THE GEOGRAPHY AND ARCHITECTURE OF THE FACILITIES. CONSEQUENTLY, THE HUDSON COUNTY FACILITIES, BECAUSE OF THEIR NATURE, ARE ONLY SUBJECT TO DEFICIENCIES AND CRITICISMS. WE, OBVIOUSLY, WOULD OBJECT TO THE WITHHOLDING OF MEDICAID FUNDS UNTIL A NEW STRUCTURE IS BUILT.

WE ALSO OBJECT TO THE INTERPRETATION OF THE 514 STANDARDS THAT ARE NOT UNIFORMLY SUBJECT TO INTERPRETATION THAT ONE INSPECTOR MAY FIND AS A DEFICIENCY AND ANOTHER INSPECTOR NOT FIND AS A DEFICIENCY. FURTHER, WE WOULD OBJECT TO THE WITHHOLDING OF FUNDS THAT WOULD PERMIT THE CORRECTION OF DEFICIENCIES. WE FIND IT MOST UNUSUAL THAT THE LEGISLATION WOULD WITHHOLD MONEY FOR CORRECTION OF DEFICIENCIES FOR LONG TERM CARE FACILITIES AND MAKE NO REFERENCE TO THE SAME DEFICIENCIES IN HOSPITALS. IT IS OUR CONSIDERED OPINION THAT THE PUBLIC HAS A RIGHT TO KNOW WHAT DEFICIENCIES EXIST IN THE HEALTH FIELD. AT PRESENT THE INSPECTION OF HOSPITALS AND THE DEFICIENCIES FOUND THERE ARE PUBLISHED TO NO MAN OR FACILITY AS THEY ARE IN LONG TERM CARE FACILITIES. CONSEQUENTLY, IT WOULD APPEAR THAT WHAT IS DONE FOR NURSING HOMES AND LONG TERM INTERMEDIATE CARE FACILITIES SHOULD BE DONE FOR HOSPITALS. THEREFORE, IF YOU FEEL THAT THE REMEDY FOR QUALITY OF CARE IN NURSING HOMES REQUIRES YOU TO WITHHOLD MONIES ON THE REPORTING OF DEFICIENCIES BY THE HEALTH INSPECTORS, THEN WHY NOT DO THE SAME FOR THE REPORT OF DEFICIENCIES WITHIN GENERAL HOSPITALS IN OUR COMMUNITY?

IT IS ALSO INTERESTING TO SEE THAT THE FACILITIES IN BERGEN COUNTY WHERE THE ALLEGED ABUSES TO PATIENTS TOOK PLACE SHOULD HAVE BEEN VISITED ALMOST ON A DAILY BASIS BY THE MEDICAID NURSES. WE QUESTION WHY IT TOOK SO LONG FOR THE ALLEGED ABUSES TO SURFACE. WE CANNOT UNDERSTAND WHY PATIENT ABUSE TO THE EXTENT AS REPORTED, WOULD HAVE TAKEN SO LONG TO COME TO THE SURFACE. WE THINK AN INVESTIGATION SHOULD BE REQUESTED TO FIND OUT WHY THESE ALLEGED ABUSES WERE SO LONG IN BEING DISCOVERED.

WE ALSO, IN HUDSON COUNTY, FEEL OBLIGATED TO OUR SENIOR CITIZENS AND CITIZENS WHO REQUIRE HEALTH CARE FROM ALL FACETS AND WE CERTAINLY WOULD APPRECIATE OUR LEGISLATORS PROCEEDING WITH US FOR THE BETTERMENT OF HEALTH CARE. WHILE PEOPLE IN BERGEN COUNTY HAVE COUNTY FACILITIES WE PEOPLE IN HUDSON HAVE PROBABLY MORE PROBLEMS THAN THEY WHO HAVE MORE RESOURCES THAN HUDSON COUNTY, SINCE WE HAVE THE LOWEST PER CAPITA INCOME OF ANY COUNTY IN NEW JERSEY. WE CERTAINLY WOULD APPRECIATE LEGISLATIVE ASSISTANCE IN HUDSON COUNTY AND, WHILE WE ARE VERY INTERESTED IN SEEING THAT OUR LEGISLATORS ARE BEING PALADINS FOR THE ABUSES IN BERGEN COUNTY AND HOLDING PUBLIC HEARINGS IN MIDDLESEX AND OTHER COUNTIES, WE WOULD APPRECIATE THEIR COMING TO HUDSON COUNTY AND GIVING US THEIR EAR AND SUPPORT TO HELP US IMPROVE OUR SERVICES.

ON BEHALF OF MR. CLARK, DIRECTOR JONES AND MYSELF, I THANK YOU FOR THE OPPORTUNITY TO PRESENT OUR VIEWS.

TESTIMONY OF NATHAN HONIG, PARTNER, SAMUEL KLEIN AND COMPANY

BEFORE THE ASSEMBLY CORRECTIONS, HEALTH AND HUMAN SERVICES COMMITTEE

JUNE 25, 1985

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

I am a partner in the firm of Samuel Klein and Company, Certified Public Accountants, of Newark, New Jersey. Our firm was retained by the County Nursing Home Administrators Association to provide technical assistance in documenting the undeniable need for increased Medicaid reimbursement for Government-operated nursing homes. We presented our findings in a Position Paper dated February 22, 1983, entitled "The Indispensable Need of a PEER Grouping for County-Operated Nursing Homes in the State of New Jersey". For your immediate reference, copies of the Position Paper are attached to copies of this testimony.

The New Jersey Medicaid Reimbursement Plan makes no additional financial allowance for the unique circumstances under which counties operate nursing homes for the care of the State's indigent. The present Plan costs New Jersey taxpayers over $20,000,000 a year of additional Federal reimbursement for the nursing care of the medically needy, by imposing the same ceiling on reimbursement for County nursing home costs as for proprietary and voluntary homes.

County nursing homes accept medically indigent patients to the full extent of their available capacity. In many parts of the State, it is only the County nursing home that will accept a new patient, whose sole resources come from the Medicaid program. As a result, almost all of the patients in County nursing homes are covered by Title XIX, Medicaid and, as indicated in the attached Position Paper, many county homes care for virtually 100% Medicaid patients. These patients have nowhere else to go and County homes are their "last resort".

This patient population often requires a more intensive treatment program and other special considerations. An example of special costs and considerations is that of the superb care that Karen Anne Quinlan received at Morris View Nursing Home, a Morris County facility, which over the years cost the County of Morris hundreds of thousands of dollars in excess of the reimbursement from the Medicaid program.

The case for PEER Grouping is well documented in our report. The Governor, in his State-of-the-State message, recommended its adoption. I urge you and your Committee, Mr. Chairman, to come to the same conclusion.

I wish to express my appreciation for the opportunity to appear before the Committee.

MEDICAID REIMBURSEMENT POSITION PAPER

THE INDISPENSABLE NEED OF A PEER GROUPING
FOR
COUNTY OPERATED NURSING HOMES
IN THE
STATE OF NEW JERSEY

FEBRUARY 22, 1983

SAMUEL KLEIN AND COMPANY
CERTIFIED PUBLIC ACCOUNTANTS

MEDICAID REIMBURSEMENT POSITION PAPER

THE INDISPENSABLE NEED OF A PEER GROUPING

FOR

COUNTY OPERATED NURSING HOMES

IN THE

STATE OF NEW JERSEY

FEBRUARY 22, 1983

SAMUEL KLEIN AND COMPANY
CERTIFIED PUBLIC ACCOUNTANTS

THE PREAKNESS HOSPITAL

Passaic County, New Jersey
P. O. Box V
Paterson, New Jersey 07509
(201) 942-6800

February 22, 1983

Thomas M. Russo, Director
Division of Medical Assistance and
Health Services
State of New Jersey
Department of Human Services
CN-712
324 East State Street
Trenton, New Jersey 08625

Dear Mr. Russo:

Thank you for your staff's participation, guidance and cooperation with the County Nursing Home Administrators objective to obtain separate Medicaid nursing home screens based on data supplied by County Nursing Homes. The attached Position Paper documents the reasons why we, the County Nursing Home Administrators, believe that our unique situation warrants the establishment of separate "peer-grouping" screens as developed within the present Cost Accounting and Rate Evaluation ("CARE") methodology presently utilized for nursing home Medicaid rate setting.

THE COUNTIES' POSITION

As presented in the attached Position Paper, the justification for this request is that County Nursing Homes have unique problems in operations, age of facility, the number of "long-time" employees and patient "type", all of which result in additional essential costs.

The New Jersey Medicaid Reimbursement Plan makes no financial allowance for the unique situation which County operated nursing homes have in the care of the State's indigent. The present Plan costs New Jersey taxpayers millions of dollars of additional Federal reimbursement for the nursing care of the medically needy by imposing the same ceiling on reimbursement for County nursing homes as on proprietary (private) and voluntary (non-profit) homes. The added tax burden is difficult if not impossible for the Counties to obtain under the present "CAP" restrictions. Any reimbursement reductions to the Medicaid program will have a far-reaching adverse impact on patients in County homes and taxpayers in New Jersey.

The Counties alone cannot resolve the issues related to equitable "reasonable cost" for Medicaid reimbursement. This responsibility is shared jointly by the State and Federal Governments. In this time of fiscal austerity, government policymakers face difficult choices; but decisions must be made realizing that the Counties cannot continue to offer Medicaid patients adequate nursing home care unless equitable reimbursement is provided. Accordingly, it could be a matter of survival and certainly a question of the continuation of quality care that the Counties are requesting Medicaid per diem reimbursement for patient services which are reasonable and adequate to meet the costs which must be incurred.

These reimburseable costs should be established solely for County homes by creating a Peer grouping to consider the special circumstances of County homes which serve a disproportionate number of low income patients with special needs. Fair per diem reimbursement is absolutely necessary to have Medicaid patients receive quality service.

THE PROBLEM WITH THE PRESENT REIMBURSEMENT SYSTEM

On January 1, 1978, the New Jersey Medicaid Program instituted a system of cost-related reimbursement to all nursing homes in the State (known as the CARE system). Unfortunately this system only utilizes costs reported from proprietary and voluntary nursing homes with more than 20% Medicaid patient days. These costs were then used to establish screens by which the "reasonableness" of expenditures was judged for all nursing homes in the State which participate in the Medicaid program. Costs deemed to be unreasonable (in excess of the screens) were not reimbursed.

County facilities, however, comprise the only nursing home group which has cost data excluded from the development of the reasonableness cost limitations. The State does not include County nursing home data in the development of Medicaid reimbursement rates, contending that County nursing home costs are higher than other nursing homes in the State. Although the State does not utilize the County cost data in the development of "reasonable" reimbursement rates, the Counties are reimbursed by the State for the care and maintenance of Medicaid patients based solely on the cost data from other nursing homes.

It is a known fact that proprietary facilities with unreimbursed costs usually shift these costs to their private-patient rate scales (or occasionally back onto Medicaid through the "hardship appeal"). Non-profit facilities have charitable contributions to make up any deficit, but County homes are forced to make up the difference with appropriations, etc. financed through property taxes.

BACKGROUND

In October 1978 the State of New Jersey recognized the inequity of the State's CARE system to County Nursing Homes and initiated correspondence with Region II of the Department of Health, Education and Welfare (now HHS) requesting permission to establish a peer grouping for County operated long-term care facilities within the Nursing Home Medicaid reimbursment methodology. As a result of various communications through August 1980, HHS indicated willingness to accept the State's request if the State would furnish data supporting its position. Subsequently, the State abandoned its request and nothing further was done on this matter.

Spearheaded by Jean Sickles of Warren County and supported by the New Jersey Association of Not-for-Profit Homes for the Aging, a group of New Jersey Nursing Home Administrators of County-operated long-term care facilities met in May 1982 with Thomas M. Russo, the Director of the New Jersey Division of Medical Assistance (Medicaid) and his key staff members to discuss State support for the County's position. It was decided to renew the request for establishing a peer grouping of reasonable costs solely for County operated facilities. A listing of County Nursing Home Administrators and other participants is attached. Additionally, the Commissioner of the Department of Human Services indicated his support of the County's efforts in his July 2, 1982 response to William Stilwell, Administrator of John E. Runnels Hospital is also attached.

SHORTAGE OF NURSING HOME BEDS IN THE STATE

There is a severe shortage of nursing beds in the State. In the recently released message from Commissioner Albanese to the newly established Nursing Home Task Force, he stated,

> "The Medicaid Nursing Home waiting list, compiled monthly by the Division of Medical Assistance and Health Services, has averaged about 3,000 patients over the past several years. About a third of the waiting list at any point is awaiting placement from a general hospital, a bit less than a third is in the community, and the balance is (discharged) pending placement from State or County psychiatric hospitals. In addition to the 3,000 known patients awaiting nursing home placements, there are many other potential patients who may have been discouraged from seeking admission due to the highly publicized waiting list."

Additionally, major revisions of the Tax Equity and Fiscal Responsibility Act of 1983 (TEFRA) could have a significant impact upon increasing the shortage of nursing home beds in the State. The aspect of TEFRA which will affect New Jersey hospitals and impact adversely the need for nursing home beds is the elimination of separate cost limits for hospital-based and free standing facilities. Previously, hospital-based SNF units were allowed higher Medicare cost limits than free standing units. TEFRA no longer distinguishes between the two types of units. Effective retroactively to October 1982, hospital based SNF units will be reimbursed at a lower rate. Undoubtedly the Hospitals will seek to eliminate services to patients requiring nursing home care, thereby placing a greater strain upon the remaining nursing home providers.

Many of the non-County nursing homes restrict Medicaid participation by limiting the number of such patients whom they will accept to 5% of total beds, restricting the physical disabilities they will treat, requiring private placement for periods of time before accepting Medicaid or minimizing the length of stay of such Medicaid patients. Some impose a combination of those limitations. This action of non-County nursing homes is primarily due to the ceilings placed on the Medicaid per diem reimbursement in which current payments are limited by the development of cost limitation screens. As a result, placement of "undesirable" patients including those whose only resource is Medicaid is extremely limited throughout New Jersey.

Conversely, County nursing homes must accept such patients to the full extent of their available capacity. In many parts of the State, only the County homes will accept a new patient whose sole resources come from the Medicaid program. As a result, almost all (at least 93.0 percent) of the patients in County nursing homes are covered by Title XIX, Medicaid. As indicated in the attached Position Paper, many County homes have virtually 100% Medicaid patients. The County homes are "the last resort" for these patients; there is nowhere else they can go and yet Medicaid per diem rates are developed without the inclusion of County data.

Our analysis of the current allowable reimbursement revealed that except for the Nursing Home Administrator and Assistant Administrator screens, County Nursing Homes are in excess of all of the "reasonableness" limits (screens). However, County homes do not have the ability to recoup deficiencies in their reimbursement from private pay patients, nor can they receive subsidies from charitable contributions. The additional funds to provide care for Medicaid patients in County homes come almost entirely from County property taxes.

SUGGESTED PLAN OF ACTION

Based upon an inter-office communication dated October 16, 1978 to the Director of the Division of Medical Assistance (Medicaid) entitled "Reimbursement of Screened-Out Cost to County Nursing Homes" from Chaim S. Gold:

> "The HEW Region II office indicated that it would consider screening nursing homes by peer groups as long as the groups were legitimate and not designed to take advantage of the reimbursement regulations to the unreasonable benefit of a single institution. I inquired specifically if it would be acceptable to establish screens separately for the nineteen county nursing homes in New Jersey, separate and discreet from the screens used collectively for the proprietary and voluntary nursing homes, and it was indicated that this would be acceptable. Seymour Budoff of HEW Region II subsequently confirmed the Federal government's willingness to accept this concept."
>
> "In order to improve our data for decision-making, and in order to have rates available in an appropriate format, should we decide to pay them, I met last week with Jim Hub of the Health Economics Service; we discussed the proposal, he indicated his strong support and reiterated his previous support of this concept...."

IMPLEMENTATION STEPS

We recognize the number of steps which must be taken before implementing such a change in the reimbursement system, such as:

1) This important issue will have to be taken directly to the Commissioner for a decision.

2) The change must be submitted to the HHS Regional Office and approved thereof.

3) The proposed change must be submitted to the New Jersey Register for comment.

4) The State Plan amendment must be formulated and submitted.

5) Rates must be struck and promulgated. Mechanical complexities may develop and must be worked out, preferably in advance.

6) Internal administrative procedures for implementing the rates, especially any retroactive adjustments, also must be worked out.

* * *

Again, thank you for your support and that of Richard Speranza, Chief, Long-Term Care Rate Setting Unit. Should you have any questions regarding the attached Position Paper, I or the participating members of Samuel Klein and Company, will be pleased to respond.

Very truly yours,

Victor R. Kattak
Executive Director

VRK:ea
Encl/

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
CAPITAL PLACE ONE
222 SOUTH WARREN STREET
TRENTON, NEW JERSEY 08625

GEORGE J. ALBANESE
Commissioner

Walter E. Ulrich
Deputy Commissioner

July 2, 1982

Mr. William M. Stilwell
Hospital Administrator
John E. Runnells Hospital
Berkeley Heights, New Jersey 07922

Dear Bill:

Thank you for your letter of June 21, 1982 on the subject of equitable Medicaid per diem rates for County long term care facilities. As you know, this is an area in which I am most interested, but have certain limitations at this time because of the tremendous budgetary problems.

The possibility of developing a unique set of per diem rates for the County institutions was discussed at one of my meetings last week with senior staff and it was indicated that the only way higher per diems could be obtained would be to identify the unique factors that are cost related to County facilities. If this can be accomplished, it would also be necessary to identify a manner in which the additional State share of any increased costs would be handled. Perhaps it might be possible to utilize some portion of County funds for this purpose. This is an area in which I am looking into at the present time.

Best regards.

Sincerely yours,

George J. Albanese
Commissioner

GJA:2

c.c. Larry Lockhart

MEDICAID REIMBURSEMENT POSITION PAPER

THE INDISPENSABLE NEED OF A PEER GROUPING

FOR

COUNTY OPERATED NURSING HOMES

IN THE

STATE OF NEW JERSEY

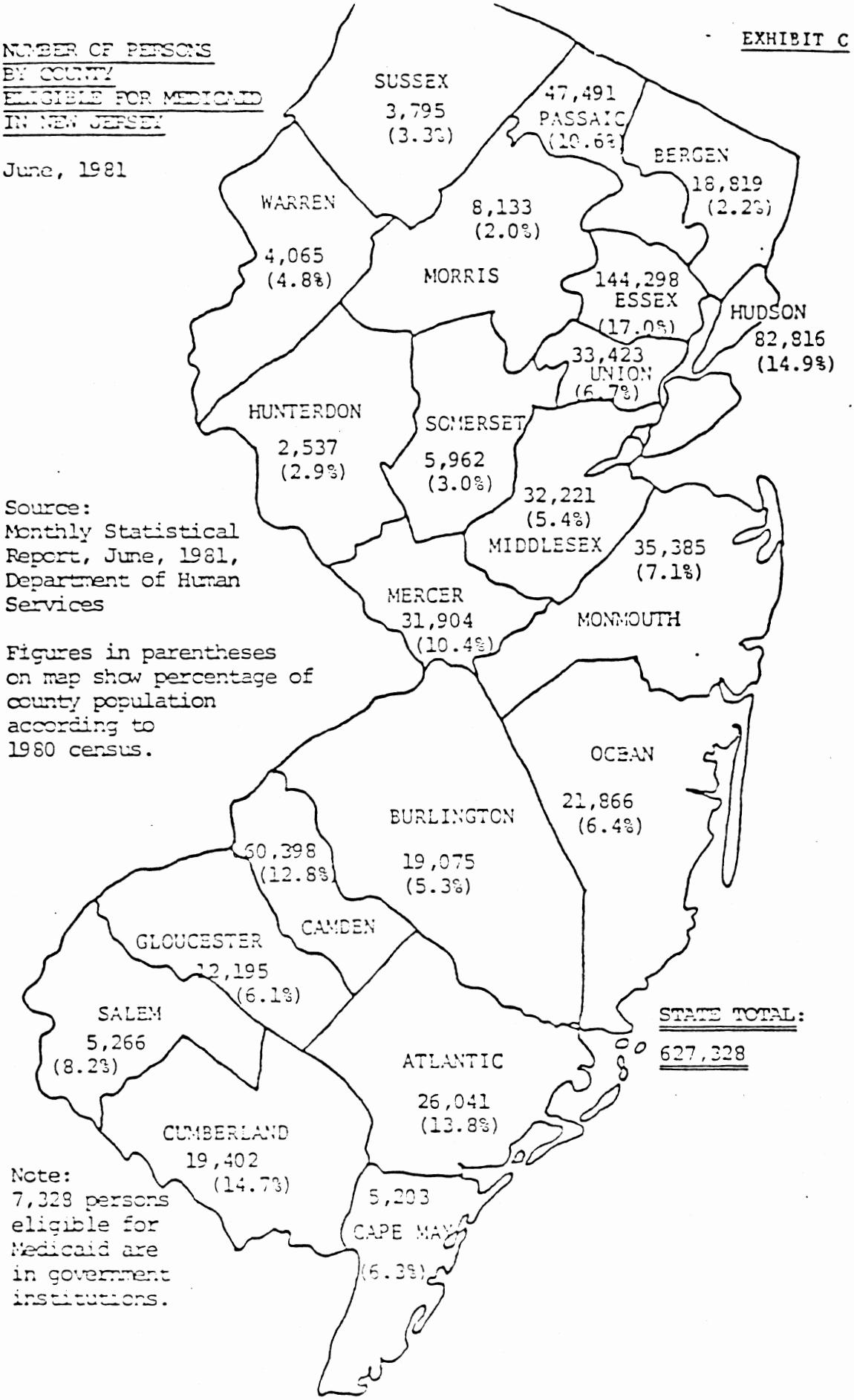
FEBRUARY 22, 1983

SAMUEL KLEIN AND COMPANY
CERTIFIED PUBLIC ACCOUNTANTS

EXHIBIT C

NUMBER OF PERSONS BY COUNTY ELIGIBLE FOR MEDICAID IN NEW JERSEY

June, 1981



Source:
Monthly Statistical Report, June, 1981, Department of Human Services

Figures in parentheses on map show percentage of county population according to 1980 census.

STATE TOTAL:
627,328

Note:
7,328 persons eligible for Medicaid are in government institutions.

MEDICAID REIMBURSEMENT POSITION PAPER

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MEDICAID REIMBURSEMENT POSITION PAPER

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I. INTRODUCTION

County nursing facilities play a vital role in the care of the State's frail or ill elderly citizens by serving in the unique role of the provider of "last resort". These homes care for the poorest and most ill individuals, including those who have been unable to find care elsewhere and who have exhausted the benefits which allowed them to remain in other long-term care facilities. Under the existing Medicare/Medicaid reimbursement methodology, however, the Counties cannot afford to continue to provide the necessary services for these citizens. The major objective of the Counties, therefore, is to obtain a separate "peer-grouping" for the establishment of Medicaid rates which more equitably cover County nursing home costs and make possible the high level of quality nursing home care for which our County homes are noted.

Eighteen of the twenty-one counties in the State of New Jersey presently operate twenty-one nursing homes. Monmouth, Camden and Hudson Counties each operate two nursing homes while Hunterdon, Ocean and Somerset Counties operate no homes. Ninety-three percent of the patients residing in these homes are Medicaid patients. (Exhibit A)

A report entitled "Medicaid: FY 1981 Expenditures in New Jersey", prepared by the Department of Planning and Regulatory Affairs of the New Jersey Hospital Association (Exhibit B), revealed that, of the total 1981 State and Federal Medicaid appropriation of $792 million, $79,595,000 (27.6%) was expended for Long-Term Care (SNF, ICF/A and ICF/B). Exhibit C illustrates, by County, that 627,328 persons were eligible for Medicaid in New Jersey as of June, 1981.

EXHIBIT A

ANALYSIS OF PATIENT DAYS IN COUNTY NURSING HOMES

1981

Number	County Facility	Beds	Total Days	Medicaid Days	% Medicaid Occupancy
1	Atlantic County Home	179	60,362	58,082	96.2%
2	B.S. Pollak Hospital	596	166,336	160,756	96.6
3	Bergen Pines County Hospital	691	202,416	182,484	90.2
4	Buttonwood Hall	134	45,443	44,344	97.6
5	Camden County Chestnut Home	199	56,000	51,976	92.8
6	Camden Red Oak Pavilion	122	42,131	36,845	87.5
7	Crest Haven	140	50,474	49,107	97.3
8	Cumberland Manor	196	68,169	59,848	87.8
9	Essex County Geriatrics Center	332	96,150	96,150	100.0
10	F.W. Donnelly Memorial Hospital	214	67,608	67,327	99.6
11	Geraldine L. Thompson Home	73	25,001	24,997	99.9
12	John E. Runnells Hospital	235	54,613	41,300	75.7
13	John L. Montgomery Home	119	43,205	41,831	96.8
14	Meadowview Hospital - Nursing Unit	110	38,523	38,414	97.2
15	Middlesex Hospital Chron. Ill*	51	18,230	18,230	100.0
16	Morris View	371	130,127	130,127	100.0
17	Preakness Hospital	380	137,836	135,649	98.4
18	Roosevelt Hospital	280	101,024	79,363	78.6
19	Salem County Home	110	39,980	29,455	98.2
20	Shady Lane	121	41,179	29,106	70.7
21	The Homestead	98	34,814	34,708	99.7
22	Warren Haven	108	38,863	38,857	100.0
		4,859	1,558,484	1,448,956	93.0

Source: New Jersey Department of Health

*Now Closed

EXHIBIT B

NJHA/9

EXPENDITURES BY HEALTH PROVIDER

FY 1981, FY 1980 AND PERCENT OF TOTAL

Service	Payments FY 1981	Percent of Total	Payments FY 1980	Percent of Total	Percent Change from Prior FYTD
LONG-TERM CARE TOTAL	$369,381,476	46.7	$357,588,482	48.9	3.3
SNF*	16,290,357	2.1	13,600,932	1.9	19.8
ICF/A*	153,964,302	19.4	141,089,899	19.3	9.1
ICF/B*	47,907,746	6.1	46,940,356	6.4	2.1
Mental Hospital	42,442,294	5.4	47,934,664	6.5	-11.5
ICF/MR*	108,776,777	13.7	108,022,631	14.8	0.7
CONTRACTOR TOTAL	$414,004,139	52.3	$366,693,176	50.1	12.9
Inpatient Hospital	189,932,163	24.0	167,661,973	22.9	13.3
Outpatient Hospital	51,745,447	6.5	41,769,401	5.7	23.9
Home Health	12,448,739	1.6	8,991,375	1.2	38.5
Physician	62,551,476	7.9	58,889,737	8.0	6.2
Dentist	24,569,249	3.1	22,246,706	3.0	10.4
Podiatrist	973,823	0.1	851,747	0.1	14.3
Optometrist	2,473,528	0.3	2,351,090	0.3	5.2
Drugs	48,998,847	6.2	44,131,216	6.0	11.0
Clinic	4,802,923	0.6	5,145,766	0.7	-6.7
Medical Day Care	630,436	0.1	440,046	0.1	43.3
Lab & X-Ray	2,331,422	0.3	2,179,825	0.3	7.0
Optical Appliances	3,146,833	0.4	2,857,240	0.4	10.1
Prosthetics	912,738	0.1	1,037,856	0.1	-12.1
Medical Supplies	2,932,712	0.4	2,712,430	0.4	8.1
Transportation	5,553,803	0.7	5,426,768	0.7	2.3
MEDICARE B PREMIUMS	8,359,775	1.1	7,657,866	1.0	9.2
TOTALS	$791,745,390	100	$731,939,524	100	8.2

*See Explanatory Notes, Page 10.

Source: New Jersey State Department of Human Services, Division of Medical Assistance & Health Services, NJ Health Services Program Monthly Statistical Report, June 1981

The importance of County nursing homes within the State of New Jersey's long-term care program can be best illustrated that for the fiscal year ending June 30, 1981 (Exhibit D) County homes represent only 10.3% of the nursing homes in the State and 17.1% of the nursing beds available. County homes, however, provided 21.6% of the total Medicaid days which equates to one of every 4 SNF, one of every 5 Level A and one of every 6 Level B Medicaid days in the State (Exhibit E).

The reason for this disproportionate allocation is primarily financial, as written by economist Paul Grimaldi in Medicaid Reimbursement of Nursing Care:

> "Because Medicaid doesn't fully cover nursing home costs, it encourages them to reduce the amount and quality of care. The policy also forces nursing homes (private) to deny admission to public patients, restrict admission to patients with less serious problems, charge unreimbursed costs to private patients...".

Obviously, County nursing homes, which have a 93% Medicaid population and the majority of the remaining (6%) residents on public assistance, cannot reallocate costs not reimbursed by Medicaid.

EXHIBIT D

ANALYSIS OF MEDICAID NURSING HOME PROGRAM*

CALENDAR YEAR 1981

	County Homes**		Private Homes		Non-Profit Homes		
	Number	%	Number	%	Number	%	Number
Number of Facilities	22	10.3	148	69.2	44	20.5	214
Number of Beds	4,859	17.1	18,864	65.6	4,617	16.3	28,340
Total Days	1,558,484	16.0	6,645,493	68.1	1,555,442	15.9	9,759,419
Total Medicaid Days	1,448,956	21.6	4,243,312	63.1	1,024,938	15.3	6,717,206
% Medicaid Days	92.97	-	63.85	-	65.89	-	68.82

*Based upon Department of Health Statistics as reported from Medicaid Cost Report Submissions

**Does not include:
Meadowview ICF
South Carolina ICF
Glen Gardner

EXHIBIT E

State of New Jersey

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

ADMINISTRATIVE OFFICES
324 EAST STATE STREET
TRENTON, NEW JERSEY 08625
TELEPHONE
AREA CODE 609

ADDRESS REPLY TO:
CN-712
TRENTON, NEW JERSEY 08625

November 24, 1982

Mr. Arthur Plotkin
Samuel Kline & Company
1180 Raymond Boulevard
Newark, NJ 07102

Dear Mr. Plotkin:

This letter is a follow-up of our recent meeting during which you requested a break-down of Medicaid paid days by level of care for the fiscal year ending June 30, 1982. These days are as follows:

	SNF	ICF-A	ICF-B	TOTALS
All LTCF's	479,201	4,802,987	1,937,004	7,219,192
County LTCF's	121,858	928,084	345,636	1,395,578

If additional information is needed, feel free to contact me.

Sincerely,

Richard R. Speranza

Richard R. Speranza, Chief
Long Term Care Rate Setting Unit

RRS/vf

II. THE POSITION OF THE COUNTIES

It is the conviction of the participating County Nursing Home Administrators that the Medicaid reimbursement to County homes is unreasonable, partly because the State does not include County nursing home cost data in developing "screens" or limitations for allowable reasonable costs. These Administrators maintain that the costs for County facilities should be part of a separate (peer) grouping for the development of County nursing home per diem Medicaid reimbursement rates.

County Administrators propose development of a peer grouping of County nursing facilities utilizing the same CARE methodology and guidelines for determining Medicaid per diem rates currently in effect. This concept of establishing a peer grouping has been confirmed by Seymour L. Budoff, Director of Program Operations, Region II, Department of Health, Education and Welfare on October 24, 1978 in a letter to Chaim S. Gold, Chief Bureau of Planning and Management of the State Department of Human Services.

Developing a peer grouping of County nursing homes utilizing the same cost reimbursement methodology for establishing Medicaid screen limitations for proprietary (private) and voluntary (non-profit) homes will recognize the important and valid differences between County and all other nursing homes. Such a peer grouping will detail the valid, unique costs incurred in caring for Medicaid patients in County facilities. These major differences include:

1. Greater severity of physical problems of patients requiring increased staffing, and more expensive and complicated care.

2. Aging facilities of County Nursing Homes which have not been adequately renovated or replaced because of limited County finances resulting, in higher maintenance and energy costs

3. Compliance with union contracts, dedicated employees with long-term seniority, more costly fringe benefit packages not required in other nursing homes and Civil Service regulations.

4. A higher proportion of Medicaid patients

As reported by the New York Times February 28th, March 7th and November 1, 1982,

> "New Jersey County Nursing Home Services for the Aged is Impaired. The inclusion of County facilities in the overall pattern of Health Care for the financially needy is imperative as County Homes never turn patients away. The patients generally cared for by County nursing facilities are identified primarily as dependent, infirm persons who, because of financial, social, as well as medical status, cannot obtain appropriate care in a general long-term care facility".

III. JUSTIFICATION FOR THE POSITION OF THE COUNTIES

The special problems which County facilities face or have in the currently "under-bedded" State Medicaid nursing home system justifies the establishment of a separate cost screen for the following reasons:

1. Counties Service More Total Care Patients

   County institutions require additional nursing staff and related services to meet the needs of the preponderance of total care patients. Medical characteristics of these patients distinguish County homes from other homes. Information of patient medical characteristics, based upon medical assessments, was compiled from 17 County facilities in 14 Counties and 15 non-profit facilities in 12 Counties. Although measurement of "difficulty of treatment" is somewhat subjective, Exhibit F (the result of this compilation) shows that the proportion of patients in the most difficult health categories are substantially higher in County homes than in other homes. For example, County homes have twice as many bedfast patients; more patients who require full assistance in eating; more patients with indwelling catheters and more patients who are confused or disoriented than private or not-for-profit facilities. In every major physical characteristic (hygiene, special procedures and behavorial problems), the County nursing homes serviced patients who require higher staffing levels and more intensive nursing care.

EXHIBIT F

NEW JERSEY COUNTY NURSING HOMES

PATIENT MEDICAL CHARACTERISTICS

	County	Voluntary	
Patients in Sampled Facilities	3,137	1,527	
Characteristic	%	%	% Difference
Ambulation			
Completely bedfast patients (completely dependent	7.7	3.9	197.4
Change position in bed - (completely dependent)	16.3	5.8	281.0
Bed to chair assistance	45.1	28.9	156.0
Propped wheelchair - (completely dependent)	25.2	7.4	340.5
assistance required (ambulatory)	39.0	21.9	178.0
Feeding			
Self feeding	77.5	46.8	165.6
Full assistance required	22.3	12.5	178.4
Some assistance required	28.1	9.3	302.2
Tube feeding	2.8	.7	400.0
Incontinence			
Indwelling catheters	9.2	3.5	252.9
Incontinent (bowel and/or bladder)	44.6	28.9	154.3
Indiviaully written bowel and bladder retraining program	7.6	3.7	205.4
Colostomy/Illeostomy	1.5	.6	250.0
Skin Problems			
Decubitis ulcers	7.6	5.3	143.4
Special skin care	39.4	14.5	271.7
Dressings required	7.4	7.2	102.8
Personal Hygiene			
Daily personal hygiene - (completely dependent)	58.9	27.0	218.2
Tub, shower - (completely dependent)	55.7	35.0	159.1
Toilet - (completely dependent)	40.0	22.8	175.4
Special Procedures			
Oxygen inhalation therapy	1.1	.5	220.0
Intravenous	.3	.1	300.0
Inhalation therapy	.3	.2	150.0
Critical diabetic	2.2	.5	440.0
Blind	2.6	1.7	152.9
Behavior			
Oriented	20.4	37.7	(184.8)
Confused	51.3	20.2	254.0
Belligerent	7.6	3.8	200.0
Withdrawn	6.1	4.3	141.9
Wandering	3.8	3.3	115.2
Overactive	3.3	1.4	235.7
Noisy	12.6	3.0	420.0
Terminal	3.7	1.6	231.2

The severity of County Medicaid patients' needs, as well as the quality of care necessary for these patients, require a greater intensity of nursing care (restraints, ostomy care, injections, assistance in the activities of daily living, mobility, dressing, bathing, continence and feeding, special services such as turning, tube feeding, decubitus care, positioning, etc.), as well as other required professional nursing services such as the taking of blood, urine samples, enemas, etc. In addition to requiring more nursing care, other services such as housekeeping, laundry and special therapy are needed in greater extent by County Nursing Home patients because of their debilitative state. Two patient biographies and four Level A patient profiles selected at random are included in Appendix A and represent typical Medicaid patients for whom County homes are required to care. These patients were not accepted by private nursing homes as "too difficult to care for", but are in fact, typical of Level A County nursing home patients.

Exhibit G demonstrates that there is a high proportion of patients in County homes who are under age 65 (13.5%) as well as 40% who were over the age of 85. Younger patients in nursing homes tend to have greater disabilities, resulting from accidents, multiple sclerosis, Huntington's Disease and, to some extent, mental illness. Younger and older patients tend to be more demanding and require higher levels of nursing care.

EXHIBIT G

NEW JERSEY COUNTY NURSING HOMES

ANALYSIS OF CENSUS AND PATIENT AGE

Total Patient Census on Specific Date	3,137
	%
Private	4.2
Medicare	.7
Medicaid	93.8
Other	1.3

Age of Patients

Under 64	13.5
65-74	15.2
75-84	31.8
85 and Over	39.5
	100.00

EXHIBIT H

NEW JERSEY COUNTY NURSING HOMES

ADMISSION/DISCHARGE DATA

Admission Source	County Homes %
General Hospital	52.4%
Other L.T.C. Facility	8.1
Psychiatric Facility	7.6
Residential Facility	4.3
Private Residence	27.6
Total Admissions	100.0%
Discharges To	
General Hospital	37.6%
Other L.T.C. Facility	2.7
Residential Facility	7.3
Private Residence	4.3
Deaths	48.1
Total Discharges	100.0%
Total Deaths Within 3 Months of Admission	8.9%
Waiting List Source (Total on List)	
General Hospital	18.4%
Other L.T.C. Facility	11.9
Residential Facility	1.1
Private Residence	55.4
Psychiatric Facility	7.6
Other	5.6
Total on List	100.0%
Average per Institution	
Average Waiting Time Prior to Admission:	
Days	219
Months	7.3

Exhibit H also demonstrates the role of the County homes as the last resort for severely ill or disabled Medicaid patients. Fifty-two percent of admissions to County homes are from general hospitals; possibly reflecting the unavailability of Medicare or other insurance benefits. Almost eight percent of admissions are from psychiatric hospitals, patients generally not accepted by other homes. The proportion of referrals to County Homes from other long-term care facilities is two and one-half times as for non-county nursing homes. Generally this is a result of other nursing homes sending to County homes patients whose financial resources are exhausted or who require more extensive services and more care than they are willing or able to provide. It must be remembered that almost all (93%) of the patients in County homes are Medicaid patients.

The rate of patient recovery is also lower at County homes, which means that the level of health care constantly increases rather than decreases and this in turn means more nursing care which results in greater nursing home costs. This fact is supported by statistics which show that almost 50 percent of County home patients are "discharged" because of death and 8.9 percent expire within three months of admission.

2. Age of County Facilities

As revealed in an article which appeared in the New York

Times, March 14, 1982, "County Hospitals are old structures with worn-out floors and tired walls...". These old facilities must continue to be used because the Counties often do not have the money to replace them.

Facts show that 65% of the County homes are pre 1930 construction (Exhibit I), and most facilities were never intended to function as nursing homes; 29% were built as T.B. Sanitoriums, 38% were originally Welfare Houses and 14% were General Hospitals. More than 88% of the County homes are multi-storied and more than one third are in excess of two stories. These facilities are not cost-effective to operate as nursing homes. As a result County facilities expend more for current housekeeping, building repair, maintenance and energy than the "reasonable" costs Medicaid screens permit. These screens, which exclude County nursing home cost data, do not consider the problems inherent in operating aging facilities over the cost of meeting life safety codes and/or costs of mandated renovations of these facilities to serve a nursing home population.

Counties such as Morris and Warren have built more modern facilities and the request for increased reimbursement, in accordance with special needs of County homes, should be instrumental in enabling counties with old and inadequate facilities to erect new units which will be more economical to operate.

Only three of the County homes have less than 100 beds, eleven have between 100 and 200 beds and nine homes (36.4%) of the

EXHIBIT I

NEW JERSEY COUNTY NURSING HOMES

FACILITY ANALYSIS

Original Structure Design	%
Welfare House	38.0
T.B. Sanitarium	28.6
General Hospital	14.3
Nursing Home	19.0
	100.0
Year Original Structure was Built and Number of Beds	
Pre 1930	64.6
1931-1950	11.8
1951-1960	11.8
1961-1970	5.9
1970 to Present	5.9
Year of Major Addition/Renovation and Number of Beds	
Pre 1960	29.4
1961-1970	17.7
1971 - Present	
Number of Floors for Patient Care	
One Level	11.8
Two Levels	52.9
Three Levels	5.9
Four Levels	5.9
Over Five Levels	23.5

Expansion Program Status and Number of Beds

Planned	-	2 Facilities - 200 Beds
C/N	-	6 Facilities - 556 Beds
Construction Started	-	0 Facilities - 0 Beds

EXHIBIT J

NEW JERSEY COUNTY NURSING HOMES

ANALYSIS OF HOMES BY BED CAPACITY

Bed Size	Number of Facilities							
	Governmental		Proprietary		Voluntary		Total	
	No.	%	No.	%	No.	%	No.	%
Under 50	0	0	22	14.9	7	15.9	29	13.4
50 - 100	3	13.6	35	23.6	18	40.9	57	26.3
101 - 200	10	45.5	73	49.3	13	29.6	97	44.7
201 - 300	3	13.6	13	8.8	6	13.6	22	10.1
301 - 400	2	9.1	3	2.0	0	0	6	2.8
401 - 500	1	4.5	2	1.4	0	0	3	1.4
Over 500	2	9.1	1	.7	0	0	3	1.4
	22	100.0	148	100.0	44	100.0	217	100.0

twenty-two County homes accomodate more than 200 residents, compared to only 15.7% for all other homes (Exhibit J). It is impossible, however, to measure the degree of additional staffing costs for transportation, food service, housekeeping, supervision, maintenance and coordination which are imposed by multiple storied, older and larger size facilities not originally constructed as nursing homes.

3. Statewide Shortage of Medicaid Beds

Also, according to Commissioner Albanese's report to the Nursing Home Task Force, Medicaid nursing beds are increasingly more difficult to obtain. "It is estimated that there are at least 3,000 Medicaid-eligible patients in hospitals awaiting nursing home placement".

The State Health Coordinating Council recently reported that many of the Certificate of Need applications granted to private nursing homes for the construction of additional nursing home beds will not become a reality. With the loss of these "paper beds", the Counties are the only logical source for additional Medicaid bed applications.

Based upon our survey of fourteen Counties, county facilities, in an attempt to alleviate the Medicaid nursing bed shortage, have applied for, or are in the process of constructing, an additional 756 beds (Exhibit I) primarily to accomodate Medicaid residents. These additional beds may not be built if the Counties cannot obtain increased Medicaid per diem rates, which would be an added incentive for public officials to approve more County nursing home construction.

EXHIBIT K

NEW JERSEY COUNTY NURSING HOMES

ANALYSIS OF FRINGE BENEFITS

	County Homes %	Voluntary Homes %
Unionized Facility	94.1	14.3
Under Civil Service	100.0	-
Shift Differential		
Evening	88.2	50.0
Night	88.2	57.1
Weekend	29.4	7.1
Holiday	41.2	21.4
Days Paid but not Worked	Average Number of Days	Average Number of Days
Holiday	14.2	7.6
Administrative Leave, Nursing Training (Education) and Personal Days	3.5	.6
Vacation - Up to 1 Year	12.0	(9.3)
10 Years	17.4	14.6
Over 20 Years	(22.8)	(19.9)
Sick Leave (Allotment per Year)	15.0	8.9
Total Days	50.1	31.7
Pensions	%	%
Social Security	88.2	84.6
State/County	100.0	-
Employees Meals Provided (No Charge)	34.6	38.5
Charge per Meal		
Average Annual Cost per Employee for		
Life Insurance	88.2	50.0
Overtime Pay	94.1	92.9
Health Insurance	100.0	92.9
Major Medical	47.0	85.7
Dental Coverage	47.0	35.7
Tuition Reimbursement	29.4	46.1
Uniform Allowance	70.6	

Generally, this proposed construction will not replace existing beds and facilities but should increase bed capacity to reduce the present Medicaid waiting lists.

4. Compliance with Union Contracts

Our survey indicated that base salaries paid County employees for comparable positions were equal to most other nursing homes in similar geographic areas. However, all but one of the County facilities are unionized (Exhibit I), while only 14.3 percent of the non-profit facilities are unionized, and therefore subject to the special employee union contract demands.

The effect of operating unionized County Nursing Homes results in increasing fringe benefit costs. Exhibit K demonstrates the fringe benefit programs provided in County homes. Not only are County homes required to fund extensive life insurance, medical and employees' retirement programs, uniform allowances and other programs, but they also must provide for a greater number of "days paid, but not worked", including holidays, vacation entitlement, staff training and administrative leave days. These benefit costs (approximately 25% of salaries) are substantially higher then those paid by private and voluntary homes and are the result of unionization.

Additionally, all of the County facilities have been operating for more than 60 years and thereby have many employees with long seniority who receive maximum fringe benefits (longevity salary increases, additional vacation entitlement, etc.). This compares to private facilities which are comparatively new, many starting operations in the late 1960's with the advent of Mediicare and do not provide as extensive a fringe benefit package to their employees.

5. Civil Service

County nursing homes must contend with restrictive Civil Service programs and regulations. Reference has already been made to the fact that

there are no provisions within the present Medicaid screens to compensate for these extra Civil Service costs. Accordingly, much of the discussion for the preceding Section 4 Compliance with union contracts is also applicable to Civil Service.

* * *

CONCLUSION

This Position Paper supports the contention that a peer grouping of County Nursing facilities for the establishment of Medicaid reimbursement rates for is indispensably necessary. In summary, based upon data provided by the State Department of Health, (Exhibit D, page 5), County nursing homes represent only 10.3% of the total homes, and 17.1% of the available nursing beds in the State while providing 21.6% of the total State Medicaid days. For the fiscal year ending June 30, 1982, County facilities provided more than one of every five of the total Medicaid nursing days within the State (Exhibit L); and 93.7% of the patient days in County homes were Medicaid days (Exhibit A, page 2).

County nursing homes provide more nursing care for their residents, because the state of illness and disability of County home residents is greater than patients in non-County facilities. Exhibit L illustrates that, proportionately, the County institutions care for 40% more SNF patients (requiring the greatest care) than non-profit and proprietary homes in the State. This is equivalent to County homes providing one out of every four SNF patient days. On the other hand, County homes provide 10% fewer (24.8% vs. 27.3%) ICF Level B patients days, the group requiring the lowest level of nursing care. County institutions also provided services for one out of every five "Level A" days paid by Medicaid. This is a disproportionate share of the total Level A nursing

care beds available in the State. County homes, however, serve "more ill" Level A patients who have multiple problems of poor health, many that require "total care".

For the reasons outlined in theis report, we request that the State of New Jersey formulate a peer grouping of County nursing facilities utilizing the same regulations and methodology as used to establish the current nursing screens.

EXHIBIT L

STATE OF NEW JERSEY

ANALYSIS OF MEDICAID DAYS BY LEVELS OF NURSING CARE

FISCAL YEAR ENDED JUNE 30, 1982

	County Homes			Proprietary and Voluntary Homes			Total		
		%			%			%	
Level of Care	Days	Within County Homes	Of Level of Care	Days	Within Homes	Of Level of Care	Days	Of Total Days	Of Level of Care
SNF	121,858	8.7%	25.4%	357,343	6.1%	74.6%	479,201	6.6%	100.0%
A	928,084	66.5	19.3	3,874,903	66.6	80.7	4,802,987	66.6	100.0
B	345,636	24.8	24.8	1,591,368	27.3	82.2	1,937,004	26.8	100.0
Totals	1,395,578	100.0%	19.3%	100.0%	100.0%	80.7%	7,219,192	100.0%	100.0%

*Source New Jersey Department of Human Services

**County Homes Provide Service to:

1 of Every 4 SNF Medicaid Patients within State
1 of Every 5 Level A Medicaid Patients within State
1 of Every 6 Level B Patients within State
1 of Every 5 Medicaid Days in the State

APPENDIX

LEVEL A PATIENT PROFILES

SAMPLE CASE HISTORIES

Admitted 8/28/62

Lorena is a 58 year old white female who was admitted on August 28, 1962, with the admitting diagnosis of Residual Paralysis of the Respiratory Muscles and Quadriplegia following Poliomyelitis. The polio occurred in 1953.

She uses the following medical equipment: (1) a rocking bed which rocks every minute, 18 to 20 times; (2) a portable chest respirator and shell; (3) a suction machine and (4) a special call bell that is tongue operated and an alarm device. In addition, she has available to her an iron lung. In case of power failure, the hospital has also provided electrical hook-ups to a portable generator and has battery packs on standby. This equipment requires the use of a room licensed for three beds and only she utilizes this room resulting in the loss of the other two beds.

The average length of professional care needed by her is approximately three hours and thirty-five minutes. The care is usually given by two people so that it is as expedient as possible. She requires total care which is complicated by the fact that she cannot be out of her shell for any significant length of time. Feeding and toileting of this patient alone can take more than one hour. This certainly does not include such things as a total bed change, suctioning, trach, care, etc.

* * *

Admitted 1/11/82

Gary was a 27 year old balck male who passed away in August, 1982. While in the nursing home, he was totally dependent upon his respirator. He used the following medical equipment: (1) an IPPB machine; (2) a humidifier; (3) a suction machine; (4) a tilt table and (5) a reclining geriatric chair.

Due to his apprehension and adjustment to the disease process, his nursing care could range anywhere from four hours to six plus hours. As with Lorena, nursing care was often provided by pairs of personnel in order to maintain the patient as comfortable as possible. Gary required suctioning and repositioning. To change his bed linens and provide him with A.M. took as long as an hour in order for him to achieve some type of comfort.

In addition to the above, physical therapy tried to get him to stand using a tilt table for approximately 40 minutes a day in order to stregthen his legs. The nursing staff also encouraged him to spend time in a reclining wheel chair. However, both of these treatment modalities were not as successful as they could have been due to the lack of participation by the patient.

LEVEL A PATIENT PROFILE #1

#19715 KW 85' YEARS OLD ADMISSION: 3/16/71

DIAGNOSIS:

1. S/P CVA WITH TRIPLEGIA
2. ASHD
3. HCVD
4. LEFT ACETABULOR DYSPLASIA
5. DEGENERATIVE ARTHRITIS
6. S/P URETHRAL STRICTURE
7. CHRONIC RENAL FAILURE
8. BURSITIS
9. ANEMIA
10. FAMILIAL EXOPHTHALMUS
11. DEHYDRATION

SUMMARY

PATIENT HAS TO BE FED AS HE TENDS TO ASPIRATE. HAS A RECURRENT DECUBITUS ON LEFT HIP. PATIENT IS UNABLE TO MOVE ABOUT-CONTRACTURES OF LEGS, HIPS, AND ARMS.

PRESENT MEDICATIONS AND ORDERS

1. FLUIDS TO PREVENT DEHYDRATION
2. LEFT ARM SPLINT-HEAD AND NECK SUPPORT
3. RANGE OF MOTION TO ALL EXTREMITIES DAILY
4. HEEL PROTECTORS
5. VITAMINS
6. LASIX 20 MG. BID
7. ALDOMET 250MG BID
8. B12 IM MONTHLY
9. ORAL HYGIENE BID
10. INCONTINENT CARE
11. SUCTION PRN
12. DECUBITUS CARE PRN
13. SKIN CARE PRN FOR ERYTHEMATOSIS

RECOMMENDATIONS

1. PREVENT DEHYDRATION
2. PREVENT ASPIRATION
3. PREVENT PRICKLY HEAT
4. CONTROL BLOOD PRESSURE AND RENAL FAILURE
5. MAINTAIN QUALITY OF LIFE

LEVEL A PATIENT PROFILE #2

#24669 KW 100 YEARS OLD ADMISSION: 1/4/83

DIAGNOSIS:

1. SENILE DEMENTIA, OBS WITH PARANOID DELUSIONS
2. T.I.A.'S
3. BLINDNESS (BILATERAL)
4. GENERALIZED DEGENERATIVE ARTHRITIS

SUMMARY

PATIENT IS AMBULATORY AND ALERT BUT HAS DELUSIONS. PATIENT IS A BEHAVIOR PROBLEM, COMPLAINS SHE FEELS PERSECUTED, AND CLAIMS SHE IS MISTREATED. NEEDS ASSIST IN ALL ADL, AS SHE IS BLIND.

PRESENT MEDICATIONS AND ORDERS

1. HYDERGINE TID
2. PERSANTINE 50 BID
3. VASODILAN 10MG TID
4. TYLENOL PRN
5. DARVOCET PRN
6. ROUTINE SKIN CARE
7. RESTORIL HS
8. DECUBITUS CARE PRN
9. OCCUPATIONAL & PHYSICAL THERAPY TIW
10. SYMPTOMATIC CARE OF RECTAL PROLAPSE
11. EYE CONSULT FOR CATARACT

RECOMMENDATIONS

1. CATARACT CONSULT WITH SURGICAL REMOVAL
2. KEEP AS INDEPENDANT AS POSSIBLE
3. REYAIN QUALITY OF LIFE
4. CONTROL PARANOID EPISODES

LEVEL A PATIENT PROFILE #3

#21869 KW 74 YEARS OLD ADMISSION: 4/23/79

DIAGNOSIS:

1. OBS WITH PSYCHOSIS
2. S/P CVA
3. S/P CHOLECYSTECTOMY
4. S/P CYSTOCELE REPAIR
5. INACTIVE PULMONARY TBC
6. LEFT OPTIC ATROPHY WITH BLINDNESS
7. ANKLE AND BUNION DECUBITUS
8. PRICKLY HEAT RASHES-RECURRENT

SUMMARY

PATIENT IS TOTAL CARE, CONTRACTURES OF ARMS AND KNEES. UNABLE TO MOVE ABOUT ON OWN. SELDOM SPEAKS, IS APPREHENSIVE OF ANY APPROACH. HAS PERIODS OF DEHYDRATION WITH RECURRENT DECUBITI. FOOD AND FLUIDS MUST BE MONITORED. A HOYER LIFT IS NECESSARY TO TRANSFER PATIENT.

PRESENT MEDICATIONS AND ORDERS

1. FLUIDS TO 1000CC EACH SHIFT
2. VITAMINS DAILY
3. DECUBITUS CARE
4. BETADINE DOUCHE PRN
5. LECITHIN
6. ELBOW PROTECTORS
7. RECREATION PRN

RECOMMENDATIONS

1. DECUBITUS PREVENTION
2. SKIN CARE
3. HYDRATION AND NUTRITION
4. PREVENT FECAL IMPACTIONS
5. PREVENT HEAT-HYPERPYREXIA

LEVEL A PATIENT PROFILE #4

#24593 KW 96 YEARS OLD ADMISSION: 12/1/82

DIAGNOSIS:

1. AHCVD
2. ANEURYSM OF DESCENDING THORACIC AORTA
3. S/P CVA
4. S/P A/K AMPUTATION
5. ANEMIA
6. BLINDNESS OF LEFT EYE
7. HEARING IMPAIRMENT, LEFT EAR
8. FLEXION CONTRACTURES, RIGHT HAND
9. DEGENERATIVE ARTHRITIS LUMBAR SPINE

SUMMARY

PATIENT IS WHEELCHAIR BOUND. RECURRENT CHEST PAIN AND SHORTNESS OF BREATH. REPEATED EKG'S. PATIENT FEEDS SELF. NEEDS ASSIST WITH ALL ADL ACTIVITIES. IS MEDICALLY LABILE.

PRESENT MEDICATIONS AND ORDERS

1. NITRO DISC DAILY
2. LASIX 40MG OD
3. TRINSICON BID
4. HYDERGINE QID
5. PAVABID Q12H
6. CATAPRESS OD
7. LANOXIN OD
8. MOTRIN TID

RECOMMENDATIONS

1. MONITOR CHEST PAIN
2. MONITOR SHORTNESS OF BREATH
3. LAB STUDIES AS NEEDED
4. OCCUPATIONAL AND PHYSICAL THERAPY, RECREATION AS TOLERATED
5. MONITOR VITAL SIGNS
6. TREAT ACUTE EPISODES OF CHEST PAIN MEDICALLY

COUNTY OF MERCER

OFFICE OF THE COUNTY EXECUTIVE

ADMINISTRATION BUILDING

TRENTON, NEW JERSEY 08650

BILL MATHESIUS
COUNTY EXECUTIVE

July 20, 1985

Assemblyman George Otlowski
Assembly Corrections, Health and Human Services Committee

Dear Assemblyman Otlowski:

The County of Mercer supports the establishment of peer grouping for government nursing homes and has so notified the State Department of Human Services. Further this County has agreed in principle to allocate a minimum of 25% of the anticipated savings to the priorities established by the Mercer County Human Services Advisory Council. This committment is made contingent upon the vagaries of other cogent county budget needs in FY1986. Currently 28% of Mercer County's budget goes toward human service needs, including community based long term care , the county hospital, and county share of institutional (mental health and mental retardation) costs.

We are mindful of a potential cut in Federal Revenue Sharing and since a portion of our human service delivery system is funded out of Federal Revenue Sharing dollars, we do not feel that we can commit more of the "potential" savings until we are aware of the actual amount which will accrue to the County under the peer grouping plan.

I do not feel that legislation mandating a specific amount of the monies realized under peer grouping be allocated to specific programs allows each county the flexibility necessary, especially in light of other mandated expenses which have not been fully funded--even with legislation to that effect (e.g. County colleges).

Another area of concern relates to the proposed requirement that each county allocate "savings" to establishing or expanding community based long term care programs.

There is a need to firm up the core of community services prior to adding on. Without a firm base,it is dangerous to add a superstructure. In this area counties need maximum flexibility. It is possible that a given county may wish to allocate monies to existing programs in order to merely keep up with current caseloads in a more efficient manner.

The funds provided under the peer grouping concept are reimbursements to the county and should be used for county purposes without undo restrictions from either the Department of Human Services or the Legislature. The County of Mercer recognizes the desire of both aforementioned parties to maintain some control over the delivery of human services according to statewide priorities, however it is at the local level where service needs vary and where government must be reponsive to those varing needs. Therefore, I reiterate my support for peer grouping statewide for government nursing homes with as few strings attached as possible.

Thank you.

Sincerely,

Bill Mathesius
Mercer County Executive

c.c. Walter DeAngelo, County Administrator
Joyce McDade, Clerk to the Board