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

before

SENATE INSTITUTIONS, HEALTH, AND WELFARE COMMITTEE

MEDICALLY NEEDY PROGRAM

February 11, 1987
Room 410
State House Annex
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Senator Richard J. Codey, Chairman
Senator Francis J. McManimon, Vice Chairman
Senator C. Louis Bassano
Senator John H. Dorsey

ALSO PRESENT:

Eleanor H. Seel
Office of Legislative Services
Aide, Senate Institutions, Health,
and Welfare Committee

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SENATOR RICHARD J. CODEY (Chairman): I would like to convene our hearing this morning. The purpose of the hearing today by the Committee is to talk about the Medically Needy Program, which passed the Legislature some time ago, and which all of us had very high hopes for. We had hoped that over 200,000 people would be recipients of this program. Those people who, "fell between the gaps of poverty" -- Medicaid, whatever.

I hope that our research is incorrect, but it would appear that we spent over $6 million to administer this program, of which $450,000 in benefits were given out to just about 2000 recipients.

So, obviously the much heralded and much valued program that we thought would come as a result of the bill that passed the Legislature and was signed into law by the Governor, obviously, did not happen. And, that's why we're here today; to find out why.

Our first witness this morning will be Commissioner Drew Altman, the Commissioner of Human Services for the State of New Jersey. Commissioner?

C O M M I S S I O N E R D R E W A L T M A N: Mr. Chairman, thank you for inviting me. I'd like to make two introductions. With me is Stephen Pelovitz, right here, who is the Department's Chief of Staff, and is really the person who has taken the lead in the Department in assessing the situation with regard to the Medically Needy Program. And, I don't think I need to introduce Tom Russo to you. You must know Tom over the years.

I'm really pleased that you're holding these hearings. This is obviously an important program, and it's a program which can make the difference for so many low-income people, between getting the health care they need and going without that health care.

In offering this testimony here today -- which I hope you'll find to be about as frank a testimony as can be offered by a Commissioner; certainly that is my intent -- I think I want everyone to know that I am really very sensitive and appreciative of the fact that this program, even with its problems, is a program that was developed over many years. I think as much as 10 years. Great struggle; lots of compromise-- And there are a number of people who are really heroes in the medically needy story through those years, in the Legislature, especially the client advocacy groups, as well, and possibly also in government. And I think we need to recognize that, in spite of the fact that we've got some problems to talk about here today.

Though I was not here, I have taken a very close look at the history of this program as part of our general assessment of it. One thing that is clear to me is that the program that was developed in New Jersey is a real departure from the medically needy programs that have been developed by other states around the country. The simple truth is that there's no medically needy program anywhere else that looks anything quite like it. So, in some sense, I suppose you can say that this is an experimental program. It is accurate to say that a medically needy program like this has never been tried anywhere before, and I think you know that that has to do with the flexibility that was offered in 1981 to states to design these programs in different ways, and the decision that was obviously made collectively here to start with a more limited program, and then I assume, hopefully, expand it over a period of time.

At any rate, and this is really the most important thing -- one of the two important things you need to hear from me here today -- experimental or not, the plain truth is, as you said, our medically needy program just simply is not working today. And, I will say that in whatever words and as

strongly as I possibly can. And probably the most important failing -- but there are others I'm going to talk about as well -- is that it is not serving the people it was intended to serve, as you alluded. We really have only served a few thousand people to date, in the first, roughly, half year of operation of this program. And, that's the most important failing. We're just not serving the people everyone expected would be served under the program.

SENATOR CODEY: Commissioner, why were our estimates so incredibly far off?

COMMISSIONER ALTMAN: Well, if you let me continue, I'm going to try to give you a complete explanation of why, because it is somewhat complex. And then, if there are gaps, we'll try to answer.

SENATOR CODEY: I saw you weren't reading a prepared statement, so--

COMMISSIONER ALTMAN: No, I'm not. But I have submitted a much more detailed statement for the record for you, and for others.

The second failure, which is also a very serious one, is that it is a program that is unacceptably expensive to administer. In fact, I'm going to give you some numbers, which are annualized numbers, and so they're a little worse than the ones you mentioned a moment ago.

If nothing were to change in the first year of this program, we would spend about $10 million to administer the program to deliver less than $1 million in benefits. Now, I think those are extraordinary numbers, and I think the implications of that are clear to anybody.

When I say that, I want to be quick to say something else. That number might have been -- would have been -- three times that -- as a matter of fact, more than three times that, to administer the program, had the Department not taken, what I feel, are some very aggressive steps in September and October

to control administrative costs as much as possible. We froze all hiring related to the program in the Department and in the Division. We worked with the counties with some pain to establish and then monitor county hiring levels which were appropriate, given the low volume of patients that were being served, and we reduced contractor budgets. I want to be clear about that. This program would have cost, as designed -- and I'll talk about why -- perhaps $30 to $35 million to administer had we not taken those steps, even after only a couple of months of operation. Which is, you know, a hard time to make a judgment about whether something is working -- or could still work -- or not.

I think there's a third problem with the medically needy program, which I suspect some of the other witnesses today will mention, and that is that it offers only a limited benefit package in light of the people that it's designed to serve; primarily, those who have high medical bills because they are real sick -- they may have a chronic illness, or they may have a catastrophic illness. Yet, we have a program for good and sufficient reason, I suppose, when it was designed, that does not cover hospital care, and does not cover long-term care. And, those are important benefits for those particular groups.

So, I guess to sum up the first part of my testimony, I would say as clearly as I can that as it stands now the administrative costs of this program are just not worth the benefits -- the program deliverance. I think that's obvious that it's a program which is not working very well.

The major culprit in all this -- and it begins to answer your question, is the so-called or infamous spend-down process, which is with us because spend-down was an absolute requirement of Federal law at the time this program was developed, if you were to receive Federal matching funds as part of the Medicaid program. Spend-down is something that

came from Washington, not from Trenton. The spend-down process is hard to understand, it is hard to navigate, particularly if you are an elderly person. It is extremely expensive to administer, and cumbersome. Perhaps half, or even perhaps more than that, of the administrative costs in the program associated with this process of checking bills and looking at expenditures, and looking at resources and assets and people coming back again -- "am I eligible now?"-- A very expensive and cumbersome process to administer.

And then, also in our program, people don't get the help that they get in some other states' programs in navigating that admittedly cumbersome and complicated process. And that's because, if you look at other states, what you find is people get a lot of help from hospitals and nursing homes in helping them through that system, because those hospitals and nursing homes have a direct interest: their bills are paid. We don't pay their bills in our program. Again, we don't cover hospital care and nursing home care.

So, that's another aspect of the program which relates to the fact that we went in a slightly different way when we developed it.

And, last on the list of problems is one that we've struggled with in the Department since I took over in July, and that is the conflict between a statute that requires that we pay reasonable costs to the counties for the administration of the program, and an appropriations act which caps on a percentage basis the administration of the program. Now, those two things are simply in conflict. There's no way to resolve that conflict, and that prevented us from signing contracts with the counties. So, we've been working with the counties and the State, and the counties have hung in under difficult circumstances. Money has flowed; budgets have been agreed to. That conflict between the statute and the appropriations act has also been a big problem in trying to administer this

program, and one I'm sure the counties will tell you about if they've not told you about it already.

Since the problems with the program have become apparent, as I've said, we've moved to hold down administrative costs in every way we could think of. But, I think much more importantly we've also moved as fast as we can to develop a new program, and we think it's a program that will meet the needs that are still out there, because we're not meeting them with the current Medically Needy program. Essentially, we want a program that will cover as many people as possible without a spend-down process. I really think the spend-down process is a major, major problem here.

We want a program that operates as a part of the regular Medicaid program, not some separate program with separate processes to the extent possible, which has such a strong track record for administration and management. I was an official and so was Steve Pelovitz in HCVA, the Federal agency that monitors -- runs Medicare and Medicaid. And it has always been the case that New Jersey has been regarded as having one of the strongest, if not the strongest, best administered Medicaid programs in the country. But, we've not used that strength in the Medically Needy program. And, I'd like a program that offers a better benefit package, if possible, that deals with the fact that we've had a more limited benefit package.

Fortunately, there are some new Federal options under legislation that you may be familiar with, that weren't around before; they're very new. The so-called SOBRA legislation will allow us to do this, and most importantly, it will allow us to do it with Federal matching funds. The truth is that we've wanted to do this anyway, and we were in Washington discussing doing this through some waiver process before SOBRA came along, because we knew this was the kind of change that we wanted to make. That would have been a difficult waiver to obtain, and

then again, the legislation did come along making it possible for us to go ahead.

What does SOBRA do? It allows us to extend Medicaid coverage to cover pregnant women and children and the elderly and disabled up to 100% of the Federal poverty standard. That's a 47% increase as compared with the current Medically Needy income standard. It allows us to do that without a spend-down process of any kind. So, people know that if they make a certain amount of money, they're eligible for the program. It's very simple.

And that would be, I think, a very major change and a real improvement. It allows us to offer this as part of the regular Medicaid program, which has the benefits I mentioned before, and it allows us to offer the regular Medicaid benefit package, which is a much richer benefit package -- hospital care, long-term care, and so on.

So, SOBRA, we expect, will be the building blocks of a new program. And we're now determining -- and this is a key issue, and the technical work here is difficult. I do not want to wind up in the situation we were in before, obviously, where estimates were made, and promises were made, and the numbers were wrong: exactly who we cannot cover through SOBRA, who we thought we should cover under the Medically Needy program, and how to go about covering those people, so nobody falls through the cracks of the group we initially intended to cover through this program.

Within a month -- we've been working with the advocacy groups, and with the Governor's office, and we've been talking with the original legislative sponsors -- we will have for everybody to look at, and not as a "cast in stone" proposal that we don't want to talk further about, our best thinking about how this should work, how we can use SOBRA, and what the new program should look like. And it would be our plan to have a new program in place and operating in July.

Why July? Because the Federal law only allows us to take advantage of -- it's in two pieces, the pregnant women and children piece, and the elderly and disabled piece -- in April and then in July. So, we can't do it by Federal law until July.

So, within a year we will have recognized the problems, moved to deal with the administrative problem with the program as best we could, and have a new program in place, which I hope you'll agree, offers at least the promise of doing a much better job. Obviously, what's happened with Medically Needy is disappointing. As I said, I don't know how to be more frank with the numbers I gave with the problems with the program. But, I would say that the Medicaid program around the country and in New Jersey has been a huge success in bringing health care to these groups, and the new program we're designing will be part of the Medicaid program. So, I can't see a reason to expect that it would be any less successful, that it would not be administered at least as well as that program has been.

That's what I wanted to say here this morning. And we'd be happy as a group -- and some other staff is here if you have real technical questions -- to answer any questions you may have.

SENATOR CODEY: Commissioner, why were our estimates so far off? So incredibly off in terms of the projection of 200,000 recipients, in actuality, 2000?

COMMISSIONER ALTMAN: As best I can tell, having looked at those estimates -- and I'm going to ask the others to chime in here -- the number that was used was an estimate of eligibles as opposed to people who would be served. But, there's no question that it was a high number. There's no question that it does not relate to the pool of people out there who really could be served through this program. The two of you may have some--

S T E V E N P E L O V I T Z: I think there were a couple of factors. I think--

SENATOR CODEY: Could you identify yourself, sir?

MR. PELOVITZ: I'm sorry. My name is Steven Pelovitz, and I'm Chief of Staff for the Department.

I think there are a couple of factors. I think in all probability, looking back, the estimates of 200,000 probably were very much on the high side. But, those estimates were drawn without any experience in the population that the State was trying to reach with the program, drawing to a large extent on some experience in other states, and trying to apply that to New Jersey populations.

SENATOR CODEY: Yeah, but I mean, you knew the eligibility criteria in terms of finances.

MR. PELOVITZ: We knew the eligibility criteria, we also had some idea of the package of services, but it's still the number of people that will come and avail themselves of those. The cumbersome nature of the eligibility process determination--

SENATOR CODEY: Are you saying the numbers were off because 198,000 people who could have been eligible did not declare themselves?

MR. PELOVITZ: No. I think there were two sets of factors. One was I think there were just overestimates of the numbers to begin with. But, compounding that, I think the most telling factor was that the program did not prove to be accessible to the people who are in New Jersey and who are eligible.

I think if we were to do the overall estimates at this point in time, the numbers would probably be closer to 120,000 or 130,000 actual eligibles out there. I think that beyond that, the ability to come in and determine eligibility and know whether or when you are eligible, decrease that number greatly, and the fact that going through this very long and cumbersome process, the benefits that you achieved at the end were reasonably small. And I think those all combined to give us a program that left us with just a few thousand eligibles.

COMMISSIONER ALTMAN: I would add that this is an issue we've been going over with the client advocacy groups who've been dealing with this, and for a similar set of reasons, they agree, in their discussions with us, that the original number was just not a realistic number.

SENATOR CODEY: How many new positions were created for this program?

MR. PELOVITZ: There were originally authorized approximately 200 new positions within the State.

SENATOR CODEY: Within the State alone. Was that out of the central office in Trenton?

MR. PELOVITZ: That was within the Division--

T H O M A S M. R U S S O: It was a central office, plus field positions in each of the counties that helped administer the program.

SENATOR CODEY: At what cost was that? Do you know, off the top of your head?

MR. RUSSO: The total cost if all of those--

SENATOR CODEY: Of the new positions.

MR. RUSSO: --positions were filled?

SENATOR CODEY: On an annual--

MR. RUSSO: If they were all filled on a 12 month basis, which they had not been filled on a 12 month basis, I guess the cost would be -- what, around $10 million or so, Ann?

A N N C. K O H L E R: (speaking from audience, portions of responses inaudible) In salaries?

MR. RUSSO: If everyone of the 200 positions were filled in a 12 month basis for administration at the State level, the cost would be what, around $10 million?

MS. KOHLER: Not for just salaries.

SENATOR CODEY: No, no, the question was, on an annual basis, how much were the salaries, for this program?

MS. KOHLER: Well, (a few words inaudible) -- approximately $2 million in salaries now. Those tend to be

about 75% matching Federal dollars. That $2 million-- (remainder inaudible)

SENATOR CODEY: Okay, there's a discrepancy of $8 million between what you said, and -- I don't know who this lady is--

MS. KOHLER: My name is Ann Kohler, I'm from the Medical Office -- the Division of Medical Assistance.

SENATOR CODEY: What would be the-- Mr. Russo, you had mentioned a figure of 10 million in salaries.

MR. RUSSO: Well, I was taking the assumption that if every single position that was allocated to this program were filled and occupied on a 12 month basis. That is not the case.

SENATOR CODEY: No, I understand that, but your answer goes to my question, as opposed to the $2 million.

Okay, if the Legislature through the appropriations process did not cap the cost at 15%, wouldn't it have run much beyond that in regards to the counties?

COMMISSIONER ALTMAN: Yes. I think it's perfectly reasonable to say that the cost of a program should not exceed 15% to administer. From there, though, we were presented with some difficulties. This is a program that has a percentage as designed -- and I don't think this was realized way back when -- would have a much higher administrative cost as a percentage, because the benefit package, without hospital care and without long-term care, was by definition a low-cost benefit package.

Second, the statute required that we pay the counties their reasonable costs. Those reasonable costs would have exceeded 15%, even as I've agreed 15% is to anyone an unreasonable (sic) number. That put us in an impossible situation. We had a conflict between the statute and the appropriations act that there was no way for us to resolve. What we proceeded to do was what we could do, and that was drive down the administrative costs as much as we could

possibly do, again with great pain with the counties, and freezing hiring in the Division, and cutting the contractor budgets, and so on, without eliminating the program. I don't have the authority; it's a legislative program. And, I didn't want to be in a situation where we had enfranchised people and then we would no long know at the end of the year whether we had a program, and we'd have to take their benefits away.

So, we did what there was to do, given that conflict in our authority, to hold down the administrative costs. They're unacceptably high, as I described. Ten million dollars at the end of a year to deliver $1 million in benefits is a set of numbers I've never seen before. So, I just don't know how to agree more strongly that that's a bad situation.

SENATOR CODEY: The figure that I had given -- $6.45 million as of now -- you're annualizing--

COMMISSIONER ALTMAN: Yeah, at the end of a year, if nothing changed.

MR. PELOVITZ: Yes. Our difficulty with the 15% cap was not the idea of limiting the amount of expenditures for administrative costs. One of the difficult issues that we tried to deal with, with the county welfare agencies -- and we were unsuccessful in doing -- was being able to actually sign a contract with them. And we could not sign a contract because we could not write a legal document which would be consistent with both paying full reasonable costs, but capping it at 15%. The two might be in conflict.

So, that was our only difficulty with the 15% cap.

SENATOR CODEY: Commissioner, should we have included a hospital and long-term costs to be included in the program?

COMMISSIONER ALTMAN: There's no question in my mind that it would be a better health program for people -- a better health insurance program -- if we included those things. But, there are a lot of things that we'd like to do. And, I assume it was a matter of cost, and the decision was made to start

with a more limited program, get some experience, and then extend that program.

The thing that I like about the new program we're developing, for those covered under the SOBRA option, we will be able to cover hospital care and cover long-term care. That's one of the real selling points, among the others I mentioned, of the changes that we're going to be able to make.

It is not the same, in my judgment as a person with a health care background, to say that hospital care is covered in the end through a DRG system, albeit the best such system in the country -- and it's a system we all should be proud of -- as to give somebody an insurance card that says you're entitled to this and you can get it whenever you need it. Those aren't the same.

SENATOR CODEY: Commissioner, should the Medically Needy program be repealed?

COMMISSIONER ALTMAN: I think we need a new program. The need is still there. We all want and need to serve to meet that need. And so, I think my view is we ought to focus our attention on that, put the new program in place as fast as we can humanly possibly put it in place. To appeal it right now, I think would only cause harm to people who are on the roles and people who could come onto the roles for the rest of the year. I think we have to recognize that we've got a big problem, and just move as expeditiously as we can to fix it.

SENATOR BASSANO: Mr. Chairman?

SENATOR CODEY: Senator?

SENATOR BASSANO: Through you. Commissioner, can you tell me if the Department is working on making some changes in the program?

COMMISSIONER ALTMAN: Yeah. I had gone through some of those before you came in, Senator. Within a couple of weeks, we will have for your review, the client advocacy groups', and others, our best thinking as to how the new

program will work. The new program will take advantage of the so-called SOBRA Federal options. So, we'll be able to cover people without spend-down; we'll be able to cover more people; we'll be part of the Medicaid program; it'll cover hospital and long-term care, which we don't do now. There's very little question that it will be a much much better program.

SENATOR BASSANO: My reasoning for the earlier question was that in October I met with Michael Cole in the Governor's office, and we talked about Medically Needy. As the Senate sponsor, he called me in and he also called in Assemblyman Deverin. And at that time, the Administration, I believe, recognized that there were problems, and they were drafting -- or starting to draft -- changes in the program. To date I have not reviewed those changes, and that's the reason for the earlier question.

COMMISSIONER ALTMAN: And the game plan has not changed, and I was, I believe, with you that day. And my commitment to you then, and my commitment to you today is as soon as we've got our ducks in a row, and our numbers together, we will give that to you to look at and to review, and will not be, from my point of view, cast in stone. We want your reaction, we want the others' reactions. It's simply -- and I did not-- We've had a major problem with this program, and I did not want to come back or go public until we were confident about the numbers, who would be served, how it would work. And that's an extremely complicated task, technically. Remember, it took 10 years to put the original -- or a number of years -- to put the original program together. I guess you know that better than anyone.

So, you will get it as soon as we have it. And that will be in a couple of weeks.

SENATOR BASSANO: Fine

SENATOR CODEY: Senator McManimon, any questions?

SENATOR McMANIMON: No questions.

SENATOR CODEY: Okay. Thank you, Commissioner, and gentlemen.

Our next witness this morning will be Cornelia Thum, President of the County Welfare Directors Association.

C O R N E L I A B. T H U M: Good morning, Senators. The County Welfare Directors Association of New Jersey welcomes this opportunity to present our concerns relative to the Medically Needy program in New Jersey.

As a preface to my specific remarks let me indicate that the 21 County Welfare Agencies in New Jersey have committed their time, expertise, and commitment to assist the State of New Jersey to implement this much needed program. However, we have been dissatisfied with the program from the start. We will continue to make the commitment to work with the program but certain major changes must be addressed.

Changes are required in these major areas as the following information will indicate. And, I do give you some information regarding income eligibility just to once again reaffirm what Commissioner Altman said. Just quickly:

If a person is one dollar over the SSI eligibility level, which makes them ineligible for the regular Medicaid program, their spend-down is $235.50 before they would become eligible for Medically Needy. And, the numbers increase if you consider eligibility for a couple.

Once again, the service package offered by Medically Needy is considered to be restrictive both by the applicants and the service providers. Different services are available to different categories of recipients. Inpatient hospital costs are not covered except for pregnant women, and in this case only pregnancy related illnesses are covered. Thus, an important element of health coverage is missing. And one of the toughest things to explain to a pregnant woman entering into the hospital is to let her know that her newborn child will not be covered. Long-term care should also be added to the service package, which was indicated by Commissioner Altman.

Prescriptions are not covered for SSI related clients. Persons receiving Medically Needy assistance are assumed to be eligible for the PAAD program. In order to receive PAAD, the person must be over 65 or receiving Social Security disability benefits. There are many disabled persons under 65 who are eligible for the Medically Needy program, but who are not eligible for Social Security disability. And these are disabled persons who are not eligible to receive Social Security disability payments because of no work history. Most of these persons are divorced women, widows, and children whose income is above the SSI level.

The program discourages the payment of bills because bills can be used to satisfy spend-down only under very restricted circumstances. Unpaid bills are more useful.

The administration of this program is very cumbersome. The spend-down provisions are especially complicated which causes problems for both the agency workers and the applicants. Often a worker spends hours on a case in which the client's spend-down is actually never reached.

The AFDC related program offers no coverage to caretaker adults. Sick parents are unable to care for children properly and also illness may delete the assets of a family. The failure to provide for parents interferes with their ability to care for their children's health properly. And the parents' income and resources still are used to determine eligibility.

The computer system that was provided is not efficient. Because there is no relationship between the eligibility file and the application file, all information must be entered twice and updated twice.

Persons with catastrophic illnesses which do not completely disable a person, are not covered. Many persons who are dying of cancer have enormous medical bills, but are ineligible to continue working, which is mainly for

psychological reasons, and cannot, therefore, be classified disabled.

We cannot give assistance to persons who have applications pending for SSI or SSD. Decisions often take months during which time the applicant has no coverage. And, in the case of SSD recipients or clients refused SSI for financial reasons only, retroactive payments will not go back far enough.

Additionally, over and above concerns relative to the program, certain administrative concerns must be addressed:

No contract was ever provided to the County Welfare Agencies delineating our responsibilities and reimbursement in determining eligibility for the Aged and disabled population.

No authorized budget was provided to the County Welfare Agencies, although we provided a revised 1986 budget, that was prepared and submitted to the State in June 1986. A letter was finally provided to us in January of 1987, six months after the program started.

The 15% administrative cap is entirely unreasonable given the cumbersome requirements of the program and the amount of staff time required to determine eligibility.

No statewide publicity for the program was ever generated with the exception of coverage of the Governor's announcement of the program. Individual counties have attempted publicity but with no assurance of adequate reimbursement, there was reluctance to continue. At the least, as the program is fixed, massive publicity will be required.

What to do with the program? We strongly urge the adoption of a higher income eligibility standard as per the revised Federal regulations which permit this, and this is SOBRA, which was mentioned before. We also urge the elimination of the spend-down, except in cases, perhaps of catastrophic illness. The service package must be increased, with inclusion of inpatient hospital care and long-term care.

There is no doubt that major revisions need to be made. The inquiries have fallen off significantly.

We, the County Welfare Directors Association, are prepared to work with the Department of Human Services and the Legislature to improve this program so that it serves those who are truly "Medically Needy."

SENATOR CODEY: If the program had been publicized, like maybe it should have been, how much do you think that would have increased the percentage of applicants and those who would have been eligible?

MS. THUM: I can only speak for my county, which is Somerset, and I'm the Director of Somerset County Board of Social Services. We did do a lot of our own local publicity, and we felt we really exhausted every opportunity of potentially eligible clients. One of the increased difficulties was the fact that the program was so complicated by the time it was explained to an inquiring person, in most cases they did not want to make an appointment to apply. And those that did, if they were deemed eligible pending spend-down, even after the complicated spend-down process-- We've been redetermining eligibility now after the first six months of the program, and none of them have met the spend-down.

So, the number of people that have actually been served are really minute, compared to those that it potentially could have served. And I can tell you, the computations that have to be done manually in a spend-down case take a worker at least a day and perhaps longer to do. That's why it takes a lot of people to administer this kind of program.

SENATOR CODEY: But what do you think were your actual costs? Above 15%?

MS. THUM: Oh, quite definitely. In fact, what we did was we anticipated a budget in my own county which would have run about $65,000 for the first six months of the program. And I think ultimately the reimbursement that would be allowed is

about 25% of that. You know, what we did in the first go-round-- I think all 21 county welfare agencies really felt the estimates were too high, and so I don't think many, if any, went to the suggested staffing that was indicated right at the beginning.

And thereafter, as the program really did not develop, Steven Pelovitz and the Commissioner really did give us feedback on an ongoing basis as to how to really reduce the numbers of staff accordingly. And unfortunately, you know, we deal with a Civil Service system where you need to give 45 day notices in terms of layoff and that kind of thing, so you can't immediately reduce the numbers of your staff, even though you feel that there isn't a continued need for them.

But, without question, all of the counties have cut back their numbers significantly. I have one person now.

SENATOR CODEY: Okay, thank you very much. Our next witness will be Ciro Scalera, Executive Director of the Association for Children of New Jersey.

C I R O A. S C A L E R A: Good morning, Senators. To my left is Shirley Geismar, who is a Staff Associate at the Association for Children of New Jersey.

I would like to summarize a statement that we presented to the Committee in lieu of time interests, and to commend the Legislature for its look today at this particular program, and to also commend the Commissioner for a frank and forthcoming statement about what some of the problems are with this program.

We are here to speak as a child advocacy organization, and as one who had held high hopes in terms of a significant number of children who are without regular access to medical care being so entitled to this particular program.

The number that was projected was 100,000. We felt at that time it was a high number, that would not have been perhaps a full number, but nonetheless recognized that the

Department did not want to come to the legislative body with a number that was unrealistic only later to say-- I know earlier you had asked about why was that number high? And I think, very frankly, it was some concern that earlier in the legislative process, around the Pharmaceutical Service to the Aged program estimates were given that were lower than the response, and I think that there was a fear that they would be selling a bill of goods that wasn't--

SENATOR CODEY: But the number wasn't 100, it was 200.

MR. SCALERA: Right, 200. I was only referring to children, though.

SENATOR CODEY: Oh, okay.

MR. SCALERA: They had estimated 100,000 for children, and we didn't really think it was going to be quite that high.

We would like to share with the Committee some of our observations about the problems, and I will summarize. We had been scheduled to begin a very intensive monitoring and evaluation of this program this January of '87, but we've delayed doing that because we had been informed by the Department that they were beginning to look at some changes to that.

The problems with the program are basically many of the ones that you have already heard, but I will briefly summarize them.

First, from our perspective, there was very little outreach for children done in terms of this particular program. We were not pleased with the level of effort to try to enroll children and pregnant women in the program. This manifested itself, really, in two ways: In terms of any central State office effort for children for outreach in the program, and then secondly county coordination ensuring a consistent level of outreach in and among all of the different counties in this State.

The second thing, and again we don't have any hard empirical data, but we received numerous and persistent reports that people were calling to get information about the program, and that information -- in many cases, incorrect information -- about whether or not they would be eligible was given. And what tended to happen was, if someone would call and receive incorrect information, they would tend not to try again in terms of enrolling themselves in the program. So, we feel that whatever new proposals emerge around a restructuring of this, care and attention has to be paid to this issue of outreach, and how is this program going to be targeted in an effective way to reach out to the children and families that need the particular program.

In terms of the administrative difficulties, the main problem is the spend-down problem. That is one that is required by Federal law, and I don't know what our options are, but suffice to say that it is a manual process, and it's very time consuming. There's another issue involved too -- and again, I'm not sure if it's absolutely required in Federal law. Currently, bills that have not been paid are countable towards the spend-down process. The result of that is it forced many hard decisions on the part of some families and senior citizens who would, out of principle or whatever, do without other things in order to pay their bills, only to find that that was not going to be counted towards their spend-down eligibility. Or, it had the other effect with some people of promoting them not to pay their bills, which caused certain vendors to have problems.

So, the spend-down issue is a very difficult one, and one that really will have to be addressed in whatever program is put forth.

A fourth cause, from our point of view, is the fact that it was only limited to outpatient care services, and that the hospitals were not involved in any meaningful way in terms of the enrollment and delivery of services for this program.

We have put in our written statement a section that talked about the high level of ongoing need. We've given you recent poverty data -- the most recent data that we have, that shows that the need among children and families and the aging and disabled still exists very clearly for this program, and that we need to go forward with it. And we know that, as State legislators, you'll be very strongly supportive of efforts to modify this.

In conclusion, I'd like to comment on a couple of issues that did come up in the Commissioner's comments. First, we generally support the idea of using SOBRA, the new Medicaid provisions, for covering children. Frankly, this would provide a broader benefits package, and would allow for a more streamlined and efficient administrative process to meet the vast bulk of these children. We would note, however, that SOBRA, as far as we understand, covers children only up to the age of five. And the question comes up as to children who are above the age of five. And this is something that we're going to be looking at the Commissioner's proposal; we were one of those client advocacy groups that he referred to. We will look at the draft proposal and see how that issue is handled. There may well need to be some backup program beyond the regular Medicaid program in the context of a medically needy program. It may not be the same medically needy program, but a backup medically needy program in order to deal with, perhaps, some of the limitation that SOBRA cannot address.

So, that would be one area that we would be looking at. And, secondly, I would say that the whole method of administration, whatever way we end up with, whatever the final proposal, would be we would need to look at that very carefully to ensure that some of the problems that have come up before -- the high administrative costs and that outreach issue -- are addressed, even within the context of the Medicaid program. Which, is a much more established program, but still we feel

that outreach has to be vigorous even in the context of that long-term program which is a successful program. But, those issues will still have to be covered.

SENATOR CODEY: Senator Bassano, any questions? (negative response) Thank you very much, Mr. Scalera.

MR. SCALERA: Thank you, Senator Codey.

SENATOR CODEY: Edith Edelson, from the New Jersey Federation of Senior Citizens? Go right ahead, Ms. Edelson.

E D I T H E D E L S O N: Thank you. We are delighted that we have this opportunity to review the whole situation, and I'm glad that the different suggestions made -- that the suggestions made cover a variety of suggestions which are very important and which we certainly agree with.

We in the New Jersey Federation of Senior Citizens and the New Jersey Health Care Coalition appreciate your concern for the people in need of the health care that the Medically Needy program was designed to provide. In spite of its failure to reach most of these people, it is a program urgently needed, and so we have to make every effort to make it viable.

We can see several reasons for its shortcomings: The income guidelines mandated by Federal law -- $333 for an individual, and $416 for a couple -- are far below the Federal poverty guideline of $447 for an individual and $604 for a couple. More people would be served by the Medically Needy program if the resource limits would be increased from the $3400 for an individual and $5100 for a couple.

The income guideline being as low as it is, 333, highlights the need for a spend-down program for bringing people even up to the poverty level, or a little bit above it. What is needed is a Medicaid waiver to raise the income and resource guidelines.

The Medically Needy program does not cover inpatient hospital services for seniors, the disabled and blind, and for

the needy children under 21 years of age. This service would reduce the discrepancy between the administrative expenses and the cost of the direct services, and still be a very important service for the people. And, so inpatient hospital services should be covered. This would also help pay for the shortfall if New Jersey loses the Medicare waiver.

The determination of eligibility under the complex spend-down provision is in the hands of the boards of social service in 21 counties. The determination should be in a centralized group. This would result in quick and cost-effective decisions.

Under the Federal law, SOBRA, the states are empowered to extend Medicaid up to 100% of the Federal poverty level. This means that New Jersey would have to pass a law, and I hope that they would pass a law, calling for 100%. Not up to 100%, but making 100% poverty level the level that would be used. That is extremely important.

If New Jersey uses the top limit -- 100% of poverty -- it would extend Medicaid to seniors, the disabled, and the blind with incomes between $333 and $447 for an individual, and between $416 and $603 for a couple.

While this would take care of some of the people rejected by the Medically Needy program, it definitely should not replace the Medically Needy program, since people with an income just $1 above poverty would be denied Medicaid coverage. It is our position that the flexibility, that is the spend-down provision of the Medically Needy program, is vital if we are to reach the people hovering above the poverty level who cannot afford to pay for the health care they need.

We recognize that Commissioner Altman is working on making the Medically Needy program a viable one for all concerned, and he has assured us that he will consult with us on the changes. We just hope for an expeditious resolution of the problems.

Thank you, Chairman Codey and members of the Committee.

SENATOR CODEY: Thank you very much, Ms. Edelson. Our next witness is Margaret Biegalski, the Assistant Administrative Supervisor for Gloucester County Board of Social Services. Good morning, Ms. Biegalski.

M A R G A R E T E. B I E G A L S K I: Good morning. As administrator of the Medically Needy program to the citizens of our county, the Gloucester County Board of Social Services has several concerns about the program as it now exists.

With 490 applications taken to date, we found that most people applying for this program are not eligible. Thirty percent of our applications have been denied or withdrawn. Thirty-eight percent are approved spending spend-down. This means that they meet all eligibility factors except income, but could become eligible through the spend-down process. About 21% of these cases actually achieve eligibility. With income limits this low, our potential population is very small.

We highly recommend increasing the income limits to expand the size of the program. We propose two suggestions:

1) To set the income standards at the Federal poverty level; or

2) Set the standard for the SSI related cases at 133 1/3% of the SSI standard, and for the AFDC related cases at 200% of the Public Assistance Allowance.

We would like to see coverage added for caretaker relatives on the AFDC related cases. Many times the parents are more in need of medical coverage than the children. Improvements to the service package would also be helpful. Inpatient hospital care for all eligibility groups is desperately needed. Applicants facing surgery get little relief from a program that might only cover their physician's services. Adding coverage for prescription drugs for the adult groups is also warranted. Not all of our disabled clients are eligible for the PAAD program, but by reason of their disability are in need of medication.

While we seek streamlining of the spend-down process, we do not wish to see this option eliminated. From an administrative viewpoint, this process is very complicated and time-consuming. A generous increase in the income limit should decrease the need for this procedure, but we still feel that it is vital to keep this option for those persons suffering catastrophic illnesses.

Publicity from the State level should be a requirement if any substantial changes are made in the program, as we are now faced with overcoming the program's bad reputation. The adoption of one manual encompassing all program regulations, and one application for all eligibility groups would serve greatly to improve the administration of the program. At present, these administrative difficulties are only enhanced by the lack of a signed contract between Medicaid and the county welfare agencies.

We heartily endorse any changes made in these areas to improve this program, as we believe there are people in Gloucester County and throughout New Jersey in need of medical care and unable to afford it, who would benefit from an improved medically needy program.

SENATOR CODEY: Ms. Biegalski, do you know what the cost percentage to administer this program was?

MS. BIEGALSKI: No, I don't.

SENATOR CODEY: A lady -- I guess it was from Somerset County -- had said 25%. You didn't--

MS. BIEGALSKI: No, I don't know what the cost is.

SENATOR CODEY: Okay, but you found most of the people who were applying were ineligible?

MS. BIEGALSKI: Most of our people. We apparently have a higher percentage of eligibles than most counties. Twenty-six percent of our applicants are eventually determined eligible.

SENATOR CODEY: And that was on the high side?

MS. BIEGALSKI: That's high. We've heard there's some counties whose percentage of eligibles is as low as 5%. That's a lot of worker time--

SENATOR CODEY: A lot of time and cost.

MS. BIEGALSKI: A lot of applicant time for nothing. A lot of people don't come back. The word around the county is that it isn't worth the time. A lot of people can't even get into the spend-down process. They may be approved pending spend-down, but we've found most senior citizens don't have the unpaid bills to apply for the program because they won't go to the doctor unless they can afford to pay him, or have some way to pay.

SENATOR CODEY: Okay. Thank you very much.

Our next witness is Avon Arnold, Deputy Director of the Henry J. Austin Health Center in Trenton, New Jersey. Is Mr. Arnold here? No. Okay, Louise O'Connor, Assistant Administrative Supervisor of the Monmouth County Board of Social Services. Ms. O'Connor?

L O U I S E O' C O N N O R: Good morning. Thank you for the opportunity of coming. I'm just going to say ditto to everything else that you've heard. But, I want to point out that in Monmouth County, less than 80% of the people who apply are eligible. (sic) So, obviously, there are flaws in the program that must be eliminated.

I'd also like to indicate how stressful this is for the staff who have to try to explain this program to the people who have come to them seeking help for critical needs. It's a nightmare to administer, and I certainly hope that there will be changes to simplify the process.

SENATOR CODEY: What percentage of the cost were you running in Monmouth County?

MS. O'CONNOR: I couldn't answer that question. It's a percentage of cost.

SENATOR CODEY: And you estimate that 20% of your applicants became eligible.

MS. O'CONNOR: Less than 20.

SENATOR CODEY: Oh, less than 20.

MS. O'CONNOR: Less than 20.

SENATOR CODEY: Do you hire new people to help you with--

MS. O'CONNOR: Well, that was one of the things that created great stress. Yes, indeed we did. We hired-- We certainly thought at the time we were under-hiring in anticipation of gradually bringing in new people and training them as they went along, but it created the necessity for us to lay off 75% of our staff.

SENATOR CODEY: How many people did you in fact hire?

MS. O'CONNOR: We hired 16 additional people. We had to lay off 11 of those; the rest were absorbed in other areas in the agency where vacancies had appeared.

SENATOR CODEY: So now you have nobody in the program?

MS. O'CONNOR: Yes, we still have four.

SENATOR CODEY: Oh, you have four.

MS. O'CONNOR: We have four because of cleaning up the applications that came from the first six month eligibility period. Of the first initial eligible people there were only 54 that were found eligible, and about 22 of those reapplied. So, obviously, the majority of them didn't even feel it was worth reapplying. Kind of feel like the captain of the Titanic.

SENATOR CODEY: Yes. That's a big ocean out there.

Senator Bassano? Senator McManimon? (negative response)

Thank you very much. That concludes our hearing this morning. Thank you.

SENATOR BASSANO: Mr. Chairman, the only other comment that I have is that I would suggest what we do is retain the comments of the people who spoke earlier, and to take a look at

the new amendments that will be handed down to us shortly, and to make sure that a lot of the comments that were given this morning are incorporated into those new amendments so that this law can work for the people of New Jersey.

As I stated earlier, about 90 to 120 days after the program went into effect, I was aware that there were some problems. I don't know if the rest of the Committee members were contacted. But, hopefully we'll get it right the second time.

SENATOR CODEY: Okay. Thank you.

(HEARING CONCLUDED)

APPENDIX

COMMISSIONER DREW ALTMAN

NEW JERSEY DEPARTMENT OF HUMAN SERVICES

TESTIMONY ON MEDICALLY NEEDY PROGRAM

SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE

FEB. 11, 1987

IX

Good morning Chairman Codey and members of the Institutions, Health and Welfare Committee.

I want to thank you for the opportunity to discuss the Medically Needy program, its present status and its future direction.

Let me begin by pointing out just how important this program can be to the people of New Jersey. It can do what no other program does. It can meet many of the health care needs of poor pregnant women and children, and those of the elderly and disabled who do not qualify for public assistance.

It can mean eyeglasses for a child who otherwise would fall behind in his grades.

It can mean the difference between a healthy baby and one plagued with a preventable chronic condition.

It can mean an elderly person can be cared for at home rather than in an institution.

This program was a long time in coming. It is the result of 10 years of struggle and compromise. It was developed to meet the real needs of real people; people who are simply unable to obtain the costly medical care they need. 2x

Though I was not here, having looked back at the record, it is clear to me that New Jersey's Medically Needy program is a departure from medically needy programs in other states, and that it has been somewhat experimental in nature. Other states, in effect, expanded their Medicaid programs to encompass the medically needy. New Jersey did something different. We chose to offer only ambulatory care, which includes most services other than in-patient hospital and nursing home care.

This was done through a change in the federal law in 1981 which allowed New Jersey the flexibility to create a Medically Needy program that was very different from the Medicaid program. The plan was to start slowly, gain expertise, and then expand the program over time.

However, the plain truth is that today our Medically Needy program is not working to anyone's satisfaction. Let's talk about where it is falling short:

1. Few people are being served: When the department developed the Medically Needy program, it projected that 200,000 people would be eligible for the program. It was expected a substantial number of those eligibles would receive services. Whether or not that estimate was high, to date Medically Needy has served about 3,500 people, only a tiny percentage of those who could have reasonably been expected to be served.

2. High fixed administrative costs: This program is unacceptably expensive to administer. Frankly, Senator, if nothing changes we will spend $10 million in administrative costs to deliver about $1 million worth of medical services this fiscal year. And we might have spent much more, had we not moved forcefully in September to freeze state hiring for the program, establish and monitor county staffing levels, and reduce fiscal agent budgets. Had we not have taken these steps, the program, as designed, would have cost three times this amount to administer.

3. Limited benefits: Almost all the professionals and advocates who deal with medically needy clients agree that these people are looking for hospital care and other long-term benefits for catastrophic and chronic illnesses. In fact, it has been demonstrated that pregnant women comprise five percent of the current medically needy population but consume almost half of the service dollars for their hospital care.

In sum, as currently designed, the cost of administration for the Medically Needy program is just not worth the benefits the program delivers.

How did this happen? Why did this long-awaited program run into such serious trouble in its infancy?

There are a number of reasons.

First, cumbersome federal requirements. The federal legislation authorizing both Medicaid and the Medically Needy eligibility is notorious for its difficulty to understand and administer. In fact, a federal judge called upon to interpret that law in 1985 called it "a statute of unparalleled complexity." (CASE JUDGEMENT DE JESUS V. PERALES, U.S. COURT OF APPEALS, SECOND CIRCUIT, NO. 85-7327,7345, AUG. 12, 1985)

A prime example of how red tape bars people from eligibility is the infamous "spend-down" provision, a complicated procedure to allow those with high medical bills to qualify.

Let me explain this with an example:

Joan B. is a single mother with three young sons. She is working as a waitress, but has no health insurance benefits. Because Joan's income is $10,000 a year, her children can qualify for the program only if they meet the "spend-down" requirements. To do that, Joan must accumulate and document $1,250 worth of medical bills in a six-month period.

This sounds difficult enough, but it gets even more complex. Bills will be counted toward the "spend-down" based on whether they are paid or unpaid within certain periods. Bills for the children must be accompanied by statements of payment from their father's health plan.

5x

Even if Joan is persistent enough - and many people are not - to do all that, her sons may end up receiving only two to three months of coverage.

The bottom line is that Joan could spend months of aggravation and effort getting her sons into the program and end up having only a few bills paid for a brief period.

And when you consider that our program does not cover the big ticket medical items, such as in-patient hospital care, is it any wonder many people decide it just isn't worth the trouble? Even more important, since we do not pay their bills under Medically Needy, hospitals and nursing homes have no incentive to help their patients become eligible for the program, as they do in other states.

Now I am sure some of you are thinking, "Other states have to meet the same federal requirements. Why is New Jersey plagued with problems while other states avoid them?"

The answer is in the nature of our program which I touched on earlier in this address. New Jersey's program covers only a portion of relatively low-cost ambulatory services, but we still have to run an inflexible and complicated administrative process in order to obtain federal dollars. These administrative costs are simply not justified in light of the benefits payable under the present program design.

Besides these federal requirements, the program has suffered from apparently conflicting state requirements. This is a problem that I'm sure you've heard about at length from your county officials, but let me detail it for the record.

The enabling legislation for the Medically Needy program requires the department to contract with county welfare agencies to determine eligibility and to reimburse them for their "reasonable costs". The department, however, could not contract with the counties because the appropriations act placed a 15 percent cap on administrative funding for the program.

We found ourselves in a bind. The state could not pay the counties what they were expecting, and still remain within the 15 percent limit. Though some counties staffed up too fast given applicant volume, the real problem was that the inherent fixed costs of administering a "spend-down" program exceeds 15 percent of a benefit package that excludes hospital and long-term care.

7X

The problems I have just described have almost brought the Medically Needy program to a standstill. The administrative costs are prohibitively high and its complex requirements drive away the very people it is meant to serve. The program designed to fill in the cracks in coverage has left large gaps still to fill.

Since the department became aware of these problems, we have been working to redesign and revitalize this important program.

We are working closely with everyone involved: with you, the original legislative sponsors, with the Governor's office and the OMB, with the county welfare directors and with the client advocacy groups. Our goal is to have a redesigned program in place by the summer.

There is one point on which everyone agrees: The problem lies with the program design and not with the concept. There is a documented need for health care coverage for people who are too poor to pay for their own care. We must and will find a better way.

Fortunately, there is new federal legislation which enables us to put together a more effective and less complex program. This legislation was not enacted until last November, five months after our Medically Needy program was in place.

This legislation, commonly referred to as SOBRA (Sixth Omnibus Budget Reconciliation Act), allows the state to extend regular Medicaid coverage to pregnant women, children under age one (and eventually up to age five), and elderly and disabled people whose income falls below the federal poverty level but above cash assistance levels.

Eligibility rules and processing are easier to understand. There is no "spend-down." Income requirements are clear. People will know if they have a certain income they will qualify.

For example, an elderly couple with an annual income of $7,200, the federal poverty level, would qualify for full Medicaid benefits under SOBRA without going through the frustration of the Medically Needy "spend-down" process to receive partial benefits. These are a substantial number of the people we intended to reach with our Medically Needy program and SOBRA now offers us a streamlined way to do that.

SOBRA offers New Jersey another advantage in caring for the medically needy population. Coincidentally, it strengthens a new program my department and the Department of Health have developed to care for poor mothers and their babies. This program, called Health Start, will provide comprehensive prenatal, delivery and monitoring to mothers and babies from families with income below the federal poverty level. SOBRA makes available federal matching funds for a portion of the cost of Health Start.

Because it is essentially an extension of our Medicaid program, a new Medically Needy Program based on SOBRA will also be much easier to administer. New Jersey has won recognition for having one of the best, if not the best managed Medicaid program in the nation. Our new Medically Needy program would be managed through this proven administrative system.

But SOBRA is not the entire answer. Other options are under consideration which could expand the medically needy service package, seek federal waivers of certain unwieldy requirements and develop state-funded programs to redirect funds from administration into service delivery. The critical question we are assessing is how far, if at all, do we need to go beyond SOBRA to cover those who originally expected to benefit from Medically Needy.

10x

We are not redesigning this program in a vacuum. My department has been consulting with client advocacy groups and county welfare officials to get their views.

Within the month, I expect to have a program design to share with the legislature, the counties and community groups. Legally, we are able to implement both of the new SOBRA options by July. Thus, we hope to have a revised program in place by the summer.

Our aim is to have a redesigned program in place that will provide access to medical care for people too poor to obtain that care on their own.

We want to cover more people. We want to provide better benefits. And we want to keep our administrative costs at realistic levels.

This effort will take the cooperation of many of the people here today, but mostly I will need the strong support of the legislature.

Senator Codey, I ask that you and your committee continue to work with us to provide legislation to make our Medically Needy program a success New Jersey can be proud of.

ACNJ
ASSOCIATION FOR CHILDREN OF NEW JERSEY
17 Academy Street, Suite 7
Newark, New Jersey 071

February 10, 1987

TO: Senator Richard J. Codey, Chairman
Members, Senate Institutions, Health and Welfare Committee

FROM: Ciro A. Scalera, Executive Director
Cecilia Zalkind, Staff Associate
Shirley Geismar, Staff Associate
Association for Children of New Jersey (ACNJ)

RE: PUBLIC HEARING ON THE MEDICALLY NEEDY PROGRAM IN NEW JERSEY

We are here today to testify on behalf of the Association for Children of New Jersey (ACNJ), a state-wide child advocacy organization working for the wellbeing of children and their families in our state. We do so because of our commitment to these children, our involvement over the past few years in the establishment of the Medically Needy Program and our concern regarding the implementation problems that are being experienced in running the program.

Initially, when the program was being established, it was projected that about 100,000 children would be served. The monthly Medicaid report of January 12, 1987, however, shows that about 1,387 children and 159 pregnant women were receiving care. This is nowhere near the estimates that were cited the year before. This has been disappointing to us, to the Department of Human Services and to all concerned with the program.

We would like to share with the Committee some of our observations about the problems facing this program as well as about the continuing need on the part of children, pregnant women and the aged and disabled for access to medical care. One point bears mentioning, however, at this time. ACNJ had been scheduled to begin a rather extensive monitoring and evaluation effort in January on implementation of this program. We decided not to do this because the Department informed us that they were developing proposals for major changes to the program. Nonetheless, we have been informally monitoring the program and related issues and have some comments on this.

I. Problems with the Program

1. Outreach Efforts

First of all, very little outreach has been done statewide to the child and pregnant women population, with the result that few of those potentially eligible know of the new program. Any state outreach that was done was targeted only to the elderly. Mailed announcements were sent to all those who received benefits under the PAAD program. Unfortunately, almost all of these older individuals were ineligible because their incomes were too high and they could only join the program through the spend-down provisions which also are stringent.

The little outreach that was specifically focused on women and children came primarily from the counties. However, only some of the counties initiated these efforts and there was no coordination among them. Additionally, most of these outreach efforts involved getting the word out to social service agencies. Although the families that would be helped by Medically Needy are low-income, there is no indication that all or most of them have dealings with social service agencies. In short, the means taken to spread the word were less than effectual.

Second, there is some question about the correctness of information given by telephone operators at the Welfare Offices when people who had heard about the program called for information. We have heard many stories indicating that there were incorrect responses and discouraging replies given to individuals who called and may have qualified for benefits. The number and persistence of these reports as well as the credibility of the sources make us wonder if enough preparation had gone into the training of those responsible to screen incoming inquiries. Being discouraged in this fashion most probably meant that many of these individuals did not try to enroll again.

2. Administrative Difficulties

It is clear to us that the federal law and regulations, the state enabling legislation and the Department's regulations and administrative procedures all have had a part in the fact that the New Jersey Medically Needy program is an extremely complex one to understand and administer. This complexity has undoubtedly been the cause of the high cost to administer the program.

One of the most difficult and costly aspects of administration has been the provisions allowing a client to "spend down" to eligibility. Various conditions and individual manual case computations are required to determine eligibility on this basis. Additionally, only medical bills that have not been paid in the preceding months are counted toward the spend-down process. This provision has had a dual negative policy effect. It has forced hard choices and produced hardship for families already financially strapped who pay their medical bills but don't receive full credit for these payments when they apply to the program. For others, it has encouraged them not to pay their bills.

3. Lack of Inclusion of Hospital Services and Their Help in Enrollment.

A fourth cause for low enrollment is related to the fact that only outpatient care services are included in the Medically Needy Program. Additionally, it was decided that outpatient clinics that are hospital based should also be excluded, even though the care they provide is to ambulatory clients who do not stay in the hospital. This has impacted particularly on pregnant women, since so much of the prenatal care given to the poor is done through these clinics - especially since the institution of the Healthy Mothers-Healthy Babies Campaigns. By its very nature, the population that would be eligible for the Medically Needy Program is the same one that is being served in hospital-based clinics and hospital-based WIC services. If these entities were allowed to be formally involved, they could assist in needed identification and enrollment and thus maximize federal dollars.

Children who are being taken to these clinics by their parents have the same problem because hospitals clinics cannot be reimbursed for caring for them. Their parents, the "Working Poor" with little or no health insurance, most likely get the benefit of sliding-scale fees at the clinics. But they have the greatest

difficulty paying them, and therefore defer taking the children until absolutely necessary. The hospitals have followed the same practice with the children as they have with their pregnant women - they do not help in enrollment. In other states where these programs have proved successful, health institutions such as hospitals have been most instrumental in getting patients enrolled, because it is to their benefit to do so. In our state, since they are not eligible for reimbursement, they take no part in helping in enrollment.

We have heard that after January, it is likely that these hospital outpatient clinics would become eligible for Medically Needy reimbursements, because of negotiations now going on with the Federal Health Care Financing Administration. If this happens, it may be that one major impediment to the enrolling of recipients will soon be removed. This would benefit not only women and children but the elderly, disabled and blind as well, since all these groups make use of hospital clinics. The effect would be that federal dollars will enhance outlays for medical care while the children in particular will receive more comprehensive help - in the form of such things as eyeglasses and prescriptions which they do not have currently in hospital settings.

II. High Level of Ongoing Need

In the foregoing paragraphs we have catalogued some of what we see as the problems in the implementation of the Medically Needy Program. The public and legislators may ask if indeed there is a need to continue this program, considering its low cost-benefit ratio. It is our firm and strong belief that the numbers of clients estimated in need at the time of enactment are still in need and that some form of Medically Needy program SHOULD BE CONTINUED.

Poverty among children and families has increased. The poverty rates for New Jersey families HAVE NOT DECLINED. The estimates of poverty from the Census Bureau for the year 1984 show that 8.5% of all families lived beneath the poverty level, compared to 7.6% in 1980. Single-women households continue to increase, from about 15% of all families in 1980 to 17% in 1984. They have a poverty rate of 30% and are half of all families that are poor. There continue to be two New Jerseys - one of affluence and the other of extreme hardship and deprivation. The gap is not decreasing but widening. The increasing affluence and the highly publicized economic activity has not helped these poor families. The creation of many new jobs has not changed the prospects of the poor. If they have benefited by the new jobs it is primarily in terms of work at very poorly paid, service sector positions. It is known that having a full-time job at minimum, or somewhat higher than minimum, wage will not allow a family to rise up to, let alone above, the poverty level.

It is erroneous to believe that all these families below the poverty level receive AFDC benefits and therefore are eligible for Medicaid. Thousands were terminated from supplemental aid in 1981-1982, and they have never been re-enlisted. Thousands more were never in the program to begin with. If poor families work at low-paying jobs they have either no health insurance or poor insurance, which gives little or no protection to their children. Time and again in forums and testimony during the setting up of the Medically Needy Program, physicians testified as to the two-tier medical system that was in place, a system that did not adequately serve the children of the poor.

Secondly, whatever modification is decided upon, if indeed that is the ultimate decision, there MUST be a program to help provide access to medical care to

children and pregnant women with income above the outrageously low Medicaid/AFDC eligibility levels but below the poverty line. The poor performance of this particular program does not negate the need for a plan with such a goal; it only points to the fact that this one was not well designed. In a state such as New Jersey, there must continue to be efforts to care for the children of the "Working Poor". It would be unconscionable to ignore their plight and take the poor performance of the Medically Needy Program as evidence of their non-existence. We know that our state legislators who so strongly supported this program will not let this happen and will help shape the solution.

It is our understanding from the Department of Human Services that they are committed both to meet the needs of these client populations and to improve the Medically Needy Program. For our part, we have agreed to help in any review of their draft proposals and to work closely with them and with you toward this desired end.

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TOUCH A LIFE

New Jersey Foster Parents Association

P.O. Box 220, Middlesex, New Jersey 08846 • (201) 356-0667

SENATE INSTITUTIONS, HEATH AND WELFARE

HONORABLE RICHARD CODEY, CHARMAN

PUBLIC HEARING

EXAMINATION OF THE IMPLEMENTATION
OF THE MEDICALLY NEEDY PROGRAM

February 11, 1987
Room 410
State House Annex

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The New Jersey Foster Parents Association is a non-profit organization which provides support services to foster parents statewide, and serves as an advocate for foster parents, children and families.

As foster parents, we are primarily concerned with improvements in foster care but we also work for, and support programs which would benefit families and hopefully reduce the number of foster care placements.

We were well aware that many living in poverty, had no access to health care. These included the elderly, other adults and over a hundred thousand children.

We strongly supported the Medically Needy legislation which was intended to help these individuals and families.

Unfortunately, the program is not reaching a vast majority of those it was meant to help. Less than 3,000 people are actually benefiting from the program.

The Department of Human Services has recognized that, in its present state, the program is not working and will join with others to make improvements.

We urge this Committee to support a Medically Needy program, and assist the Department of Human Services, in their efforts to redesign the program to meet the needs of those it was intented to help.

Sue Dondiego, President
NJ Foster Parents Association
February 11, 1987

17x

PASSAIC COUNTY BOARD OF SOCIAL SERVICES

(201) 881-0100

Edmond A. DeSantis, M. P. A.
Director

Arthur Booth, M. P. A.
Deputy Director

February 3, 1987

Eleanor H. Seel
Section Chief
Office of Legislative Services
State House Annex, CN-068
Trenton, New Jersey 08625

Re: Public Hearing to Examine Implementation of the Medically Needy Program

Dear Ms. Seel:

As per our telephone conversation of February 3, 1987 concerning the sumbission of written testimony for the Senate Institutions, Health and Welfare Committe Public Hearing to Examine Implementation of the Medically Needy Program on Wednesday, February 11, 1987, please find attached written testimony (9 copies). These comments are submitted based on experience with the Medically Needy Program from its onset July 1, 1986 to date.

The Passaic County Board of Social Services has been from the beginning, very involved in the formation of the new program with administrators serving on several key state wide committees. We truly believe that this program is essential to meeting the legitimate medical needs of lower income individuals and families. Experience with the program in all county welfare agencies, has indicated that there are serious program and administrative flaws. We hope that these comments will assist in correcting these problems and enabling the Medically Needy benefits to accrue to a much larger eligible population.

Yours truly,

Arthur D. Booth, Deputy Director

ADB/djp
Attachments

c: Edmond A. DeSantis, Director
Cornelia Thum, Directors Association President

T E S T I M O N Y

DELINEATING MEDICALLY NEEDY PROBLEM AREAS

PASSAIC COUNTY BOARD OF SOCIAL SERVICES
80 Hamilton Street
Paterson, New Jersey 07505

Submitted February 3, 1987 by Arthur D. Booth, Deputy Director

(1) The income/resource levels are set too low, especially for SSI type cases, causing a majority of applicants to fall into the complicated spend down category.

(2) Spend down policies and procedures have created an administrative nightmare both for applicants and for CWA staff. In particular, staff faces on-going difficulties in obtaining required spend down documentation from Medically Needy applicants. It is also difficult for the applying public to comprehend spend down; including the required follow through. For example, aged or disabled applicants may not retain necessary information for documentation of spend down eligibility. We suggest that spend down be limited only to applicants applying for reason of catastrophic illnesses. Also, we strongly recommend that if income eligibility limits were to be increased, the target population would be better served. Changes in circumstances affecting eligibility forces applicants in and out of spend down status. For recipients in this type of situation, there should be no spend down option. Possibly a medical extension concept could be developed for cases losing eligibility due to changes reported in the retrospective budget period.

(3) The service package offered by Medically Needy is considered to be restrictive both by the applicants and the service providers. In many instances, applicants feel that the complex application process and tedious amounts of paper work is not worth the minimal service package, even if eligibility is to be obtained. We are encouraged by the expansion of coverage to include clinic out-patient as a move in the right direction. We believe that including in-patient hospital care coverage would benefit the program.

SSI type applicants must cross over several different bureaucratic program structures in order to apply for necessary benefits, thus creating problems for this generally vulnerable population . . . . PAAD for drugs, Social Security, or General Assistance for cash assistance, CWA for Food Stamps and Medicaid. The service package should be streamlined to avoid these "cross over" problems.

(4) The ADC type cases should include parents and caretaker relatives which were originally scheduled for inclusion in the Medically Needy Program. The omission of parents/caretakers is difficult for recipients and staff to understand because their income and resources are used for determining eligibility. Furthermore, their exclusion complicates budget unit definitions in companion type cases [e.g., disabled father, pregnant mother, needy children]. We believe that including parents and/or caretaker relatives, makes more sense both from a humanitarian and from a program basis.

(5) For pregnant applicant cases, there is a great possibility of sifting through various applications processes in a relative short period of time. An applicant may start as a Medically Needy recipient, move to Medicaid Only recipient for the last month of pregnancy, and then revert back to the status of a Medically Needy payee for an eligible child (ADC type case) or receive AFDC cash assistance and Medicaid benefits. For pregnant applicants to be required to make duplicate applications is both administratively cumbersome and difficult for the average applicant to understand and to cope with.

(6) Despite repeated committments from Medicaid personnel during the early part of the program, there has been practically no state wide publicity for the new program. Out reach efforts have been conducted mainly on the local level. Although local out reach efforts in Passaic County have resulted in a proportionately high number of applications - at the same time, the result of low program eligibles points to a need for program restructuring. In addition, this lack of eligibility has created an atmosphere of negativism in the client community. What is needed following program eligibility restructuring is a massive state wide out reach effort of a very positive nature to deal with the current bad reputation of the Medically Needy Program.

(7) There should be attention paid to the current fragmented service package which allows for different services to different eligible categories of recipients of the Medically Needy Program. The current situation relating to the service package is confusing to staff applicants and providers.

(8) The processing of disabled type Medically Needy cases through Social Security Offices for eligibility determination (Medical) is very time consuming.

(9) Data Processing efforts for the Medically Needy Program should be actively supported. There is the need to automate spend down cases and to simplify current processes that now require CWA updating of two separate systems with little output for local management useages.

(10) While the focus of our testimony is relating to program problems, we would also like to go on record as recommending the continuation of the one agency concept for both segments of the Medically Needy Program. The continuation of this concept requires the addressing of serious administrative issues such as the absence of contracts for the adult categories, inadequate and delayed funding, and clarification of the administrative cap as it applies to CWA administrative costs for this program. If the program, once restructured, is to work in the State of New Jersey, efforts should be made to rebuild the relationship between CWAs and the Division of Medicaid which has been damaged over administrative issues relevant to the start-up of the new program.

(11) The restructuring of the Medically Needy Program can become a key element in New Jersey's Welfare Reform initiatives. To date, the main focus of Welfare Reform has been on the work/training element. In many areas of New Jersey, jobs are already available. Most of these are service jobs paying close to or minimum wages without medical benefits. It is our belief that many AFDC families would elect to go off the cash program if they could retain Medicaid benefits for their families. This coverage would have to be provided on an extended basis to avoid problems relating to program cross over mentioned previously.

LEGISLATIVE MEMORANDUM

Cancer Care, Inc.
AND THE NATIONAL CANCER CARE FOUNDATION, INC.

February 12, 1987

To: Richard J. Codey, Chairman
Committee on Institutions, Health and Welfare
New Jersey Senate

Re: New Jersey's Medically Needy Program

We want to express our appreciation to you for convening this hearing on the very important issue of the Medically Needy program and its problems. Since we cannot be present at the hearing we are submitting this written testimony.

Cancer Care, Inc. is a not-for-profit social service agency which has been helping cancer patients and their families for over 42 years. We provide individual and group counseling, help with planning for the patient's care, as well as some financial assistance to help eligible families meet the costs of needed home care services or transportation to and from chemo and radiation therapy. Clearly we deal on a daily basis with the many needs of cancer patients and the financial and emotional problems with which they and their families must cope.

While we traditionally offered services to New Jersey residents who lived within 50 miles of New York City, it was not until we opened offices here several years ago that we began to serve really significant numbers of New Jersey cancer patients. These figures have increased each year.

For example, during our 1985-86 fiscal year, we received 2029 requests for help in New Jersey as compared to 1441 during the previous year, and 1272 the year before that. Cancer Care disbursed over $276,000 during '85-'86 to 336 needy New Jersey patients; the amount that had been disbursed during '84-'85 was $200,976, to approximately 250 patients. Each year New Jersey disbursements have taken up larger percentages of the agency's total disbursement budget. This appears to be related to the fact that New York's Medicaid-only program has somewhat more generous eligibility levels, and apparently less cumbersome application procedures.

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During the first 6 months of our '86-87 year we have already disbursed $91,883 to 477 New Jersey patients to help them pay for home care. It is important to note at this point that we had to reduce the maximum amount of weekly disbursements to patients from $75 a week to $60 a week. This was necessitated by decreased resources — and we would like to emphasize here that we are completely supported by private donations. Our decision to reduce the amounts of our grants was based on our commitment not to turn away any eligible needy patients.

During 1984, Cancer Care presented its first public policy statement in New Jersey in support of the "Medically Needy" legislation introduced by Assemblyman Deverin and Senator Bassano. We stated then that we had found that approximately 23% of the patients we were serving in New Jersey had incomes as low as $600 a month or less. We have since estimated that as many as one-third of our disbursement families are in that category! One could expect that such low-income elderly cancer patients would soon be eligible for the Medically Needy or the CCPED programs. In fact, our practice with such patients is to alert them to these entitlements at the onset of our assistance. We do this because we are able to offer financial help only for a limited period of time, and in many instances we can predict which patients/families will spend down to the Medicaid-eligible level by the time our assistance runs out. But, our social workers have found that none of the patients who applied for the Medically Needy program have actually been accepted. For some it was because the procedure was so lengthy, considerably more so than in New York which has had a Medicaid spend-down program for many years. Such lengthy eligibility procedures are not helpful to advanced cancer patients who are close to death.

It appears that New Jersey's Medically Needy program has been set up in such a way as to confound those who apply and to impede acceptance into the program. A serious drawback to the establishment of eligibility could well be the requirement that the applicant has to spend down for 6 months in order to be eligible. In New York, the patient is deemed eligible the first month that he/she experiences greater expenses than income.

Another contributing factor was that patients lost interest in applying when they realized that the Medically Needy coverage did not include emergency room services, inpatient services, or nursing home care. The fact that emergency room services are now included might attract more applicants.

But, the greatest contributory factor causing the small number of persons enrolled in the Medically Needy program is the very low income eligibility standards. An income of only $333 for one person is mighty low, as is $416 for 2 people. This means that the Medically Needy program is unavailable to those others who are scratching their way through life with slightly higher but basically inadequate incomes.

Such low income eligibility standards are truly unreasonable. This would appear to be borne out by Congress's decision to include in the FY '87 Budget Reconciliation Act a provision which allows states to take into their Medicaid programs the elderly and disabled, as well as pregnant women and children whose incomes are below the federal poverty line. At this writing these levels are $446 a month for 1 person, $603 for 2, $760 for 3, and $916 for 4 and they are due to be revised higher very soon.

We are very pleased that the Commissioner of Human Services, Drew Altman, is working towards a solution to the problems with the Medically Needy program. We understand that under serious consideration is the possibility of a recommendation that New Jersey expand its Medicaid program by taking advantage of the option, described above, which has been made available by the Budget Reconciliation measure. And, we hope that the committee on Institutions, Health and Welfare will be supportive of this.

We are grateful for this opportunity to share our thinking with you, and we would be pleased to respond to any questions you may have.