

974.90
H434
1984f

PUBLIC HEARING

before

ASSEMBLY REVENUE, FINANCE AND APPROPRIATIONS COMMITTEE

on

ASSEMBLY BILL 608

(Allows "medically needy" persons to qualify for Medicaid)

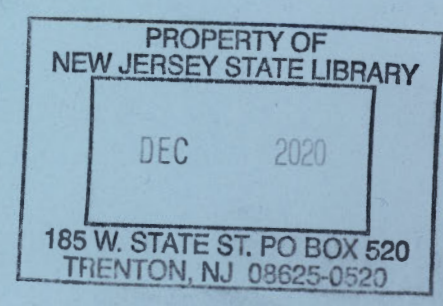
Held:
December 5, 1984
Room 114
State House Annex
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Assemblyman John S. Watson, Acting Chairman
Assemblyman Rodney P. Frelinghuysen
Assemblyman Walter J. Kavanaugh
Assemblyman Anthony M. Villane, Jr.
Assemblyman Karl Weidel

ALSO PRESENT:

Jay A. Hershberg, Analyst
Office of Legislative Services
Special Aide to the Assembly Revenue,
Finance and Appropriations Committee



ATTORNEY GENERAL'S LIBRARY
APR 03 1985

TABLE OF CONTENTS

	<u>Page</u>
Assemblyman Thomas J. Deverin District 20	2
George J. Albanese Commissioner New Jersey Department of Human Services	5
Thomas M. Russo Director Division of Medical Assistance and Health Services New Jersey Department of Human Services	8
Ann Kohler Chief Bureau of Health Statistics and Economics New Jersey Department of Human Services	10
Scott Crawford Reimbursement Specialist Office of Health Planning and Resources Development New Jersey Department of Health	12
Edmund Abramovitz Assistant Vice President and Director of Management Practices New Jersey Hospital Association	18
Edward H. Tetelman Assistant Deputy Public Advocate Division of Public Interest Advocacy New Jersey Department of the Public Advocate	26
Ann Zahora Director Division on Aging New Jersey Department of Community Affairs	30
Doris B. Nash Public Affairs Director Cancer Care, Inc.	37
Helene Feldman Social Work Supervisor New Jersey Branch Cancer Care, Inc.	39

TABLE OF CONTENTS (continued)

	<u>Page</u>
Edith Edelson New Jersey Federation of Senior Citizens	44
Kim D. Osterhoudt Assistant Director of Financial Planning University of Medicine and Dentistry of New Jersey	51
Sue Dondiego New Jersey Foster Parents Association	54
John Paul Marosy Executive Director Home Health Agency Assembly of New Jersey	55
Judith L. Miller, R.N. MCOSS Nursing Services	57
Ciro Scalera Director Association for Children of New Jersey	61
Grey Dimenna New Jersey Department of Higher Education	65
George Hooper Essex County Council on Senior Citizens	65
APPENDIX	
"Facts About the Medically Needy Program" submitted by the New Jersey Department of Human Services	1x
Statement and News Release submitted by Ann Zahora	60x
Statement from Cancer Care, Inc. submitted by William C. Pelster Chairman, Public Affairs Committee	64x
Statement and Fact Sheet from the New Jersey Federation of Senior Citizens, Inc. submitted by Edith Edelson, Chairperson Health/Welfare Task Force	71x
Statement from MCOSS Nursing Services submitted by Judith L. Miller, R.N.	77x

TABLE OF CONTENTS (continued)

	<u>Page</u>
Memorandum from the New Jersey Council of Senior Citizens submitted by John P. Tergis Legislative Chairman	80x
Memorandum and Attachments submitted by the Association for Children of New Jersey	81x
Letter and Attachments submitted by J. Richard Goldstein, M.D.	90x
Testimony of Rebecca Doggett Andrade Essex County Department of Citizen Services	95x
Letter to Michael J. Basarab of Legislative Services submitted by Louis Armour, Director Monmouth County Board of Social Services	99x
Letter and attached materials submitted to Assemblywoman Barbara F. Kalik by John Paul Marosy	100x

* * * * *

mjz: 1-29
cwr: 30-60
mjz: 61-67

ASSEMBLY, No. 608

STATE OF NEW JERSEY

PRE-FILED FOR INTRODUCTION IN THE 1984 SESSION

By Assemblyman DEVERIN

AN ACT to amend the "New Jersey Medical Assistance and Health Services Act," approved January 15, 1969 (P. L. 1968, c. 413).

1 **BE IT ENACTED** *by the Senate and General Assembly of the State*
2 *of New Jersey:*

1 1. Section 3 of P. L. 1968, c. 413 (C. 30:4D-3) is amended to
2 read as follows:

3 3. Definitions. As used in this act, and unless the context other-
4 wise requires:

5 a. "Applicant" means any person who has made application for
6 purposes of becoming a "qualified applicant."

7 b. "Commissioner" means the Commissioner of the Department
8 of Human Services.

9 c. "Department" means the Department of Human Services,
10 which is herein designated as the single State agency to administer
11 the provisions of this act.

12 d. "Director" means the Director of the Division of Medical
13 Assistance and Health Services.

14 e. "Division" means the Division of Medical Assistance and
15 Health Services.

16 f. "Medicaid" means the New Jersey Medical Assistance and
17 Health Services Program.

18 g. "Medical assistance" means payments on behalf of recipients
19 to providers for medical care and services authorized under this
20 act.

21 h. "Provider" means any person, public or private institution,
22 agency or business concern approved by the division lawfully pro-

EXPLANATION—Matter enclosed in bold-faced brackets [thus] in the above bill
is not enacted and is intended to be omitted in the law.
Matter printed in italics *thus* is new matter.

23 viding medical care, services, goods and supplies authorized under
24 this act, holding, where applicable, a current valid license to pro-
25 vide such services or to dispense such goods or supplies.

26 i. "Qualified applicant" means a person who is a resident of
27 this State and is determined to need medical care and services as
28 provided under this act, and who:

29 (1) Is a recipient of aid to families with dependent children;
29^a **[or]**

30 (2) Is a recipient of supplemental security income for the aged,
31 blind and disabled under Title XVI of the Social Security Act; **[or]**

32 (3) Is an "ineligible spouse" of a recipient of supplemental
33 security income for the aged, blind and disabled under Title XVI of
34 the Social Security Act, as defined by the federal Social Security
35 Administration; **[or]**

36 (4) Would be eligible to receive public assistance under a cate-
37 gorical assistance program except for failure to meet an eligibility
38 condition or requirement imposed under such State program which
39 is prohibited under Title XIX of the federal Social Security Act
40 such as a durational residence requirement, relative responsibility,
41 consent to imposition of a lien; **[or]**

42 (5) Is a child between 18 and 21 years of age who would be
43 eligible for aid to families with dependent children living in the
44 family group except for lack of school attendance or pursuit of
45 formalized vocational or technical training; **[or]**

46 (6) Is an individual under 21 years of age who qualifies for
47 categorical assistance on the basis of financial eligibility, but does
48 not qualify as a dependent child under the State's program of aid
49 to families with dependent children (AFDC), or groups of such
50 individuals, including but not limited to, children in foster place-
51 ment under supervision of the Division of Youth and Family
52 Services whose maintenance is being paid in whole or in part from
53 public funds, children placed in a foster home or institution by a
54 private adoption agency in New Jersey or children in intermediate
55 care facilities, including institutions for the mentally retarded, or
56 in psychiatric hospitals; **[or]**

57 (7) Meets the standard of need applicable to his circumstances
58 under a categorical assistance program or supplemental security
59 income program, but is not receiving such assistance and applies
60 for medical assistance only.

61 A person shall not be considered a qualified applicant if, within
62 1 year of becoming or making application to become a qualified
63 applicant, he has made a voluntary assignment or transfer of real
64 or personal property, or any interest or estate in property, for less

65 than adequate consideration. Such voluntary assignment or trans-
 66 fer of property shall be deemed to have been made for the purpose
 67 of becoming a qualified applicant in the absence of evidence to
 68 the contrary supplied by the applicant. This requirement shall not
 69 be applicable to Supplemental Security Income applicants or aged,
 70 blind or disabled applicants for Medicaid only unless authorized
 71 by federal law, or

72 (6) *Meets the standard of need applicable to his circumstances*
 73 *under a medically needy category set forth in subsection b. of*
 74 *section 7 of P. L. 1968, c. 413 (C. 30:4D-7).*

75 j. "Recipient" means any qualified applicant receiving benefits
 76 under this act.

77 k. "Resident" means a person who is living in the State
 78 voluntarily with the intention of making his home there and not
 79 for a temporary purpose. Temporary absences from the State,
 80 with subsequent returns to the State or intent to return when the
 81 purposes of the absences have been accomplished, do not interrupt
 82 continuity of residence.

83 l. "State Medicaid Commission" means the Governor, the Com-
 84 missioner of Human Services, the President of the Senate and the
 85 Speaker of the General Assembly, hereby constituted a commission
 86 to approve and direct the means and method for the payment of
 87 claims pursuant to this act.

88 m. "Third party" means any person, institution, corporation,
 89 insurance company, public, private or governmental entity who
 90 is or may be liable in contract, tort, or otherwise by law or equity
 91 to pay all or part of the medical cost of injury, disease or disability
 92 of an applicant for or recipient of medical assistance payable under
 93 this act.

1 2. Section 7 of P. L. 1968, c. 413 (C. 30:4D-7) is amended to
 2 read as follows:

3 7. Duties of commissioner. The commissioner is authorized and
 4 empowered to issue, or to cause to be issued through the Division
 5 of Medical Assistance and Health Services all necessary rules and
 6 regulations and administrative orders, and to do or cause to be
 7 done all other acts and things necessary to secure for the State of
 8 New Jersey the maximum federal participation that is available
 9 with respect to a program of medical assistance, consistent with
 10 fiscal responsibility and within the limits of funds available for
 11 any fiscal year, and to the extent authorized by the medical assist-
 12 ance program plan; to adopt fee schedules with regard to medical
 13 assistance benefits and otherwise to accomplish the purposes of this
 14 act, including specifically the following:

15 a. Subject to the limits imposed by this act, to submit a plan for
16 medical assistance, as required by Title XIX of the Federal Social
17 Security Act, to the federal Department of Health, Education
18 and Welfare Human Services for approval pursuant to the pro-
19 visions of such laws; to act for the State in making negotiations
20 relative to the submission and approval of such plan, to make such
21 arrangements, not inconsistent with the law, as may be required by
22 or pursuant to federal law to obtain and retain such approval and
23 to secure for the State the benefits of the provisions of such law;

24 b. Subject to the limits imposed by this act, to determine the
25 amount and scope of services to be covered, that the amounts to be
26 paid are reasonable, and the duration of medical assistance to be
27 furnished; provided, however, that the department shall provide
28 medical assistance on behalf of all recipients of categorical assist-
29 ance and such other related groups as are mandatory under federal
30 laws and rules and regulations, as they now are or as they may
31 be hereafter amended, in order to obtain federal matching funds
32 for such purposes and, in addition, provide medical assistance for
33 the foster children specified in section 3. i. (7) of this act. The
34 medical assistance provided for these groups shall not be less in
35 scope, duration, or amount than is currently furnished such groups,
36 and in addition, shall include at least the minimum services re-
37 quired under federal laws and rules and regulations to obtain
38 federal matching funds for such purposes.

39 The commissioner is authorized and empowered, at such times
40 as he may determine feasible, within the limits of appropriated
41 funds for any fiscal year, to extend the scope, duration, and amount
42 of medical assistance on behalf of these groups of categorical
43 assistance recipients, related groups as are mandatory, and foster
44 children authorized pursuant to section 3. i. (7) of this act, so
45 as to include, in whole or in part, the optional medical services
46 authorized under federal laws and rules and regulations, and the
47 commissioner shall have the authority to establish and maintain the
48 priorities given such optional medical services; provided, however,
49 that medical assistance shall be provided to at least such groups
50 and in such scope, duration, and amount as are required to obtain
51 federal matching funds;

52 The commissioner is further authorized and empowered, at such
53 times as he may determine feasible, within the limits of appropri-
54 ated funds for any fiscal year, to issue, or cause to be issued through
55 the Division of Medical Assistance and Health Services all neces-
56 sary rules, regulations and administrative orders, and to do or
57 cause to be done all other acts and things necessary to implement

58 and administer demonstration projects pursuant to Title XI, Sec-
59 tion 1115 of the federal Social Security Act, including, but not
60 limited to waiving compliance with specific provisions of this act,
61 to the extent and for the period of time the commissioner deems
62 necessary, as well as contracting with any legal entity, including
63 but not limited to corporations organized pursuant to Title 14A,
64 New Jersey Statutes (N. J. S. 14A :1-1 et seq.) [and], Title 15, Re-
65 vised Statutes (R. S. 15:1-1 et seq.) and Title 15A, New Jersey
66 Statutes (N. J. S. 15A:1-1 et seq.) as well as boards, groups,
66A agencies, persons and other public or private entities[.];

67 *The commissioner is further authorized and empowered, at such*
68 *times as he may determine feasible, within the limits of appropri-*
69 *ated funds for any fiscal year, to expand the medical assistance*
70 *program to include medically needy groups whose income and*
71 *resources equal or exceed the levels of maintenance under the plan*
72 *but are insufficient to meet their medical costs and who, except for*
73 *their financial circumstances, meet all of the conditions of eligibility*
74 *under one of the categorical assistance or supplemental security*
75 *income recipient programs. The medical assistance provided for*
76 *these medically needy groups shall include at least the minimum*
77 *services required under federal laws, rules or regulations to obtain*
78 *federal matching funds for these purposes, and may be expanded*
79 *to provide medical assistance services currently furnished other*
80 *recipients.*

81 c. To administer the provisions of this act;

82 d. To make reports to the federal Department of Health[, Edu-
83 cation] and [Welfare] Human Services as from time to time may
84 be required by such federal department and to the New Jersey
85 Legislature as hereinafter provided;

86 e. To assure that any applicant, qualified applicant or recipient
87 shall be afforded the opportunity for a hearing should his claim for
88 medical assistance be denied, reduced, terminated or not acted upon
89 within a reasonable time;

90 f. To assure that providers shall be afforded the opportunity for
91 an administrative hearing within a reasonable time on any valid
92 complaint arising out of the claims payment process;

93 g. To provide safeguards to restrict the use or disclosure of
94 information concerning applicants and recipients to purposes
95 directly connected with administration of this act;

96 h. To take all necessary action to recover any and all payments
97 incorrectly made to or illegally received by a provider from such
98 provider or his estate or from any other person, firm, corporation,
99 partnership or entity responsible for or receiving the benefit or

100 possession of the incorrect or illegal payments or their estates,
101 successors or assigns, and to assess and collect such penalties as
102 are provided for herein;

103 i. To take all necessary action to recover the cost of benefits
104 incorrectly provided to or illegally obtained by a recipient, includ-
105 ing those made after a voluntary divestiture of real or personal
106 property or any interest or estate in property for less than adequate
107 consideration made for the purpose of qualifying for assistance
108 from such recipient, legally responsible relative, representative
109 payee, or any other party or parties whose action or inaction
110 resulted in the incorrect or illegal payments, or from their respec-
111 tive estates, as the case may be and to assess and collect such
112 penalties as are provided for herein, except that no lien may be
113 imposed against property of the recipient prior to his death except
114 in accordance with section 17 of P. L. 1968, c. 413 (C. 30:4D-17);
115 provided, however, that no recovery action shall be initiated 5
116 years after an incorrect payment has been made to a recipient
117 when such incorrect payment was due solely to an error on the
118 part of the State or any agency, agent or subdivision thereof;

119 j. To take all necessary action to recover the cost of benefits
120 correctly provided to a recipient from the estate of said recipient
121 in accordance with sections 6 through 12 of this amendatory and
122 supplementary act;

123 k. To take all reasonable measures to ascertain the legal or
124 equitable liability of third parties to pay for care and services
125 (available under the plan) arising out of injury, disease, or dis-
126 ability; where it is known that a third party has a liability, to treat
127 such liability as a resource of the individual on whose behalf the
128 care and services are made available for purposes of determining
129 eligibility; and in any case where such a liability is found to exist
130 after medical assistance has been made available on behalf of the
131 individual, to seek reimbursement for such assistance to the extent
132 of such liability;

133 l. To compromise, waive or settle and execute a release of any
134 claim arising under this act including interest or other penalties,
135 or designate another to compromise, waive or settle and execute
136 a release of any claim arising under this act. The commissioner or
137 his designee whose title shall be specified by regulation may com-
138 promise, settle or waive any such claim in whole or in part, either
139 in the interest of the medicaid program or for any other reason
140 which the commissioner by regulation shall establish;

141 m. To pay or credit to a provider any net amount found by
142 final audit as defined by regulation to be owing to the provider.

143 Such payment, if it is not made within 45 days of the final audit,
144 shall include interest on the amount due at the maximum legal rate
145 in effect on the date the payment became due, except that such
146 interest shall not be paid on any obligation for the period preceding
147 September 15, 1976. This subsection shall not apply until federal
148 financial participation is available for such interest payments:

149 n. To issue, or designate another to issue, subpoenas to compel
150 the attendance of witnesses and the production of books, records,
151 accounts, papers and documents of any party, whether or not that
152 party is a provider, which directly or indirectly relate to goods or
153 services provided under this act, for the purpose of assisting in
154 any investigation, examination, or inspection, or in any suspension,
155 debarment, disqualification, recovery, or other proceeding arising
156 under this act;

157 o. To solicit, receive and review bids pursuant to the provisions
158 of P. L. 1954, c. 48 (C. 52:34-6 et seq.) and all amendments and
159 supplements thereto, by authorized insurance companies and non-
160 profit hospital service corporations or medical service corpora-
161 tions, incorporated in New Jersey, and authorized to do business
162 pursuant to P. L. 1938, c. 366 (C. 17:48-1 et seq.) or P. L. 1940,
163 c. 74 (C. 17:48A-1 et seq.), and to make recommendations in con-
164 nection therewith to the State Medicaid Commission;

165 p. To contract, or otherwise provide as in this act provided, for
166 the payment of claims in the manner approved by the State Medi-
167 caid Commission;

168 q. Where necessary, to advance funds to the underwriter or fiscal
169 agent to enable such underwriter or fiscal agent, in accordance with
170 terms of its contract, to make payments to providers;

171 r. To enter into contracts with federal, State, or local govern-
172 mental agencies, or other appropriate parties, when necessary to
173 carry out the provisions of this act;

174 s. To assure that the nature and quality of the medical assistance
175 provided for under this act shall be uniform and equitable to all
176 recipients.

1 3. This act shall take effect six months following enactment, but
2 all arrangements necessary or appropriate to enable this act to
3 become fully effective on this date shall be made as promptly as
4 possible as though this act were effective immediately.

STATEMENT

This bill would expand the medicaid program to certain "medically needy" groups who 1. are ineligible for medicaid because their incomes are too high, but 2. can demonstrate that their incomes are insufficient to meet medical costs, and 3. except for financial circumstances, meet all of the conditions of eligibility under one of the categorical assistance or supplemental security income programs.

ASSEMBLYMAN JOHN S. WATSON (Acting Chairman): Will everyone please take a seat? We are ready to go into our second hearing. We are running about 25 minutes late, which isn't too bad.

On behalf of this Committee, I would like to thank all of you for appearing here this morning. At this time I will introduce the Assembly representatives here. On my left is the sponsor of Assembly Bill 608, Assemblyman Thomas Deverin, and in just a few moments you are going to hear from him. We also have with us Assemblyman Karl Weidel, Assemblyman Rodney Frelinghuysen, and Assemblyman Anthony Villane.

This is the second public hearing on A-608, which would extend the State's Medicaid program to individuals and households considered medically needy. At the Committee's first public hearing on July 12, 1984, this Committee requested the Department of Human Services to develop a more specific proposal than the broad and general language included in A-608. The Department was asked to recommend specific income and asset levels that might be used; specific services that should be provided to the various eligible groups; the accounting period to be used in determining eligibility; and, whether eligibility administration is best held at the State level, the county level, or perhaps should be a combination of State and county administration.

One purpose of this hearing is to obtain the Department's preferred option and then review it. I would like to apologize to the Committee members and to the general public, but in doing so I would like all of you to know that just about a half an hour ago we received the fact book which was put together by the Department of Human Services. We are now able to make that fact book available to the Committee and to the staff. Furthermore, the Department's preferred option has not been provided to the Committee. The Department has indicated that it needs another month to complete its recommendations. We will be hearing from Commissioner Albanese in just a few minutes.

The Committee also requested the Department of Health and the New Jersey Hospital Association, in cooperation with the Department of Human Services, to conduct a limited survey of hospitals to determine the extent to which medically needy persons comprise the indigent population which uses hospital services. The Committee has not

received the results of this survey, and we would like to find out the reason for the delay. We would like to determine whether hospital services should be included as one of the services provided under a medically needy program.

At this particular time, I would like to announce that I intend -- along with the other Committee members present today -- to introduce a supplemental appropriation for \$125,000 in State funds, and \$125,000 in Federal funds, for the Division of Medical Assistance and Health Services, to help to offset their costs for researching the Medically Needy Program. Their help has been of great benefit and assistance to this Committee.

When you come before us to testify this morning, we want you to be aware that we would like you to have any special amendments or recommendations you might have in mind for this Committee's consideration within the next week. We would like to have these recommendations in our hands within the next week, so would you please mail them in care of this Committee?

At this time, I would like to hear from Assemblyman Thomas Deverin.

ASSEMBLYMAN THOMAS J. DEVERIN: Mr. Chairman, thank you so very much for holding this hearing. I also thank the fine members of your Committee for being here today.

Mr. Chairman and gentlemen, I guess if I have a request today it is that somehow or other we get this legislation out of Committee and onto the floor for some debate and some action. You know, there are 43 sponsors of this legislation. Although they may not show up in the record, that is how many people have been turned in as sponsors of this legislation.

In all the years I have been here, I have never had a bill or been part of a bill that has had as much support as this bill has. I can understand the reason as I read some of the letters and reports that have come in. There seems to be an awful big gap between poverty and Medicaid. There is an awful big gap between poverty and people who need help. There are so many children who need help who are not eligible for it. There are so many senior citizens who need help who

are not eligible for it. There are so many people seriously ill who do not have to be. Those are not my words. I watched a television program the other night about preventive medicine, and the matter of taking a little prescription. For instance, I suffer from high blood pressure. If you took my pressure right now, it would probably be about 130 over 78. If I could not afford to pay for my pills for the next three days, it would be 220 over 120, and I would be a sicker man than I am right now. The problem is, we are not doing anything to prevent people from getting seriously ill. Then they become a burden to everyone -- to their families, to the State, to the hospitals, and to the institutions.

This bill is not a complicated piece of legislation, and it is not a very expensive piece of legislation. I have no qualms about setting it up on Option Two -- if those are the words that are in here properly -- or the 133%. The only opposition so far, Mr. Chairman, from what I have heard about this bill, is from some of the senior citizen groups, because there is some consideration about funding 50% of this through the Casino Fund. That doesn't bother me at all. I do not see any reason why we have to fund it through the Casino Fund, but that is a concern of some people.

We are talking about a \$38 million or \$39 million appropriation from this Committee. For the first time in our history we are blessed with a lot of money. I know there are many priorities, and I trust that this bill is one of them. It has a great deal of merit. All of the organizations which are behind it can give you reasons for doing it. All of the people who are caught in that gap need help. I think that in the long run by letting them have the preventive medicine this bill can give the children, the adults, and the senior citizens, we will save money. The Federal government believes in this bill. As a freeze is coming from the Federal government, and may come from the State government, there has to be some help for the people who are caught in this gap, not only in New Jersey, but throughout this whole country. There are 38 or 39 states using this program, and it is working well.

Mr. Chairman and gentlemen, first I want to thank you for the time you have put in on this piece of legislation, and second, I request that somehow or other we arrive at some kind of a consensus today about the funding of the bill and how it is going to be handled. Somehow or other we should get some kind of recognition, or a vote, either today or in the very near future, to get it out on the floor so we can have a real serious debate. We deeply appreciate all the State organizations and the Commissioners of Health, Human Services, and the Department of the Public Advocate who have been such a great help. With all that support, I think we ought to go along and try to get this bill moving through the process and onto the Assembly floor for some kind of action.

Mr. Chairman, that is about all I have to say, except again to thank you and the Committee for coming here and spending your time on this bill.

ASSEMBLYMAN WATSON: Thank you, Assemblyman Deverin. Are there any questions from the members of the Committee? (no response) Thank you for coming, Assemblyman Deverin. I know you have a court appearance.

ASSEMBLYMAN DEVERIN: I got a subpoena. (laughter)

ASSEMBLYMAN VILLANE: Mr. Chairman, I have one question.

ASSEMBLYMAN WATSON: Sure.

ASSEMBLYMAN VILLANE: Did you say \$38 million is the cost for Option Two?

ASSEMBLYMAN DEVERIN: Doc, it's approximately \$38 million from what I can gather, and a note from the Fiscal Affairs Department was somewhere in that range, too.

ASSEMBLYMAN VILLANE: That would be the State portion?

ASSEMBLYMAN DEVERIN: Yes, and the Federal government would put up \$38 million. It is a matching program; I'm sorry I did not mention that. That is the advantage. But, Option Two would be about 36 million, 300 and some thousand dollars. The total cost would be \$73 million with the Federal government's match.

ASSEMBLYMAN VILLANE: Thank you.

ASSEMBLYMAN DEVERIN: It would really start the program off, and that is what we want to get going.

ASSEMBLYMAN VILLANE: Thank you very much.

ASSEMBLYMAN FRELINGHUYSEN: Mr. Chairman?

ASSEMBLYMAN WATSON: Assemblyman Frelinghuysen.

ASSEMBLYMAN FRELINGHUYSEN: This is not a question for the sponsor, but it might be of assistance to those of us present. During the course of the commentary, you get individuals' testimony -- where they feel comfortable in doing so -- as to which options they feel most strongly about. I think this business of prioritizing is important. It would be valuable if those who testify -- if they have the opportunity and if they feel so inclined -- would give their feelings as to which options might perhaps be embraced initially and which ones perhaps would follow in subsequent years, if that would be the design or desire of this Committee and of the sponsor.

ASSEMBLYMAN DEVERIN: Mr. Chairman, I have just one more point, and then I will keep quiet. Even if we fund it at 133%, there would still be that gap between poverty and Medicaid persons. So, it really would not cover everyone in the State who needs it. It would just cover those who fit that category of the 133%.

ASSEMBLYMAN WATSON: Thank you, Assemblyman Deverin. Commissioner Albanese, will you please come forward? The Commissioner has interrupted a very important meeting to be here to give us some words of wisdom.

COMMISSIONER GEORGE J. ALBANESE: Thank you, Mr. Chairman and members of the Committee. I will make some brief remarks and will then turn the commentary over to Tom Russo and his staff, who are present today to discuss some of the information that is in the fact book.

First of all, I would like to restate, or reemphasize my support of the need for the Medically Needy Program in the State of New Jersey. At this point in time, I continue to favor Option Two, which covers ambulatory care for children, prenatal care, and select services for the aging and disabled in the State of New Jersey.

If I ever had a doubt about the need for this program, it was dispelled in this very room about a week ago when the Council on the Prevention of Mental Retardation convened with experts in the area of prenatal care. What was discussed was the fact that the lack of proper

prenatal care, which exists in our society, has a tremendous impact on the incidence of mental retardation in the State of New Jersey and in this nation. When we look at this program, prenatal care is certainly a priority. One child in one State institution for a lifetime is equivalent to \$1 million of State expenditures.

Prevention, as Assemblyman Deverin so eloquently stated, is certainly a position that the State of New Jersey must take. When we look at our senior citizens, we look at preventive medicine and the benefits it could have on the senior citizen population in long-term care continuing in the State of New Jersey. So, I reemphasize my support.

Since the last hearing, we gathered information across the country on the Medically Needy Program as we indicated we would do. During that period of time, I have been besieged by legislators and other people, with questions as to the impact of the eligibility and the numbers on this program. Many of them are concerned about the implications, and they use the PAAD and Lifeline programs as examples. They never expected those programs to reach the numbers we have reached today. They want my absolute assurance that the numbers we come up with, eligibility-wise and dollar-wise, will be the ultimate parameter for the Medically Needy Program. Accordingly, we are now taking the information we gathered and which we supplied to you-- Since that report was compiled, we have additional information. We are now trying to put together all of the variables of the Medically Needy Program, right now using Option Two, to come up with a definitive answer on dollars and eligibility.

We will conclude, and then I will have final recommendations. Amongst the staff, we have our own opinions on what should be provided; however, one month from today I will finalize my recommendations for this particular Committee, as I promised.

There is one complication I think we should be aware of which has been brought to my attention, and this is something I know the Department of Health will probably speak to today. That is the problem of the DRG waiver and whether that waiver for New Jersey will be approved. If it is not approved, the whole area of uncompensated care,

which at this time I think is about \$240 million for the State of New Jersey, will be the subject of great discussion. The Medically Needy Program, if we go to the full-blown Option Four covering inpatient/outpatient care, has the potential of dealing with at least a part of the uncompensated care. That variable, which right now is unknown, is something we are all waiting anxiously to see what the Federal government will do about in terms of timing, because if we do lose the waiver, inpatient hospital care becomes a viable alternative for a certain percentage of that uncompensated care to bring some Federal dollars back to the State of New Jersey in that area.

With that, I will leave you with the fact that I think we have sufficient information now. We are synthesizing that information. We are talking to our third-party intermediaries, our carriers, and our claims processing people. We will be back in one month to give you definitive numbers as best we can, selecting one of the variables in each of the areas, the level of the asset test, or whatever it might be. We will have that finalized as we see it, with the kinds of services that will be provided, so that when it is given to the Legislature the questions that I have been asked will be able to be asked by this particular Committee. It will be, in fact, what we have determined to the best of our ability. We will give it all of the unknowns and the knowns, and will say, "This is what we think it will be for the State of New Jersey."

With that, I have to get back to my office. I left the meeting in limbo. Mr. Chairman, I thank you very much, and I thank Assemblyman Deverin and the Committee for their leadership in this very, very important area for the State of New Jersey.

ASSEMBLYMAN WATSON: Commissioner, before you leave-- I am not going to question you because I know you are in a hurry, but there is just one thing I would like to ask. I did say this morning that a month would be sufficient; however, if you could get this to us at least by the end of this month, I would appreciate it. We would like to have it in our hands by then.

COMMISSIONER ALBANESE: I will make every effort to do that. We will go out of our way to try to accomplish that.

ASSEMBLYMAN WATSON: I would appreciate it. Thank you for appearing here this morning.

COMMISSIONER ALBANESE: Thank you.

ASSEMBLYMAN WATSON: I have some questions for Medicaid.

COMMISSIONER ALBANESE: I will turn you over to Mr. Russo, who is the Director of the Division of Medical Assistance and Health Services for the State of New Jersey. He is responsible, within the Department, for putting together this very, very important program. Thank you.

ASSEMBLYMAN WATSON: Mr. Russo, do you wish to make a statement before we begin our questioning?

THOMAS M. RUSSO: I would simply like to add to what the Commissioner mentioned in his opening remarks. A considerable amount of work has been done by the Department in studying the Medically Needy Program in all of the states in this country that have such a program. In this document we gave you entitled, "Facts About the Medically Needy Program," there is a chart in the appendix that quantifies the results of our study. It shows the states that have the program, it shows what their thresholds are, and, very importantly, it shows what their error rates have been in the program with reference to quality control. I think what the Commissioner alluded to was the fact that the Department needs to study this data a little bit more to come up with some firm recommendations. What we are interested in doing for New Jersey is recommending to you a medically needy program that will best meet the needs of our citizens in this State in such a manner that it can be administered in a sound fashion, with the least amount of error that can possibly exist. That is a primary concern to us.

ASSEMBLYMAN WATSON: Thank you. I have a few questions for you, and I guess the Committee will have some too. Can you tell me, are the Lifeline benefits considered as income?

MR. RUSSO: Lifeline benefits would not really be considered as income for this particular program.

ASSEMBLYMAN WATSON: In view of the problems with prescribed drugs in the Community Care Program, should prescribed drugs be included in the service package for the aged and the disabled?

MR. RUSSO: Well, that again is a decision item that would have to be made. It could or could not be considered as a part of the package. Prescription drugs are not contained in Option Two. If we were to choose Option Two as it is currently formulated, it would not cover prescription drugs, but that is a change that could be made between now and December 31 when you receive the final recommendations.

ASSEMBLYMAN WATSON: I have a question from Doctor Villane, who asks what that would cost with prescription drugs?

MR. RUSSO: To include the prescription drugs in the program?

ASSEMBLYMAN WATSON: Yes.

MR. RUSSO: I think we have that somewhere if you will give me a minute or two to try to find it. (Mr. Russo searches through his papers.) Doing some quick arithmetic here, Mr. Chairman, we estimate that to include prescription drugs in the program would cost a total of \$34 million, in addition to the \$78 million you were discussing earlier. The \$34 million, however, would include every group that could be included in the program.

ASSEMBLYMAN WATSON: Would that also include the Federal match?

MR. RUSSO: That is a total figure, so it would include the Federal match, yes.

ASSEMBLYMAN WATSON: The \$78 million would include the Federal match?

MR. RUSSO: That is correct.

ASSEMBLYMAN DEVERIN: Mr. Russo, in those figures there are some people who would fall into this eligibility category Option Two, or any PAAD people. Are they in that dollars and cents you are talking about, or are they excluded?

MR. RUSSO: They would be included in this figure.

ASSEMBLYMAN DEVERIN: So, it is not really an additional \$34 million. It includes those who are in the--

MR. RUSSO: (interrupting) That is correct.

ASSEMBLYMAN DEVERIN: So, in order to know what the additional money would be, we would have to subtract those already in the PAAD program.

MR. RUSSO: We would have to carve out those persons who are in the PAAD now.

ASSEMBLYMAN DEVERIN: That could be a considerable sum.

MR. RUSSO: It could be, yes sir.

ASSEMBLYMAN WATSON: Is the out-patient hospital service an ambulatory service?

ANN KOHLER: We are discussing that with the Federal government right now, whether or not out-patient hospitals are required to be covered under ambulatory care for children.

ASSEMBLYMAN WATSON: What do the other states do with regard to this?

MS. KOHLER: Most of the other states set up their Medically Needy Programs prior to the change in Federal law which allows us to structure a program for each individual client group. Therefore, most of the other states have programs that mirror their regular Medicaid programs under the old Federal rules where you had to provide hospital services.

ASSEMBLYMAN WATSON: Mr. Russo, can you explain why the income level for one-person and two-person households must be equal at \$391.66?

MR. RUSSO: I am going to ask Ann Kohler to handle that because that is a little on the technical side.

MS. KOHLER: The Federal regulations establishing an income level for a medically needy program require that the level cannot be higher than 133-1/3% of the AFDC payment level. Therefore, in New Jersey, you have to take the AFDC payment level for a family of two and increase it to 133-1/3%, which is the \$392.00.

MR. RUSSO: I think one of the things we should understand is that that level has to be 133-1/3% of the AFDC standard, not the SSI standard. I think there may have been some confusion on that in the past.

ASSEMBLYMAN WATSON: All right then, the 133-1/3%, as I gather from your fact book, is about \$590.66. Then, if you take it over--

MS. KOHLER: (interrupting) No, it is about \$392.00.

ASSEMBLYMAN WATSON: Oh, \$392.00.

MS. KOHLER: It's not \$500.00.

ASSEMBLYMAN WATSON: It's \$392.00 and--

MS. KOHLER: (interrupting) That's right, for a one-person or a two-person household.

ASSEMBLYMAN WATSON: Okay, all right. Are there any other questions from the Committee? Assemblyman Weidel?

ASSEMBLYMAN WEIDEL: I don't know whether this is proper right now. Should we address the question of where the money is coming from now, or should we wait?

ASSEMBLYMAN WATSON: That is not the question now. We are on the bill itself, not the funds.

ASSEMBLYMAN WEIDEL: Won't this Committee be dealing with that?

ASSEMBLYMAN WATSON: Yes, we will be dealing with that, sure.

MR. RUSSO: I think, Mr. Chairman, it might be helpful to the Department if you could provide us with some of the areas you feel may or should be included in a medically needy program. As you know, the Commissioner indicated that he would come to you with recommendations. However, I think it would be helpful to us also if possibly-- For example, if you feel that prescription drugs should be included or should not be included, possibly your Committee might make that known to the Department, not necessarily today, but possibly sometime in the interim between now and the time that the Department submits its formal recommendations.

ASSEMBLYMAN WATSON: I feel that drugs should be included for the AFDC population. I think we will be dealing with our part of the bill. We will be making our recommendations, of course. That is why we want to do it as soon as possible. We would be able to do what we have to do within the next week, but we are trying to grant Commissioner Albanese a few more weeks to really get his specific recommendations in to us so we can get this bill moving. Assemblyman Weidel?

ASSEMBLYMAN WEIDEL: Mr. Chairman, we have a lot of people here. They are spending their time, and I think maybe we ought to listen to the testimony from these groups and then go into our

questions. I think we are putting the cart before the horse right now. They may answer some of our questions.

ASSEMBLYMAN WATSON: Assemblyman Weidel, these are Department people we are talking to here, and I don't know whether they are going to stay or not.

ASSEMBLYMAN WEIDEL: They are going to stay.

ASSEMBLYMAN WATSON: We are just trying to get a few of our questions for the Department out of the way. We do not intend to question each and every one of them. But, we have a few questions we want to ask the Department and the Department of Health in the beginning. Then, of course, we are going to hear from the Public Advocate's office. From there on, we will abide by your suggestion.

ASSEMBLYMAN WEIDEL: Okay.

ASSEMBLYMAN WATSON: Assemblyman Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: I'll pass.

ASSEMBLYMAN WATSON: I do not hear any other questions from the Committee, Mr. Russo. We will look forward to your specifics within the next couple of weeks or so.

MR. RUSSO: We will be here for the duration of this hearing in order to inform ourselves about the wishes of those who testify, so that we will be in a better position to formulate a Department proposal to you.

ASSEMBLYMAN WATSON: Thank you.

MR. RUSSO: Thank you, Mr. Chairman.

ASSEMBLYMAN WATSON: Is Mr. Scott Crawford here from the Department of Health? (affirmative response) Good morning, Mr. Crawford.

SCOTT CRAWFORD: Mr. Chairman and members of the Committee: My name is Scott Crawford. I am a Reimbursement Specialist with the Office of Health Planning and Resources Development in the State Department of Health. Thank you for the opportunity to speak to you today concerning Assembly Bill 608 on behalf of the Department.

The Department of Health supports the overall purpose of the legislation, which would extend health care coverage to low-income population groups who are presently not eligible for such assistance

programs as Aid to Families with Dependent Children or Supplemental Security Income, yet who are below the Federal poverty level.

When the Department appeared before this Committee last July at the first public hearing on A-608, we explained to the Committee that a significant amount of uncompensated care is incurred in our urban hospitals. Approximately 20% of all uncompensated care is related to outpatient services, while 80% is related to inpatient services. At the present time, these services are available to needy individuals in part through the Medicare waiver which the Department of Health has received from the Health Care Financing Administration.

Following the Department testimony before this Committee last July, Vice Chairman Watson asked the Department to work with the Department of Human Services and the New Jersey Hospital Association in an effort to estimate the number of people who use inpatient and outpatient hospital services who may meet medically needy income and assets standards, and to obtain information such as the age of such people, type of services used, and the dollar amount of services received. The Department itself does not have data with this level of detail because it is not necessary for rate-setting purposes. Department of Health staff has prepared a charity care survey form as a suggested format which would not create an undue burden to the hospitals, but which should provide fairly reliable information. This charity survey form is broken up into several categories, such as the patient's income, his or her number of dependents, age, sex, and race of the patient, the type of services rendered, and the cost of the services.

The Department has provided this survey form to both the Department of Human Services and the New Jersey Hospital Association. It is our understanding that the Hospital Association is presently attempting to gather this information from various hospitals throughout the State. However, to date, the hospitals have not been willing to provide this information.

Under the State DRG system, there is full payment for the treatment of the State's medically indigent who receive inpatient and outpatient services in a hospital facility. The New Jersey DRG system

is presently an all payer system and the costs of the coverage rendered to the medically needy is spread across a wide range of payers, thereby reducing the current cost to the State. This system is made possible in part through the Medicare waiver which the Department of Health has received from the Health Care Financing Administration of the Department of Health and Human Services. In 1985, it is estimated that uncompensated care in New Jersey hospitals will be approximately \$225 million. Under the New Jersey system, Medicare shares in approximately \$90 million of this burden. However, under the national system which went into effect in 46 states in October, 1983, Medicare does not share in any of this cost. New Jersey's Medicare waiver expires on December 31, 1984.

On September 28, the Department of Health applied to the Health Care Financing Administration for an extension of our waiver for an additional three-year period. For the past several months, Department of Health officials have been involved in ongoing negotiations with the Health Care Financing Administration, and the Department is doing everything possible to secure the waiver for an additional three-year period. A renewal of our waiver would allow the cost of treating the State's medically needy population to continue to be paid under New Jersey's unique all payer system. A final decision by HCFA is expected to be given prior to the end of December. As stated at the outset, the Department of Health supports the overall purpose of a medically needy program which this legislation would provide. By increasing the medical care available to those people who would qualify for assistance under a medically needy program, it would enable many patients to receive the medical care necessary to keep them from eventually needing hospital care which they are unable to pay for and which is, therefore, picked up by other payers, including Medicare, under the State's all payer system.

However, from the Department's standpoint, the medically needy bill would be especially beneficial to the extent that it covered outpatient and inpatient hospital services. It has been estimated that the cost of providing both inpatient and outpatient hospital services to all groups that could be covered in a medically needy program would

be approximately \$134 million. To the extent that this legislation offers coverage for outpatient or inpatient hospital services for any of the four options being considered under the bill, the effect would be to reduce the pressure on the system that results from shifting large amounts of uncompensated care costs to third-party payers, including Medicare. Coverage for these services will be especially critical if the State is unsuccessful in obtaining a waiver renewal for an additional three-year period, or in the event that the waiver is not renewed in 1987, when such a waiver would expire.

ASSEMBLYMAN WATSON: Thank you. I have a couple of questions I would like to ask you. In reviewing some of the share forms submitted by hospitals for rate-setting purposes, many inner-city hospitals indicate "No indigent base," or a very low indigent base. How reliable is the information submitted by the hospitals?

MR. CRAWFORD: Generally speaking, the share forms are very reliable. Certain elements in those forms which are not used for rate-setting purposes may be less reliable than others. The extent of medical indigency in urban hospitals varies considerably.

ASSEMBLYMAN WATSON: Why have hospitals been reluctant to cooperate with the survey?

MR. CRAWFORD: I am not aware of all of the reasons. I believe that possibly the Hospital Association may be a better one to comment on that. There are issues of patient confidentiality that have to be addressed.

ASSEMBLYMAN WATSON: How do they satisfy the Hill-Burton Act when it comes to bad debts? Don't they have to give this information to them?

MR. CRAWFORD: I don't think they have to give the extent of information that is requested here. They have to document that the patients treated were truly medically needy. That doesn't require quite as many elements as are included in the form that we provided.

ASSEMBLYMAN WATSON: You know, my feeling is that if it is to their benefit, why wouldn't they cooperate with us?

MR. CRAWFORD: I really cannot say.

ASSEMBLYMAN WATSON: Suppose they lose the DRG in the end?

MR. CRAWFORD: Suppose we lose the waiver?

ASSEMBLYMAN WATSON: Yes.

MR. CRAWFORD: There are many hospitals which would suffer.

ASSEMBLYMAN WATSON: And, we are not getting the cooperation needed for this. Do you have any idea why?

MR. CRAWFORD: I have not been directly involved in attempting to obtain this information from hospitals. The Hospital Association has been carrying out this effort.

ASSEMBLYMAN WATSON: All right. Are there any other questions? Assemblyman Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: I am a little bit confused. I presume we will hear from the Hospital Association. Do you mean to say that in your Department you do not have this data?

MR. CRAWFORD: We do not have this data. The data that--

ASSEMBLYMAN FRELINGHUYSEN: (interrupting) Actually, at the last public hearing, I asked whoever it was who represented the Department of Health a question which may have led to the idea of a charity survey. Where county governments have traditionally contributed to the care of indigents within their county boundaries, sums of money have gone to hospitals on a formula basis. I would imagine that beneath the reams of paper in your Department -- with Certificates of Need and all the other types of such applications -- there must be data on what the true indigent costs are. As the Chairman said, it is really in the interest of the hospitals if, in fact, it is an inordinate burden on them to carry such costs, even if at present they are shared under an all payer system.

You said in your statement that it is only the urban areas that have indigent hospital costs. However, suburban settings have these costs as well. Having been a Freeholder, I know we received, on a regular basis, continuous complaints. To a certain extent, even today under the DRG system, we receive complaints about continuing indigent costs based on the number of individuals who come through the emergency room doors of hospitals. I can't believe there isn't someone in the bureaucracy of your Department who has those figures or who can put his fingers on them. I see no reason why anyone would be unwilling to share those figures if, in fact, we are going to be able

to grapple with this overall legislation and what it means in terms of providing health care. That was basically a question and a statement. Thank you.

MR. CRAWFORD: We do have aggregate data concerning uncompensated care. This data is collected by hospitals as they attempt to bill or as they apply financial screens to determine that patients are medically indigent. They collect data which is then aggregated on a patient-specific basis, which is what the form that was prepared requests. We have clinical information and billing information. There is no indicator of whether the patient was determined to be medically indigent on the patient-specific data we currently have.

ASSEMBLYMAN FRELINGHUYSEN: I think your answer is a fair one. I do not withdraw all of my comments, but I certainly understand that when you are dealing with clients on a governmental level, you have confidentiality. In fact, perhaps it is true, as you say, that the hospitals have difficulty, inasmuch as people do have a right to protect knowledge of their incomes. Maybe even the overall figures-- Have the overall figures you mentioned been submitted?

MR. CRAWFORD: I am not certain just what information has been supplied.

ASSEMBLYMAN FRELINGHUYSEN: That in itself may be of value. Surely someone could estimate what the other statistics may be.

MR. HERSHBERG: The Health Department has supplied the staff with certain information on indigent costs and other sources of revenue. So, they have been providing information to staff concerning hospital finances.

ASSEMBLYMAN WATSON: I would like to recognize the presence of Assemblyman Kavanaugh, who has joined us today. Assemblyman, how are you?

ASSEMBLYMAN KAVANAUGH: Fine, thank you.

ASSEMBLYMAN WATSON: Are there any other questions for Mr. Crawford? (negative response) All right, thank you, Mr. Crawford.

May we have Mr. Edmund Abramovitz from the New Jersey Hospital Association? Please state your name and title for the record.

EDMUND ABRAMOVITZ: Yes, sir. I am not Craig Becker, as the speakers' list announces; I am Edmund Abramovitz, Assistant Vice President and Director of Management Practices for the New Jersey Hospital Association. I am here to, once again, underscore the Association's support for Assembly Bill 608 and, also, to provide additional information on the nature and extent of medical indigency in New Jersey.

We believe that this Committee is certainly to be congratulated for its foresight in placing emphasis on medical indigency at this very critical time. Our support for such legislation is longstanding, and takes on particular significance now as the Federal government considers whether to renew New Jersey's Medicare waiver. As you gentlemen are certainly now aware from the testimony of the previous speakers, termination of our waiver could result in an end to Medicare's participation in payment for indigent care. The consequences for other payers, for hospitals, and for State government are enormous. Pro-active measures, carefully considered and aggressively undertaken now, may be instrumental in minimizing a crisis later, should Federal participation change.

The hospitals of our State have a long history of commitment to health care for the poor. Unfortunately, this commitment pushed many hospitals to the brink of financial collapse. Only by the establishment of financial elements of cost which recognized indigent care expenses was a crisis averted.

Since that time, the financial solvency of many of these hospitals clearly has improved. What has not improved, however, is the extent of need in the indigent populations served. Therefore, while fiscal crisis in heavily indigent hospitals has been averted, we will find ourselves quickly back where we were before adoption of Chapter 83 if we do not ensure continued support for indigent care.

Let me take a moment to illustrate the significance of Medicare participation in the care of New Jersey's indigent and the consequences of termination of that participation.

In the "average" New Jersey acute care hospital, 6% of all patients cannot afford to pay for their own care, and are not

beneficiaries of other programs. Thus, 94 patients, about 40 of whom are Medicare beneficiaries, and 54 others, collectively pay for the care of the six those care is otherwise uncompensated.

If we remove Medicare participation in uncompensated care in this "typical" hospital, that is, if the waiver expires, for every 100 patients, 89 non-Federal patients must pay for the uncompensated care of 11.

Let us for a moment consider an all-too-familiar case: An inner-city hospital, typically serving an aging Medicare population in its aging neighborhood, along with a high indigent load. In this particular, but by no means extreme example, 12% of the patients are medically indigent and are unable to pay for their care. Under the existing all payer system, the care of these 12 will be equally distributed among the remaining 88 patients, 40 of whom are Medicare beneficiaries, and about 48 of whom fall into all other categories. If Medicare drops out of uncompensated care, the resulting ratio is astonishing. Eighty patients will pay for the care of 20, or only four paying non-Federal patients paying for each individual who cannot pay.

The inevitable result of such an imbalance is to render these hospitals completely cost ineffective, uncompetitive in an age of emphasis on competition, and potentially unable to attract paying patients, thus widening the gap even further. The practical effect is a regressive tax on the paying sick and their insurers, to answer a societal problem which demands a far more broad-based public commitment.

It is in this context that we add our qualified support to Assembly Bill 608. The effect of this bill in its present form is that by committing only \$30 million, \$35 million, or \$36 million in State funds, the Legislature can provide, through matching Federal funds, \$60 million to \$70 million in much needed health services to New Jersey's citizens.

The total uncompensated care burden facing our hospitals, presently spread among all payers, amounts to some \$270 million. In the face of this large free-care burden, the dollars provided by A-608 constitute little more than a down payment. Because of the bill's

population targets, the principal beneficiaries will be prenatal and perinatal patients, and foster children. Relatively little of the \$60 million will be spent on inpatient care. The amount spent for ambulatory care will pay for services in many settings, not only in hospitals. Thus, the bulk of the \$270 million free-care bill will remain untouched, and, therefore, will still be vulnerable to Federal withdrawal from the system.

Commissioner Goldstein has confirmed Commissioner Albanese's estimates that expansion of the Medically Needy Program could provide over \$134 million for hospital services, or half of the current total of all uncompensated care costs. While this \$134 million is presently absorbed entirely by New Jersey's citizens and businesses, the medically needy option would shift half of this burden to the Federal government. Two dollars of benefits result from every State dollar spent. Your actions can help to relieve the hidden tax imposed on the paying sick, their families, and their employers at only half the cost of the program's real benefit. And, we reduce New Jersey's reliance on a Medicare waiver to support indigent care.

We urge you to adopt Assembly Bill 608, to expand its provisions, and to provide an appropriate funding level for a comprehensive medically needy plan. Gentlemen, I am prepared to take your questions.

ASSEMBLYMAN WATSON: Thank you. I think Medicaid should also be included in your statement, along with Medicare, with regard to indigent costs.

According to the data we have received on our share forms, the number of indigent patient days is only 1.6% for all hospitals from which we have gotten our information. Yet, you cite 6% indigent care. Again, I must ask, how reliable is the data supplied to the Health Department on indigent care?

MR. ABRAMOVITZ: I guess I really have to support what the Health Department speaker said, which is that data supplied on a cost accounting basis-- We expect that this is reliable information; however, it is sort of an -- if not an apples and oranges question -- an oranges and tangerines question, because there may be approximately

2% of days covered, but the costs can be measured in other ways. I am not referring to patient days, but to costs. Indeed, if the Medicare patient load is perhaps sicker or if it is composed of an outpatient component, which certainly it is, there are a lot of costs beyond a 2% free-care burden. So, it is very conceivable that while patient days might account for only 1.6%, or in that neighborhood of indigent days, indeed, the costs might be very much higher.

ASSEMBLYMAN WATSON: From what I gather, you do not have much confidence in the auditing of patient days that we requested. We get back 1.6% of it; in your testimony, you said it is 6%. There is a big difference there.

MR. ABRAMOVITZ: Sure.

ASSEMBLYMAN WATSON: That alone tells me something. The information that has been gathered, with your conflicting information here this morning, is not reliable.

MR. ABRAMOVITZ: Well, I think what I am saying, Assemblyman Watson, is that while the patient days may account for 1.6%, the costs -- because the total costs of the indigent care package also include ambulatory outpatient care -- might push that total up to more like 6% in the aggregate statewide. So, I do not think the figures are necessarily in conflict. The costs associated with those days might indeed be higher than the raw number of days would indicate.

ASSEMBLYMAN WATSON: Sir, if they are not accurate in reporting their inpatient days, how accurate are they in their cost factor?

MR. ABRAMOVITZ: Well, I am not suggesting that the inpatient day number is inaccurate. What I am saying is, that may indeed be the number of days. I am not in a position to be able to comment on the specific information contained in the share reports. I am not a financial analyst. Therefore, I think I would have to say to the Committee that we would be happy to work with the Department to try to purify those numbers, if they are, indeed, in conflict. My position is that it is not inconceivable that 1.6% of the days would result in 6% of the costs. The 1.6% of the days does not necessarily have to equate to 1.6% of the costs, because the patient days have no factor in them for ambulatory outpatient care.

ASSEMBLYMAN WATSON: I know we received zero patient days from St. Joseph's Hospital in Paterson. Does that seem logical to you?

MR. ABRAMOVITZ: No, it does not -- not nearly. I cannot explain that. It may be a reporting problem; it might even be a stenographic problem. I really cannot explain that, but it is something we would be prepared to work with the Department to purify. Indeed, a number like that is an error. Very clearly, St. Joseph's Hospital has a great deal more than zero patient days for indigent care.

ASSEMBLYMAN WATSON: I know the Department of Health has stated that the hospitals have really not cooperated in the survey. Would you agree with that?

MR. ABRAMOVITZ: I would certainly not agree. I would like to set the record straight on that matter. We have been the recipient of information copies, through the courtesy of both Commissioner Albanese and Commissioner Goldstein, of correspondence which has circulated between their offices on the preparation of the survey form you have requested. However, at no time was the participation of the New Jersey Hospital Association solicited in the development of that form. Indeed, we just received a copy of what they presume might be the final document on November 16. That is not really a very long time for us to have reacted to the survey.

We stand ready to participate at any time. We think the present survey form as sent to us -- and, by the way, that came as an information copy -- is flawed. We do not believe it will get you the information you want to receive in the form it presently takes. We think there may even be better ways to come up with the information. Certainly, we think there are problems with patient confidentiality. I suspect that none of you gentlemen on the Committee would very much appreciate a request from an admitting clerk upon entering a hospital asking you how much you make. That is a difficult question to put to people. There is really no way to tell prospectively, just by looking at an individual, whether or not he is going to fall into the indigent care category. Therefore, we are forced to ask everyone that question, and we are kind of sensitive about that. Indeed, a couple of the

hospitals with whom we shared that information told us candidly that upon review of the document with their legal counsel, they are very concerned about the appropriateness and legality of responding to the survey as it is presently constructed.

Now, that by no means suggests that we are unwilling to cooperate. We are willing now, as we have consistently been, to work up a form that we can all live with, which would give this Committee the information it needs, but would not embarrass patients nor put hospitals in a potentially threatening legal position. We will do that.

ASSEMBLYMAN WATSON: I have a couple of other questions, but I am going to hold them until my Committee members have had a chance to ask their questions. Assemblyman Villane?

ASSEMBLYMAN VILLANE: No questions.

ASSEMBLYMAN WATSON: Assemblyman Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: I have no way of knowing through your comments about the inappropriateness of the indigent care survey. But, since you have offered, perhaps the Committee should take you up on this. If, in fact, you would like to make up a survey of your own, knowing generally what we are trying to get in the way of information that would be valuable to this Committee in reaching some conclusions, I, for one, would certainly seek your assistance in gathering whatever data we could get from hospitals in different settings. Like it or not, we are all in this business together. If we are going to control health care costs, as well as expand health care services, we have to be in it together. So, if there is no objection, I would certainly like to get something from you in the way of data gathering, so we can put to rest any concerns about the lack of cooperation and other things. Thank you.

ASSEMBLYMAN WATSON: I would officially ask that of you, too. Would you kindly send it to the Chair?

MR. ABRAMOVITZ: Certainly.

ASSEMBLYMAN WATSON: Hospitals must collect the income information for the Hill-Burton Act. Is that correct?

MR. ABRAMOVITZ: Yes, that is correct.

ASSEMBLYMAN WATSON: And, to verify bad debts, right?

MR. ABRAMOVITZ: That is correct.

ASSEMBLYMAN WATSON: Why does this survey pose an additional problem, particularly since we are trying to help hospitals?

MR. ABRAMOVITZ: The difficulty is that Hill-Burton information, as the previous speaker suggested, is always aggregated. It is not retained in the form of individual patient information, which is necessary with the form which the Department has devised because it matches income level with particular information on charges that an individual accrues while hospitalized. Therefore, it must be maintained on an individual basis. That is one problem.

The second difficulty is, we collect Hill-Burton information from an individual who comes in and volunteers to the institution, "I believe I qualify for Hill-Burton care because I cannot pay my bill." The individual has been forthright and has told us that he anticipates a problem. To get a much more accurate figure -- prospectively, if you will -- on which of these patients will be unable to pay for the care, we are forced to ask this potentially embarrassing question of everyone who comes through the door. So, there is a substantial difference in those two kinds of surveys.

In addition, when we speak of bad debts rather than free care, it is sometimes impossible, prospectively, to determine which particular case is going to turn into a bad debt case. So, very often we find that information out long after the patient has left our care and far too late to be able to complete the Department's survey. We think those are some of the complicating factors.

ASSEMBLYMAN WATSON: Assemblyman Kavanaugh?

ASSEMBLYMAN KAVANAUGH: I have one question for you, sir. Is it an embarrassing situation if someone is coming into your place of business -- and that is what a hospital is -- and you ask them if they can afford to pay? I have never been able to go into a hospital and just get a free ride upstairs without putting out all my credentials.

MR. ABRAMOVITZ: That's right, but we never ask you what your income level is. That is what--

ASSEMBLYMAN KAVANAUGH: (interrupting) Is that the only thing you find offensive on the survey?

MR. ABRAMOVITZ: That is the principal thing.

ASSEMBLYMAN KAVANAUGH: Could you enumerate the things you find offensive on the survey?

MR. ABRAMOVITZ: The difficulty is, we have two documents in our hands. The Department has given us two different surveys, and we are not entirely sure which one they want to use. That is the single most offensive piece of information. There may be others that individual hospitals might find difficult but, from our view, that is the most troublesome one. However, we also concede that without that information, the survey becomes somewhat pointless. I think we may be able to get around the apparent difficulty by finding other alternative sources for this information. We think the Department may find, with our cooperation, that there are places in the data base where equivalent information may be extracted. We are not certain about that, but we think a little digging might get us the information we need without having to go to these lengths.

ASSEMBLYMAN WATSON: Mr. Abramovitz, this information is certainly needed. It is needed to the extent that this survey was sent out to the hospitals, for Human Services, and for the Department of Health to answer our questions as best as possible, so we might be able to get on with business. Before you leave, I would like to let you know that I think in dealing with this piece of legislation, the Legislature should tighten up on the viability of the hospitals in getting us better accountability and more documentation on how our money is being spent. We have not gotten the kind of information necessary here to enable us to tighten up a good bill. We could have had better help.

Our hearings have been held over four or five months, and I think that has been enough time for you to get back to us. We are not dragging our feet. It is the information we have requested, which is not here, that is going to make us drag our feet. We are trying to do the best we can for the people of this State, while also helping the hospitals, and all others, to do their jobs as easily as possible. This is beginning to be as difficult as possible. I don't see why we can't get this kind of information.

If you can, within the next few days -- because we are going to be pushing this bill out -- please try to get us some information that will be a positive kind of a thing so we might be able to use it to make this a better bill.

MR. ABRAMOVITZ: Mr. Chairman, we couldn't agree with you more. However, our attempt is just to set the record straight. Considering the fact that we still have two conflicting documents in our hands, which were provided by the Department of Health, considering that they have been in our hands for only two and a half weeks, we do not think the difficulty in compliance rests on the shoulders of the hospitals of this State. In the testimony of Mr. Becker, who met with you in July, we have committed the Association to the support of your data-gathering activities, and that commitment still stands. However, we need some help also. We are willing to do whatever we can as soon as we get a survey instrument from the departments in State government which they feel will gather the data.

ASSEMBLYMAN WATSON: That would be my next question to you. Isn't it possible for you, or someone from your Association, to sit down with the departments and hammer this thing out?

MR. ABRAMOVITZ: Absolutely.

ASSEMBLYMAN WATSON: I would like to see that done within the next couple of weeks or so, so we will be able to move this bill.

MR. ABRAMOVITZ: We stand ready, Mr. Chairman.

ASSEMBLYMAN WATSON: Thank you for your appearance here today.

Our next speaker will be Mr. Ed Tetelman from the Department of the Public Advocate.

EDWARD H. TETELMAN: I would like to thank the Committee for the opportunity to speak to you today about the Medically Needy Program, and congratulate you on the interest you have shown on this, asking what I think are some very important and pointed questions. Also, I would like to say that providing that \$125,000 to Human Services is important, so that the administrative mechanism can get moving and we can finally get this long-needed legislation through.

We have supported the Medically Needy Program for about 10 years now trying to get it established. As we see it, it covers a number of groups. It covers children, it covers disabled individuals, and it covers the elderly. We also think it should cover the single parents of those children, because if a parent is ill, he or she is not going to be able to take very good care of the child. Unlike Commissioner Albanese, we think that that group should also be covered, and that is permitted under the Federal legislation.

The services that are provided, as have been talked about, are incremental at this point. First, we would like to see the ambulatory services covered in this State. They are aimed at keeping individuals out of hospitals. They are to keep them ambulatory, to take preventive steps, and to make sure that people can meet their potentials, obtain jobs, go to school, and do well in school. We would recommend that the following types of services be covered for children: outpatient clinic services, laboratory and x-ray, freestanding clinic services, drug services for the children and single parents, dental services, optometric services, optical appliances, prosthesis and orthotic devices, medical transportation, medical equipment, and the Early Periodic Screening, Diagnosis, and Treatment Program, the only program paid for by the Federal government that is really preventive. Included under this program, the Federal government mandates postnatal care, prenatal care, and delivery services for pregnant women.

We would also like to see a similar complementary program of services provided for single parents. For the disabled and elderly, the services we have examined are home health care, laboratory/x-ray services, clinic services, medical day care, physicians' services, medical transportation, and medical supplies and equipment. We would also include dental care, podiatric care, eyeglasses, and chiropractic care. Those are the types of things we think it is important to cover.

In terms of costs, the Department of Human Services has estimated costs on a number of levels. The types of services we are talking about here fall most closely to their Option Three, which they estimate to be higher than Option Two, which is about \$70 million. In looking at this and trying to determine what kind of costs there are

out there, we called the State of Massachusetts. Massachusetts has a Medically Needy Program which is similar in its complement to what New Jersey provides and whom we would cover. We asked them what the costs would be and what the number of eligibles is. They covered 79,011 medically needy eligibles in Massachusetts as of Fiscal Year 1983.

To break down some of the costs they have actually accrued in their state, physician care cost them \$8.9 million; drug services, which included the elderly, cost them \$17.6 million; outpatient services cost \$11.2 million; medical equipment was \$2.5 million; home health services were \$3.4 million; dental care was \$3.2 million; laboratory services were \$1.1 million; and, physical therapy and other services like that were \$2.5 million. This adds up, if we are talking about ambulatory services, to \$50.4 million. If you take out the drug component -- because we haven't split it out -- it reduces the cost of their program to \$32.8 million, which is quite a bit different than the estimates we have seen.

We also agree that by providing a medically needy program, it is going to shift people out of the outpatient clinics in the hospitals. They are going to be able to obtain care from physicians who normally do not get reimbursed for indigent care, so there is an incentive not to deliver that kind of care.

We also note that this is a program that will bring Federal dollars back to New Jersey. That is one of the cries we have heard constantly in this State; even the Governor has commented on it. This is an opportunity for us to bring Federal dollars back. And, most importantly, this is the time to provide access to necessary services to low-income people, to children, to their parents, and to the disabled and elderly people who have gone without, and who often wait until they are very, very ill before they seek care in a hospital.

I am open for any questions at this point.

ASSEMBLYMAN WATSON: Thank you, Mr. Tetelman. First, I would like to have a copy of what you read.

MR. TETELMAN: They are just notes, but I can provide you with them.

ASSEMBLYMAN WATSON: Will you please send that to us in writing, through the Chair, within the next week? You named different areas you would like to see covered. What about caretaker relatives?

MR. TETELMAN: I think that depends on their incomes. You might want to look at that. If, in fact, the caretaker relative had the resources by which to cover the services, then I do not think we would want to cover that. I don't think that technically it is a question of whether or not you can help or even cover those individuals.

ASSEMBLYMAN WATSON: You have heard our concerns about documentation for the hospitals. Do you share our concerns?

MR. TETELMAN: I share your concerns very much. In fact, I am quite familiar with what the Hill-Burton Act requires, and I know what the regulations say. The regulations say that when an individual indicates that he or she cannot pay for care, the hospital then has to offer them uncompensated care. It does not say that you always have to ask when a person comes in. However, if a person indicates that he or she does not have a job, or does not have insurance, then I think the statement should be made, "Well, you might qualify for uncompensated care. We request that you apply for this." Now, when you are determining uncompensated care, you are required to ask for income. That is the way you determine if someone is eligible, both under Chapter 83 and under Hill-Burton. I don't see how you can get out from under asking for that kind of information. It may not be aggregated on an individual basis, but you could have done some kind of a service between July and now to find out that information.

ASSEMBLYMAN WATSON: Can you provide us with your recommendations within the next seven days?

MR. TETELMAN: Yes, I would be happy to. If you have other questions you would like me to respond to which would be within our area of expertise, I would be happy to do that, also.

ASSEMBLYMAN WATSON: Do any of the Committee members wish to ask Mr. Tetelman any questions? (negative response) All right, thank you, Mr. Tetelman.

MR. TETELMAN: Thank you very much.

ASSEMBLYMAN WATSON: Our next witness is Ann Zahora, the Director of the Division on Aging. Good morning, Ms. Zahora. I guess I should say "Good afternoon," since it's 12:10 p.m.

ANN ZAHORA: Good afternoon, Assemblyman.

ASSEMBLYMAN WATSON: Do you have a written statement?

MS. ZAHORA: I have some notes. I will get a written statement to you tomorrow.

I am Ann Zahora, the Director of the New Jersey--

ASSEMBLYMAN WATSON: (interrupting) Would you mind turning your microphone on? (indicates button on amplification microphone) Just push the button.

MS. ZAHORA: I am Ann Zahora, Director of the New Jersey State Division on Aging. I thank you for the opportunity to speak on Assembly Bill 608.

The medically needy concept, as you well know, has been around for quite some time. At the Division, we certainly favor this concept. No one can dispute the fact that certain groups, among them the elderly, often go without proper medical care. This, as you know, is due to low incomes, as well as the escalating cost of health care.

We sadly agree that medical care is often unavailable to people who live just above the poverty level and sometimes beyond. We do not believe, however, that passing A-608 in its present form will solve this problem. We feel this way because, first of all, the cost estimates for this program are quite soft. The range of estimates is incredible. This indicates that budgeting would be a difficult, if not next-to-impossible, task. This is due to an inability to estimate costs up front and year-to-year variations. Sound budget practices certainly require budgeting for this program at the highest range. In our opinion, this would be extremely expensive. In addition, the estimated costs for administration are extremely high.

This bill, A-608, is quite loose in its present form. We certainly hope you will look at it closely, in order to pull it together. Earlier today, I was pleased to hear that you are, in fact, accepting amendments to do this.

Another issue is that of casino funds, or the proposed funding sources for our elderly and disabled recipients. I was also pleased to hear Assemblyman Deverin say this would be looked into and, perhaps, changed. Across the State, we are concerned about the use of the casino funds, and we so testified at a casino hearing in Atlantic City last week. We are not quite sure, with regard to the the casino moneys as they stand now, that there would be enough money available to fund a portion of a program with broad parameters, such as this. We certainly don't want programs that are currently funded with this money to be cut back or eliminated.

We also ask that you consider the mood in Washinton, which appears to favor cuts in spending. As you well know, any cuts in Federal spending will affect aid to the states. Of course, the Federal deficit is also being watched closely. We are concerned with this mood, because the bill contains a 50/50 State-Federal match. At this time, given the way Washington is looking at funding situations, that is a rather precarious notion. We certainly would not want the State to end up holding the entire financial bag for this program. We ask that you examine this position carefully.

Perhaps you may consider some additional concerns of ours. One is that real efforts be made to control the rising costs of medical care. We feel these costs are almost as much to blame for people not being able to afford medical care as are low incomes.

Second, those of us in the Division, and older people with whom we have spoken, feel that home health care does need to be expanded. In our opinion, the need for home health care knows no bounds. The elderly will definitely be served if home health care is made more readily available. Mr. Chairman, the Division on Aging in the Department of Community Affairs and the Task Force on Legislative Concerns of the Elderly, which is made up of numerous senior-citizen organizations, question this legislation in its current form while favoring home health care and the medically needy concept.

In summary, we are most concerned about the efficiency, costs, and effect of A-608 on other valuable programs that serve the seniors of our State. I hope that Commissioner Albanese's report,

which I understand you will receive in a few weeks, will also address some of our concerns. Thank you, Mr. Chairman.

ASSEMBLYMAN WATSON: Thank you, Ms. Zahora. We have a few questions for you. Number one, I have in my hand a press release that was issued prior to your testimony today before this Committee. If you have any confidence in this Committee at all--

MS. ZAHORA: (interrupting) Pardon me?

ASSEMBLYMAN WATSON: If, as you have indicated, you have any confidence in this Committee at all, you have issued a press release that was--

MS. ZAHORA: (interrupting) I had asked that it not be released.

ASSEMBLYMAN WATSON: Then how was it distributed? How is it that I came into possession of it?

MS. ZAHORA: I do not know how you received it, sir. At 9:00 a.m. today I asked that it not be released. I do not know how you received it.

ASSEMBLYMAN WATSON: Was it not released with a copy of your testimony?

MS. ZAHORA: As I said, it was set to go this morning, and at 9:00 a.m. I asked that it not be released. I cannot explain how you received it.

ASSEMBLYMAN KAVANAUGH: Distribution was not made through normal channels then, as far as you know, other than the copy that came to the Committee?

MS. ZAHORA: To the best of my knowledge, that is correct. I was unaware that you had this copy. I specifically asked that nothing be sent to anyone, so I really don't know how you got it.

ASSEMBLYMAN WATSON: It is the Committee's intention, as you know, to tighten up this bill. We have not indicated from what source we are going to fund this bill, or whether it will come from casino funds. How would you feel about this funding coming from the surplus?

MS. ZAHORA: That would be fine. As I indicated earlier, our concern about casino funds and the use thereof is that they are being used in a patchwork fashion. If we pull casino moneys here and there

for so many things, we are going to have a problem down the line. This is, essentially, what we are trying to avoid.

If we don't step back and take a good, hard look at what the casino moneys are paying for, and if these moneys continue to proliferate, we are concerned that in a few years there will have to be a cutback in valuable, worthwhile programs for the elderly and the disabled. In our opinion, if you can use surplus moneys for this and not touch the Casino Revenue Fund, that would be most acceptable.

ASSEMBLYMAN WATSON: What happens when the surplus dries up?

MS. ZAHORA: Eventually, I suppose, you would have to consider additional taxes. I am not really wise enough to answer that question. All of those things would have to be considered by someone more fiscally oriented than I. In addressing this, I asked that we look at the total cost and cost-effectiveness of it, no matter where the money comes from. I think we must be very careful in our planning for the future.

ASSEMBLYMAN WATSON: Ms. Zahora, did you testify before the Corrections, Health, and Human Services Committee on A-608?

MS. ZAHORA: I did not. No, I did not.

ASSEMBLYMAN WATSON: Did someone from the Division testify?

MS. ZAHORA: At your last hearing in the summertime?

ASSEMBLYMAN WATSON: At Assemblyman Otlowski's Committee's hearing.

MS. ZAHORA: I would have to go back and check, sir. I really cannot say.

ASSEMBLYMAN WATSON: You are not aware that you testified for this bill?

MS. ZAHORA: We may have testified. I am sorry that I don't know whether we did or not.

ASSEMBLYMAN WATSON: An important piece of legislation like this--

MS. ZAHORA: (interrupting) I know it is important, but I--

ASSEMBLYMAN WATSON: (continuing) --with your feelings on it, and you don't know whether your Division testified?

MS. ZAHORA: I am embarrassed that I do not have the answer for you. We have a legislative aide, and I believe she did testify.

ASSEMBLYMAN WATSON: Do you have someone in the room that could get me the answer to--

MS. ZAHORA: (interrupting) I don't have anyone in the room, sir.

ASSEMBLYMAN WATSON: (continuing) --whether you testified favorably or unfavorably on this bill?

MS. ZAHORA: I have no one else in the room.

ASSEMBLYMAN VILLANE: Mr. Chairman, may I interrupt?

ASSEMBLYMAN WATSON: Certainly, Dr. Villane.

ASSEMBLYMAN VILLANE: Mr. Chairman, I regret that the press release was issued like that. We don't know who is responsible, but we will certainly look into it. You can tell by the attendance of the Republican members of this Committee today that we are very anxious and concerned about the bill. We want to hammer-out a piece of legislation that will address the concerns of the medically needy. We have no opinion. We are here to listen, form an opinion, and work with both you, Mr. Chairman and the sponsor of the bill. We regret that the press release was issued.

ASSEMBLYMAN WATSON: Thank you, Dr. Villane. I have one other question for the Division. The State of New Jersey previously picked up nearly 8% of the cost of Federal Medicaid cutbacks. How did the Division feel about that?

MS. ZAHORA: I am not sure I understand what you mean.

ASSEMBLYMAN WATSON: You expressed a concern that the State would be left holding the financial bag. The State, in fact, picked up about an 8% cutback in these funds, so I believe we have acted responsibly. We have tried to do what we are supposed to do. I regret, and I am a little surprised, that something like this would happen before we could have this hearing. I accept your statement, Dr. Villane. Would any other members of the Committee care to question the Director of the Division on Aging? Assemblyman Kavanaugh?

ASSEMBLYMAN KAVANAUGH: I believe the concern expressed by the Director is substantive. It is a concern that has been expressed to me and other members of the Legislature. (motions to nearest microphone, in front of Assemblyman Weidel) Would you just push that button, please, Karl?

ASSEMBLYMAN WEIDEL: That's the recorder. Try the other one. (indicates amplification microphone)

ASSEMBLYMAN KAVANAUGH: It is disconnected.

ASSEMBLYMAN WEIDEL: It may not be. It may be connected to another unit. (pushes button) Did it come on?

ASSEMBLYMAN KAVANAUGH: Yes. What has been expressed by the Director this morning is substantive because of the concerns that have been voiced by senior citizens throughout the State. Assemblyman Watson alluded to the fact that we don't know whether we are going to take this funding from the surplus or whether it will come from casino revenues. The amount of expenditures we have had in recent years coupled with proposed legislation now in the hopper exceeds \$300 million. That is a staggering sum. You are aware, I am sure, that I have an ACR in to freeze any future expenditures of casino revenues until we get input from the seniors.

We often go in the other direction. We tell individuals how we are going to spend their money. This money belongs to the seniors and the disabled. We have to be aware of that. The bill before us at this public hearing today, A-608, has a great deal of merit, but we should also remember the time when we sat back and talked about the PAA program. We had sheets with facts and figures. We were going to spend \$5-\$6 million. Today we have an excess of \$50 million. These are the concerns I have.

We have talked of \$38 million that would be spent and of matching funds. That is with Option Two. We have people here today who have major concerns about how they are going to pay for their hospital care. We have heard concerns expressed by seniors who have disabled children. Who will take care of their children when these seniors pass away? All of these things concern us as legislators.

We must be open-minded as we discuss this piece of legislation. We must ask if this is the best direction to take, or if there are other ways to go. We must take it all and make it a cohesive group, rather than just say, "This is it. We're going to spend this \$38 million, then next week we are going to look at something else."

Down the line, priorities will have to be established. We will have to look at what is in the best interest of the seniors and the disabled of the State, because this is not going to continue. We can see a leveling-off in the revenues we are receiving from the casino industry. This year, we had to dip into \$5 million of the surplus in that account in order to meet the programs that are already on the board.

As you very well stated, in a few years things that are of utmost importance in the minds of the seniors and the disabled will have to be denied them because the money will have run out. We are not going to be able to continue to spend, spend, spend, because the money is not going to continue to grow in the way it has during the last few years in Atlantic City. Thank you.

ASSEMBLYMAN WATSON: Thank you, Assemblyman. Dr. Villane or Assemblyman Frelinghuysen? (shake their heads negatively, indicating they have no further comments) I would like to ask you one other question. I would also like for you to get me some information. Would you send us the information that was used in your presentation before Assemblyman Otlowski's Committee, with regard to this bill and your testimony? I would like to have that. Would you send it to the Chair? (witness nods affirmatively) Now, you mentioned a Committee that you testified before in Atlantic City.

MS. ZAHORA: (interrupting) That was Assemblyman Kavanaugh's.

ASSEMBLYMAN WATSON: Oh, it was an Ad Hoc Committee, a Standing Committee?

COMMITTEE MEMBER: It was an Ad Hoc Committee.

ASSEMBLYMAN KAVANAUGH: I would like to mention this briefly, and I don't want to get into any type of political debate with you, John--

ASSEMBLYMAN WATSON: (interrupting) No, no. I will not go into the--

ASSEMBLYMAN KAVANAUGH: (continuing) --but it is in this interest. As you know, the problem has come about that there have been SCRs on the books, the intents of which have failed to be fulfilled.

It has now been 20 months. The Commission finally has the membership. Elections are coming up next year. There is going to be a State-of-the-State message. There was concern when members of a Republican Task Force went to Atlantic City. We are now going to Hackensack. We want to get more input from the seniors because we feel there has been inaction on the part of the Legislature. We are not out to make waves. It is something we are concerned about since the dollars are no longer coming in.

We have spoken to many people and we have received hundreds of responses. There are concerns out there. There have been major concerns expressed by the seniors, with regard to priorities. I think it is also important for us to know when that 16-member Task Force will start. As I said, it was a session when nothing happened. Then we went into a second session and nothing happened. In the hope that we will see some action, the Speaker just the other day finally finished staffing, as far as appointments go.

We met in Atlantic City, where the money is, and we heard the problems. Almost unanimously, the seniors realize that there is funding, but they want it properly allocated so it doesn't deplete to the point where their needs will be denied in the future. The longer we stay here -- the longer we delay -- the sooner the time will come when we will be senior citizens. When that time comes, I want to make sure that any of my friends who might be broke will have their needs taken care of, so they will not be institutionalized or put out of their homes. These are our major concerns. I know that you fully agree with those.

ASSEMBLYMAN WATSON: Because it was stated earlier as an Assembly Committee, I want to be sure it is noted on the record that it was a Standing Committee, an Ad Hoc Committee. I don't hear any other Committee member wanting to ask questions, so I would like to thank you for your appearance here this afternoon.

MS. ZAHORA: Thank you.

ASSEMBLYMAN WATSON: Our next witness is Doris B. Nash, the Public Affairs Director of Cancer Care, Inc. Is Ms. Nash in the room?

DORIS B. NASH: Yes.

ASSEMBLYMAN WATSON: Would you have a seat, please?

MS. NASH: Should I press the button? (indicates microphone)

ASSEMBLYMAN WATSON: Press the button, and you're on.

(laughter)

MS. NASH: Mr. William C. Pelster, the Chairman of our Public Affairs Committee and a member of the Board of Trustees, regrets that he could not be here to testify today. I am taking his place. In a sense, he is my boss on the staff of the Public Affairs Committee, which takes positions on public-policy issues. We are pleased to have the opportunity to address A-608, the concept of which we heartily endorse. Since this marks the first time we have presented public testimony in the State of New Jersey, a brief introductory description of our organization seems necessary.

For over 40 years, Cancer Care has provided social work counseling to cancer patients and their families. A professional staff helps families through the crises of cancer by providing individual and group counseling to patients, relatives, and concerned friends. Bereavement counseling is also available. Our social workers assist families in planning for the patients' care at home when it is medically feasible. Some financial assistance is available, when appropriate, to help self-supporting families maintain care-at-home plans for the patients.

Our goals are to strengthen the families' abilities to cope with the patients' illnesses and to enhance the quality of life for the patients.

We receive no government funding or third-party reimbursements; we rely solely on contributions from the public, foundations, fund-raising events, volunteer chapters, and bequests.

We have traditionally offered direct services to those persons who live in areas of northern New Jersey near New York City. In October, 1982, in an effort to reach more New Jersey residents, we opened a part-time office there. Shortly thereafter, in July, 1983, we opened a full-time office in Emerson. These offices have enabled us to serve 14 New Jersey counties. We began with one part-time social worker; so rapidly has our patient load increased, we now have four full-time social workers.

I would like to introduce Helene Feldman, the Social Work Supervisor from our New Jersey branch. She came to Cancer Care after 15 years with the Hospital Center in Orange, where she was Director of Social Services. She will present a more graphic description of our work in New Jersey, and she will be able to explain why a medically needy category is essential. I want to remind you that she and her staff are really on the firing line in that New Jersey office. Thank you.

HELENE FELDMAN: As Mrs. Nash stated--

ASSEMBLMAN WATSON: (interrupting) Would you mind pressing your button there, please? (indicates microphone)

MS. FELDMAN: (turns microphone on) As Mrs. Nash stated, the volume of work in New Jersey has rapidly increased. A vivid way of describing this would be to present statistics, beginning with those from the 1982-83 fiscal year, during which a total of \$87,437 was shared with patients and their families to help defray the cost of home care plans; this represented 12.7% of our agency's total disbursement. Our 1983-84 disbursements amounted to \$152,640, or 19% of the agency's total disbursement. The figures for July 1 through November 16, 1984, indicate that \$71,292 was given to 107 patients and families; this represents 24% of Cancer Care's total disbursement for this year.

The statistics we have offered could easily be seen as a reflection of the desperate situation of so many New Jersey cancer patients, and at least some of these situations can be attributed to the lack of a medically needy category that would allow for Medicaid assistance.

We have found that approximately 23% of the patients we serve in New Jersey have monthly incomes of \$600 or less. Some of these patients may be eligible for nursing-home placement, but they want to stay in their private homes. They should be enabled to realize that wish.

Needless to say, our social workers and the families they serve constantly cope with the harsh realities -- financial and emotional -- that frequently accompany catastrophic illnesses, such as cancer. The most heart-rending situations are those which involve

families with extremely low incomes, particularly the under-\$600-a-month group and/or those whose assets have been severely depleted because of the illness. These families often need at-home care for the patients, but cannot possibly afford it on their own. We assist them, but we find their needs to be much greater than a voluntary-community agency can fully assume.

Many of the families we see are so impoverished by the illness that the remainder of their incomes approach the defined welfare level, which is actually below the poverty level. Many of them are patients, described by the Home Health Agency Assembly in its testimony at the first hearing as those who no longer qualify for Medicare home health benefits or other third-party reimbursement. We assist many of these patients, and home health agencies frequently make referrals to us in advance of the need, because they can forecast just how far the reimbursed benefits will go.

Permit me to offer several case illustrations for which a medically needy category would be helpful. In the first I will profile a couple who are in their late 70s. The patient has bone cancer with metastasis to the pelvis and hip, as well as osteoarthritis and severe pain. The husband has emphysema and cannot be of help to his bedridden wife. Their income is \$724 a month from Social Security; they have Medicare and Blue Cross-Blue Shield supplementary coverage. The couple's children, although weighed down with their own familial responsibilities, take turns staying with the couple overnight and generally overseeing the situation. Medicare helps with nine hours of home health aid services a week, because the patient is deemed to need skilled nursing supervision. We are helping the family pay for additional hours of care, which are desperately needed.

Another situation involves a family that consists of a 42-year-old divorced woman who was operated on for cervical cancer, her 15-year-old son, and her 73-year-old father. The father has a colostomy because of colon cancer, is paralyzed from a stroke, and suffers from chronic heart failure. He receives \$359 a month from Social Security. The daughter's take-home pay as a waitress in a local diner is only \$500 a month. She has no health-insurance coverage. In

an arrangement with the hospital, she is paying off the cost of her surgery. The father needs daily help with his colostomy; the daughter is the person who performs this function. Since Medicare does not consider him to require skilled services, he was deemed ineligible for any home health services during his daughter's hospitalization. We helped him pay for home care during that critical period of time between his daughter's surgery and her recuperation.

In a third case, a 73-year-old widower lived alone and suffered from colon cancer, diabetes, arteriosclerotic heart disease, and osteoporosis. His income was \$437 a month. He had \$6,000 in medical debts. His son and daughter-in-law finally took him into their home, but their work schedules meant that additional help with home care services was needed. We shared the cost of this with them and, eventually, when he became terminally ill, there were Medicare-covered home health visits.

These and other poor patients should be given the opportunities to receive assistance from Medicaid, and home care services should be made available to them since this is so frequently the most desperate need. The lack of availability of Medicaid for these marginal-income families is usually accompanied by less-frequent medical care, particularly on an out-patient basis, and by an exacerbation of the many problems with which these patients and their families have been struggling.

It is important to mention that the DRG prospective reimbursement system in New Jersey has led to earlier hospital discharges, thereby increasing the need for more appropriate home care services.

New Jersey's Medicaid program should be commended for its home health personal care services and, now, for the community care program for the elderly and the disabled. What is so very necessary, however, is a medically needy category for those marginal-income families who, unquestionably, need Medicaid assistance. It is our understanding that more than 30 states have some form of medically needy category. New York's program, which includes the possibility of extensive home care services, has been in place for many years. Our

New York offices frequently help patients during the waiting period that follows the filing of the Medicaid application. This help is based on the fact that the patients and their families have spent-down to the Medicaid eligibility level and we can feel comfortable about discontinuing financial assistance, because Medicaid in New York will help with an adequate home care plan.

We are aware that several versions of a medically needy program are under consideration by you and the New Jersey Division of Medical Assistance. We are also aware that there is justifiable concern about costs. We do not consider ourselves qualified to comment on costs, other than to remind the Committee that society must assume responsibility for its sick poor, and that this responsibility cannot be met without the expenditure of money.

We would also like to highlight the strong possibility that a medically needy category could be expected to prevent further personal and family breakdown, problems that could eventually cost society even more. While we cannot address the fiscal ramifications of a medically needy category, we trust that we have adequately described the immense need that has been found in the community. A volunteer agency, such as ours, can only deal with some of this need. Rightfully, we should assist those with middle incomes who are trying desperately to make ends meet, but who are saddled with many expenses that were created by their illness. The public sector must extend Medicaid to those who are close to the Medicaid level and are contending with severe illness. This represents a just public-voluntary partnership in the best interest of those who need help because of illness.

We are pleased that we can provide financial assistance to needy cancer patients, but the reality is that we are currently disbursing \$1,000 a week over our budget. Moreover, we are now confronted by the possibility of having to cut back on our assistance. We urge you to amend A-608 to mandate, as does S-1718, a medically needy category, and to choose Option Four. At the very least we hope you would choose Option Two, which is described by the Division of Medicaid Assistance and Health Services as all medical services for all categories: children, pre- and post-natal care, the elderly, and the disabled.

Thank you for this opportunity to meet with you. We would be pleased to answer any questions you may have.

ASSEMBLYMAN WATSON: Thank you, Ms. Feldman. I would like to announce that this hearing will extend through lunch, in order to expedite matters. We don't intend to break for lunch. If your name is on the witness list and you are hungry and want to grab a sandwich, please let us know and we will make sure that you are called when you return. The cafeteria is right down the hall. Ms. Feldman, do you have any data on the people you serve in New Jersey, particularly on their incomes and asset levels?

MS. FELDMAN: We don't consider assets. That is a luxury we enjoy. We don't have the restrictions placed upon us that are put upon public agencies. We really do not think in terms of assets -- other than liquid assets. In each family's situation we consider their total responsibilities. We did a study of our disbursements. Our data was categorized by "incomes under \$600 a month," "incomes between \$600-\$1200 a month," and "incomes of \$1200 and over a month." We studied those disbursements carefully for a year. If you like, we would be more than happy to share this data with you.

ASSEMBLYMAN WATSON: We would be more than happy to have it. Would you please send it to the Chair?

MS. FELDMAN: Indeed.

ASSEMBLYMAN WATSON: Thank you. You mentioned that Medicare is limited on home health care services. I thought all of the restrictions on home health care were lifted from Medicare?

MS. FELDMAN: No. Another luxury we enjoy is that we can pay for any level of care that is needed by the patients and their families in order to be sustained. Medicare pays only for what is defined as skilled care and, even though close to death, many of these patients may not fit that definition.

MS. NASH: Sir, what was lifted under Medicare's home health care was the number of allowable visits, which is indefinite now. The restrictions, however, are so severe that the long-range effect has been to limit the home health benefit. This is something the National Association of Home Care is fighting, because some of the

interpretations by fiscal intermediaries have become more and more rigid. It has, in effect, compacted what people get. Mr. Marosy will be able to address that.

You must qualify for a skilled service in order to be eligible for part-time, intermittent home health care from home health aid. And two hours a day for three days a week can be a drop in the bucket for the very sick people we have described.

ASSEMBLYMAN WATSON: Assemblyman Frelinghuysen or Dr. Villane, do you have any questions? (negative responses) Hearing no other questions then, we would like to thank you for your testimony today. I would also like for you to share your data and other information with us. Thank you.

MS. FELDMAN: We would be glad to do so. Thank you.

ASSEMBLYMAN WATSON: Testifying now for the New Jersey Federation of Senior Citizens is Edith Edelson.

EDITH EDELSON: There are several copies of my testimony available if someone wants to distribute them.

ASSEMBLYMAN WATSON: Thank you. Would you mind taking a seat and pushing the button down on your microphone? And you're on.

MS. EDELSON: Thank you very much for the chance to be here, and for your real concern for this group, the medically needy.

ASSEMBLYMAN WATSON: (interrupting) Did you push your button down? (indicates microphone)

MS. EDELSON: I did, but nothing happened.

ASSEMBLYMAN WATSON: Is the red light on?

ASSEMBLYMAN VILLANE: John, check yours. I think yours is off.

ASSEMBLYMAN WATSON: (presses button on his microphone) I'm sorry. I got you fouled up over here.

MS. EDELSON: Thank you for allowing me the opportunity to talk to you. We certainly appreciate your keen interest in the medically needy in the general way and in the specifics of it. It shows a real concern. The New Jersey Federation of Senior Citizens has been working for the enactment of a medically needy program for about 10 years, ever since Assemblyman Herman introduced such a bill, at our request.

We have now reached the point where practically everyone recognizes that such a program is needed. We have the cosponsorship of 42 Senators and 21 Assemblypersons. Assembly Bill 608 has been endorsed by dozens of organizations that represent various constituencies. The Department of Health and Commissioner Albanese have lent their support to such a program. Governor Kean, in the past, has made statements pointing to the need for extending medical assistance to the medically needy.

As I sit here, I sense a change in the climate, with regard to the medically needy, and it disturbs me. Everyone says they are for it. They agree it is vitally needed. But, they also say that we must worry about what may happen in 1990, 2000, or whatnot -- that we must worry about what would happen under these contingencies or those contingencies.

If people really feel that health is the primary concern, then everything else must fall in line under that category or parameter. I don't see that happening among some of the people in the Legislature, among some of the people who will be testifying, or among some of those people who have already testified.

Assembly Bill 608 is so general in its statements. It merely says there should be a medically needy program. Now, all of the details could be worked out subsequently. If we agree that it is really needed -- and I think we do -- then let us at least get the legislation in, so the wheels can begin turning.

I would like to suggest an amendment to A-608. It has been agreed to by Assemblyman Deverin, and it merely states that the Commissioner is authorized, if the money is available, to implement a medically needy program.

I have jumped ahead of myself and skipped some sentences.
(peruses printed testimony)

ASSEMBLYMAN WATSON: It is fine that you did. In fact, some of the testimony is getting to be quite lengthy. If you would continue to summarize, it would be as effective as reading the entire testimony. So just continue to summarize.

MS. EDELSON: All right. I will try not to repeat what I said the last time I testified before you.

In the past, setting aside money from the General Fund for the medically needy was difficult because budgets were very tight. Now, the General Fund is going to help the State. In fact, I understand that even during the recent recession the economy in New Jersey was doing well, and in the past year the General Fund has accumulated a substantial surplus.

Moreover, and we learned this just recently, New Jersey will be receiving an additional \$12 million from the Federal government in the form of Medicaid reimbursement. And now, unlike in the past, the Casino Revenue Fund is available for new and expanded programs. Some legislators have questioned the depletion of this fund, yet they keep introducing bills which draw upon it. There is the contradiction that has run through this all along.

It is true that priorities have to be established for its use, but we cannot wait forever for a Casino Revenue Fund Commission to be established. It is ironic that legislation to establish such a Commission was put into use because we all felt the need for priorities. We were happy that such a bill was enacted by the Legislature. Now we find it to be a stumbling block, because the Commission has not been appointed and priorities have not been established.

I represent the Federation on the Task Force that Ms. Zahora spoke of. We brought up the question of the medically needy, and there was no vote against it. There was only a vote to table it. They did not want to vote against it. The position taken by our two organizations is this: We want priorities before we implement bills. They are not against a medically needy program or against the use of the Casino Revenue Fund, as such. They are being stopped because of the situation with the Commission. As I said, I don't think we should wait forever for the Commission.

We congratulate Assemblyman Kavanaugh for calling public hearings to resolve the question of priorities. At last someone is saying, "Let's do something about it." The top priority is health; without a medically needy program, the damage to the health of many people would be irreparable. You will hear from some of the testimony

today how some lives have been ruined because there is no medically needy program.

Among the groups that desperately need such a program are widows between the ages of 60-64. While they may be eligible for Social Security benefits, they cannot get Medicare before the age of 65; thus, they have no insurance to cover their medical needs. From a humane point of view, we are obligated to provide health care for the people who cannot afford it. From a financial point of view, the program is cost-effective. The hospitals need a medically needy program to reduce the bad debts. The State needs it because it would save them money in the long run. Being a preventive program, it would reduce the use of emergency rooms and the need for hospitalization.

Your Committee has been holding on to the bill for a long time, patiently waiting for research and so forth. We urge you to amend A-608 to make it mandatory for the Commissioner to carry out a medically needy program, and then report the bill out for a vote.

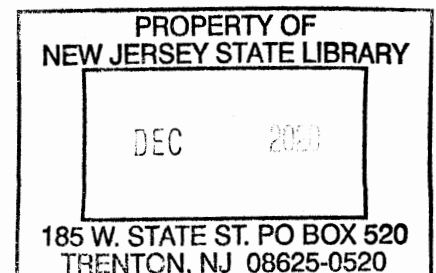
Attached to this statement is our "Fact Sheet Explaining the Medically Needy Program," and a list of co-sponsors of these bills. We ask that an advisory committee of seniors and others in the public sector be appointed, to allow them to participate in the planning of a medically needy program. Thank you very much.

ASSEMBLYMAN WATSON: Thank you. I have a couple of questions, and then my fellow Committee members, Assemblyman Villane and Assemblyman Frelinghuysen, may have questions for you.

The thrust of this bill is to retain legislative control authorizing a medically needy program. Would you give carte blanche to the Commissioner in this program?

MS. EDELSON: I think there is a need for flexibility -- with reference to the services -- depending on the cost, what money is available, and so on. From that perspective, I think control of this legislation by the Department of Human Services might be extremely helpful. We are accustomed to the Department of Human Services dealing with human needs; we have no objection to that.

ASSEMBLYMAN WATSON: Assemblyman Villane?



ASSEMBLYMAN VILLANE: Allow me to respond in defense of the legislative process. Through experience we find that the more finite and definitive we make a bill, the more the bill reflects the will of the people and the legislator who represents them. Consequently, input from public hearings such as this and data from surveys that are requested from the Department go into the refinement of a bill to make it more responsive to the needs of the people we intend to serve.

Oftentimes, we regret the passage of a bill that was intended to do one thing but which, in reality, does something else because we left the regulations up to the departments which had the prerogatives. Oftentimes, the bill is never implemented in the form that we intended. Bear with us. As far as I am concerned, there is not a more needy program in the legislative process of some 4,000 bills than this one. Outside of the Prescription Drug Act that was funded by the Casino Revenue Fund, I don't think there is another bill that addresses the real concerns of people in dire need of the State's financial help.

Many of us fully support the bill, but we believe it has a lot of loose ends, where the financial burden is concerned: where it will come from, who it will serve, who will be qualified, who will decide qualification. So you can be sure that we are going to work on those things. We are also going to demand of the departments whatever input they can deliver to us, so that we can put a bill into effect that really meets the needs of the people we are attempting to help. We appreciate your taking a day off to come here today. Thank you.

ASSEMBLYMAN WATSON: Thank you, Dr. Villane. Ms. Edelson, were you aware that the Commission on Uses of the Casino Fund has been fully appointed and is ready to have meetings?

MS. EDELSON: I called Assemblyman Karcher's office yesterday and spoke to a staff aide who said there is still one member to be appointed.

ASSEMBLYMAN WATSON: Still one member? Are you sure of that?

MS. EDELSON: One member of the public.

ASSEMBLYMAN WATSON: It is my understanding that they are fully complemented now.

MS. EDELSON: I hope so.

ASSEMBLYMAN WATSON: Knowing that we have the casino projection surplus this year, I want your reaction to a press release that we received this morning from the Director of the State Division on Aging, Ms. Zahora. It says, "Ann Zahora, Director of the State Division on Aging told an Assembly Committee today she is opposed to the medically needy bill on the grounds New Jersey cannot afford such a program." What is your reaction to that?

MS. EDELSON: I am horrified, and I am heartbroken that there is such a gap between the thinking of the Division on Aging, which represents seniors, and that of the seniors out in the field. At our meeting, nothing was said by Ms. Zahora along that line at all. It seems to me that I sense a change, and I don't know the basis for that change.

ASSEMBLYMAN WATSON: Thank you. I have no further questions. Oh, just one other thing. (reads from printed testimony) A woman aged 60-64 may not be eligible for medically needy unless she has dependent children or is disabled. Is that correct?

MS. EDELSON: She may be up to age 65; she has to be a widow; she has to be disabled. A widow has to be disabled to get Social Security, but she will not get Medicare until she is 65 years old, unless she is disabled. Some of them are not considered disabled by Social Security but they still have many medical needs.

ASSEMBLYMAN WATSON: If she receives Social Security disability, would she not be--

MS. EDELSON: (interrupting) Yes. The person who receives disability benefits is all right. There are many who have strong medical needs, however, who are not considered disabled by the Social Security Administration.

ASSEMBLYMAN WATSON: Would they not be covered by disability?

MS. EDELSON: They would be covered by medically needy.

MR. HERSHBERG: Your disability has to meet Social Security standards, and unless you meet those standards you would not be considered disabled. Therefore you would not be considered eligible.

MS. EDELSON: That is interesting. Thank you. I will have to think about that.

MR. HERSHBERG: That is, unless Medicaid can correct me.

FROM AUDIENCE: You are correct.

MS. EDELSON: Thank you for the clarification.

ASSEMBLYMAN WATSON: We have a question from Assemblyman Frelinghuysen.

ASSEMBLYMAN FRELINGHUYSEN: It is, perhaps, more a statement than a question.

ASSEMBLYMAN WATSON: I'm sorry, a statement.

ASSEMBLYMAN FRELINGHUYSEN: I commend you for your statement, Ms. Edelson. I was not aware that you have been working on this for 10 years. I have not been down here that long. I think the most important message contained in your testimony is that this is a preventive program. The Legislature is certainly interested in containing health care costs. This type of legislation may accomplish exactly that, or at least part of that.

What worries and surprises me somewhat is that individuals -- legislators included -- continue to feel that the Casino Revenue Fund is inexhaustible. As you know, and as I have perhaps heard you say on other occasions, it is not inexhaustible. I would want further assurance that we are not creating, even with excellent, worthwhile intentions, more dependency. If we set up a program of this nature, and I think we probably will, we want to make sure that those who are most in need are served. Once we create this program, there is no way -- even if the Casino Revenue Fund is depleted by other programs -- that we are going to discontinue this program. We must be extremely careful in determining which of the options to embrace initially.

There are those who feel we should go the whole route. And I think you can testify more accurately than I that it was just this type of embracement that got us into trouble with the Pharmaceutical Assistance Program -- and I assume you consider that a priority. We certainly do not want to disturb the peace of mind people have received from the existence of that program's stability by introducing a costly program. At this point, we are not sure exactly how much money, in the

form of annual tax dollars, would have to be contributed toward it. Thank you very much.

MS. EDELSON: Thank you.

ASSEMBLYMAN WATSON: Thank you again, Ms. Edelson. Thank you, Assemblyman. We will now hear from Kim D. Osterhoudt, the Assistant Director of Financial Planning for the University of Medicine and Dentistry of New Jersey.

KIM D. OSTERHOUDT: Thank you very much. I appreciate the opportunity to share my comments with you.

The University pledges support for Assembly Bill 608. Given the level of uncompensated care at University Hospital, A-608 could provide an excellent opportunity to alleviate a portion of its indigent care by expanding the criteria for Medicaid eligibility. University Hospital addresses the needs of the single-largest indigent population of any institution in New Jersey. The median per-capita income for the City of Newark is less than two-thirds of that of the State.

Furthermore, the percentage of families who live below the poverty line in Newark is 12% higher than elsewhere in the State. Although other hospitals in Newark serve the poor, the real importance of University Hospital to the population of the city is reflected in its uncompensated care statistics. Over 75% of the total number of annual indigent patient days in the City of Newark are provided by University Hospital.

The University endorses A-608. Any one of its four options would help reduce the level of uncompensated care at University Hospital. Option Four, however, would provide the greatest amount of relief to the hospital, as it would cover in-patient, as well as ambulatory, care.

Uncompensated care represents approximately one-third of all in-patient services and 25% of ambulatory services provided by University Hospital. Furthermore, if the New Jersey DRG waiver is not renewed, the impact of A-608 will be even more significant because reimbursement for uncompensated care will cease to exist, as will access to health care for indigent patients.

This bill could have a favorable impact on our hospital by increasing the volume of health care consumers who are eligible for Medicaid. In any case, however, it is important for agencies and programs that currently provide services to indigent patients to maintain their present efforts. The impact of A-608 could be neutralized if existing programs and services were withdrawn, as was the case with county and other indigent care support in New Jersey, prior to the onset of Chapter 83.

University Hospital has a vast potential for comprehensively meeting the needs of the community in the greater Newark area. If this institution is to meet its goals and its mission to provide quality care to an indigent population, the continued reimbursement of funding for such care is essential. Hence, the UMDNJ pledges its active support of A-608 to turn necessary initiatives into viable reality.

ASSEMBLYMAN WATSON: Thank you. I have several questions. Would the UMDNJ supply the Committee with copies of its share forms for 1983-84? From what I gathered when we last heard from the Department of Health, this information had not been given to them by the hospital.

MS. OSTERHOUDT: I don't know if the information from 1984 is complete yet, but I am sure 1983's is.

ASSEMBLYMAN WATSON: Would you make that available, through the Chair, to the Committee?

MS. OSTERHOUDT: Yes. I can ask that of the hospital, if you like. I haven't seen a copy of the questionnaire that is available, but I am sure that our uncompensated care--

ASSEMBLYMAN WATSON: (interrupting) We will make a copy available to you.

MS. OSTERHOUDT: Fine. I would be happy to provide you with it, if I can. Xeroxing the share forms is a big job. Could you tell me what you are specifically interested in?

ASSEMBLYMAN WATSON: We need the whole thing. You probably have not seen the survey. Evidently you have not received it.

MS. OSTERHOUDT: I have not seen it. I am in Finance and Central Administration for the University. One of my responsibilities

is to protect the University's interest. The financial management of the hospital is handled by HCA. We have open doors of communication, however, so I don't think there will be any problem getting it. Not being in the hospital, per se, I just have not seen it.

ASSEMBLYMAN WATSON: Can Medicaid share this form with you?

MS. OSTERHOUDT: Sure.

ASSEMBLYMAN WATSON: Will they be able to do that? (witness nods affirmatively) That's fine. Would you, in concert with Medicaid, provide that information to us through the Chair? If Medicaid could provide you with a survey, the hospital could then determine its own survey.

MS. OSTERHOUDT: Now I'm lost. Are you saying that, if Medicaid gives me the questionnaire, we should complete it and get it back to you?

ASSEMBLYMAN WATSON: You can, in turn, finalize it the way we want it, through the hospital.

MR. HERSHBERG: Would the hospital be willing to undertake the completion of that survey? We are having difficulty completing it on its own?

MS. OSTERHOUDT: Are you asking if they would conduct it among all of their patients?

ASSEMBLYMAN WATSON: Yes.

MS. OSTERHOUDT: I can ask them. I don't see any reason why they would not. I don't know exactly what goes into the admissions procedure as it is, but I can certainly suggest that.

MR. HERSHBERG: Okay. Medicaid will supply you with copies of the questionnaire survey form.

ASSEMBLYMAN WATSON: Do you have any reaction or comment to the Committee's concern about the data supplied by hospitals on indigent care?

MS. OSTERHOUDT: I am a little concerned. Earlier today, I heard your comment that some of the hospitals in the City of Newark seemed to have very low indigent statistics. I know we handle 75% of it, and that doesn't leave much for the other hospitals. Our statistics should, however, be readily available to you.

We provide the bulk of it, and I think this bill would help, with or without the waiver. Certainly, if we lose the waiver, it would be more helpful. As it is now, we would be just as happy to do more. I think it should be clear that, even though we provide the highest level of indigent care at University Hospital, we are not compensated for it through the DRG system, as are other hospitals.

ASSEMBLYMAN WEIDEL: They aren't compensated?

MR. HERSHBERG: They are compensated, but they only get 7%.

MS. OSTERHOUDT: Yes, we get 7%. Our actual uncompensated care figure today is about 30-34%.

MR. HERSHBERG: But 7% is more than most hospitals get.

MS. OSTERHOUDT: There are hospitals that receive more compensation, yet provide less care, than us. St. Joseph's in Patterson gets something like 13.65%, and we certainly provide more than they do. There are several hospitals that get more than 7%.

ASSEMBLYMAN WATSON: That is very interesting.

MS. OSTERHOUDT: We think so too. (laughter)

ASSEMBLYMAN WATSON: Dr. Villane? Assemblyman Weidel? (no questions) Hearing no more questions, we thank you for your attendance here this afternoon.

Our next witness is Sue Dondiego from the New Jersey Foster Parents Association.

SUE DONDIEGO: Thank you, Assemblyman Watson, for providing us with the opportunity to address the issues that have been discussed today. The New Jersey Foster Parents Association serves as an advocate voice for foster children and families across our State. There are presently 3,000 foster families in New Jersey who care for 6,800 foster children. Our organization wishes to speak initially of our strong support of Assembly Bill 608, the medically needy legislation sponsored by Assemblyman Thomas Deverin.

While our prime concern is for foster children and families, we are well aware that the lack of adequate health care for a large portion of New Jersey's population is one of the most pressing problems facing our State today. Because of the restrictions placed on Medicaid eligibility, many of those persons who live in poverty have no access

to health care. We are particularly interested in this bill's passage since estimates indicate Medicaid services would be expanded to cover not only 90,000 elderly, 12,000 disabled, and 50,000 adults but also 100,000 children.

A medically needy program will cost the State money, but inappropriate hospital emergency-room treatment and unpaid hospital bills are already an expenditure for which the State pays.

Foster parents are continually troubled by the total lack of medical services that birth parents have been able to provide for their children. As a foster parent, I have had children placed in my home who needed immediate medical or dental attention. If taken care of when first needed, their problems would not have become emergencies, or would not have required more than one visit to a doctor or dentist.

We appreciate the complexity surrounding the administration and implementation of this bill, but the New Jersey Foster Parents Association urges its speedy passage, to ensure that the medically needy of our State receive adequate health care.

ASSEMBLYMAN WATSON: Thank you. Assemblymen, do you have any questions? (negative response) Thank you for your testimony.

MS. DONDIEGO: Thank you.

ASSEMBLYMAN WATSON: We would now like to hear from John Paul Marosy of the Home Health Agency Assembly of New Jersey.

JOHN PAUL MAROSY: I am John Paul Marosy. This is my first opportunity to speak before a Committee of the New Jersey Legislature. I am the Executive Director of the Home Health Agency Assembly of New Jersey. I have run a home care program for the elderly in the Commonwealth of Massachusetts for the past 10 years. I recently returned to New Jersey, my native State.

I would like to thank the Committee for the opportunity to speak in favor of A-608. The Home Health Agency Assembly of New Jersey has been on record in support of the Medically Needy Program for New Jersey since 1978. We know there are citizens of all ages in this State who desperately need health care and who are prevented from receiving such care because they often fall through the cracks. They have neither sufficient incomes to purchase health care privately, nor

are they eligible under the existing Medicaid system. We believe that such deprivation is unacceptable in a humane society.

We have reviewed the estimated cost-and-use data on this bill, which was prepared by the Medicaid office of the Department of Human Services, and we believe it to be reasonable. We realize that, at this time, no set package of services is being recommended, and no defined population groups have been determined.

While Option One is a minimal program package, and Option Four is a maximum program package, Options Two and Three are mere examples of possible program plans.

We want to stress the importance of including home health care in any medically needy program -- whichever one the State chooses to adopt. We are particularly sensitive to the home health care needs of children and chronically ill, elderly people. Home care has great potential for cost savings, especially in the care of the elderly.

We are all aware that New Jersey's population is aging, and that there will be greater numbers of elderly people as we progress into the next decade. We know that many of these elderly people will develop chronic illnesses. We need a health care plan in this State that will assure the appropriate use of health care money. Under the present system, substantially all health care money goes for institutional care, but there is a great need for chronic care in private homes, an area that goes largely unfunded.

Today, home health care represents less than 2% of the annual Medicaid budget. While the community care program for the elderly and the disabled is reaching a limited number of people who are immediately at risk of nursing-home placement, many people do not qualify under the restrictive terms of this program.

In summary, we support a medically needy bill because it would expand health care to a vulnerable population. We believe that home health care must be a central component of any medically needy package. Promoting the good health of needy children and frail, elderly citizens has to be a wise investment for the future of the family in New Jersey.

I will be glad to answer any questions you might have.

ASSEMBLYMAN WATSON: Thank you, Mr. Marosy. Does the Agency have data on the people it serves?

MR. MAROSY: Yes, it does.

ASSEMBLYMAN WATSON: Would you make it available to this Committee through the Chair, please?

MR. MAROSY: Certainly. We can provide the Committee with a review of the current status of the home health industry. There are about 133,000 people in New Jersey who are served by home health care.

ASSEMBLYMAN WATSON: Would you also have their incomes?

MR. MAROSY: We have a breakdown of the programs which pay for the care provided. About 75% of all care is covered by Medicare.

ASSEMBLYMAN WATSON: I appreciate that. (to Committee members) Any questions? (negative response) Hearing none, thank you, Mr. Marosy, for appearing.

MR. MAROSY: Thank you.

ASSEMBLYMAN WATSON: Are Judy Miller and Mary Ann Christopher, from the Monmouth County Office of Social Services, here today? (witness comes forward) Would you please state your name for the record?

JUDITH L. MILLER, R.N.: I am Judy Miller. I want to note a change for the record. I want it noted that I am from MCOSS Nursing Services. Those initials are not an acronym. We are a health care agency that provides home health care, ambulatory services, and health-maintenance-outreach services in Monmouth County.

ASSEMBLYMAN WATSON: Could I just interrupt you? I see that you have lengthy testimony, and--

MS. MILLER: I am not going to read it all. In fact, I will probably cover the areas that are not included in my written testimony. My colleague, Mary Ann Christopher, was unable to be here today. I want to share this with you, to help you better understand our perspective. Ms. Christopher is a geriatric nurse practitioner who works with the ancillary services in our agency. As a maternal-child health clinical nurse specialist, I am responsible for our ambulatory services. This category includes the medically needy, children, and pregnant women. I also happen to be the Chairperson of the Maternal-

Child Health Division of the New Jersey State Nurses Association, so that coincides with what we will discuss today.

From the start, we have really looked at Option Two. We do not want to force excessive money into the system. We are concerned, as are the parents of eligible children, because that category is left out of Option II. Our concern, basically, is for the recipients. We are not trying to promote any particular type of health service. Likewise, we are not trying to promote any one discipline. I just want to make that comment.

In summary, we are concerned, as the previous speaker mentioned, that home health services should be a bit more defined. Our experience has been that, in actual practice, a lot of people do not fit into that category. Subsequently, they are not able to receive services in time. You have to be chronically ill for a period of time before you really fit into some of the other catchment areas. If, for example, service is not provided soon to a stroke victim, we end up creating more expense. That is one of our perspectives. We are able to provide viable, adequate home care at a reasonable cost, as compared to hospital costs.

We are particularly concerned about children with chronic illnesses. Sometimes, they fit into other categories, but there is a whole group that falls through the cracks. Without their home care needs attended to, some of these children and their families will end up in more difficult, and therefore more expensive, situations. If we are able to work within the home setting, where we can support some of setting, where we can support some of the other services that are needed, the entire family copes better. If we can help the patient learn to be compliant, and if the family is more able to cope, there is a lesser cost to society.

We have shared some examples with you. Many high-risk pregnant women and children, we know, are included in Option One, but, again, home care is not considered as an option for these people very often. Yet, along with my staff, from the home, I can help a high-risk pregnant woman with hypertensive disease of pregnancy and, monitoring that pregnancy in conjunction with a physician, keep her out of a

hospital. We can work toward a healthier, more viable child. So, I have a concern about that.

We feel, as I mentioned, that many home care programs which have been implemented throughout the country actually limit nursing. We have a concern that the professional supervision of some of these programs by professional nurses is an oversight.

We have talked with people from the Association, children of New Jersey, the Senior Citizens Federation and some coalitions. Our reason for suggesting an advisory committee is more an ongoing kind of situation. We are concerned, for example, that if specific services are chosen arbitrarily -- arbitrarily with a lot of input; I want to qualify the use of that term -- many professionals throughout the State are working on a daily basis with all of these situations. We would suggest that a multi-disciplinary advisory committee work along in an ongoing fashion in the actual implementation of this legislation.

Among the people to be included, I would highly recommend nurses who have cared for, and who have been case managers for, these types of people. I would particularly recommend people who work in community health, maternal and child health, gerontology, and rehabilitation. The New Jersey State Nurses Association is a good resource for the selection of this kind of people.

Let me just look at my notes to see if I have anything else to share with you. (peruses notes) I think I covered everything. Do you have any questions?

ASSEMBLYMAN WATSON: Does that complete your summarized statement?

MS. MILLER: Yes, it does.

ASSEMBLYMAN WATSON: Does MCOSS Nursing Services have data on the number of clients served, and the income of each client?

MS. MILLER: We have quite a bit of data. I will see if I can get some of it to you. That question, though, reminds me of something I noted on my paper while listening to other testimony.

In home care, and in the kind of ambulatory services we provide in our various clinics, in order to establish a sliding-scale fee for our clients, we ask each and every client what their income

level is. That is not a problem. I find it interesting that hospitals have that comment.

ASSEMBLYMAN WATSON: Would you find your clients offended by asking that?

MS. MILLER: They are not offended. We approach it from the standpoint that we are trying to provide a service for them and, in order to find the appropriate mechanism to enable us to continue to provide such a service, we must do this together. People have never found it offensive.

ASSEMBLYMAN WATSON: Is Medicaid's definition of home health care broad enough for your agency's purpose?

MS. MILLER: No. There are many times when people are not accorded home care by that definition. As you heard before, there has to be skilled nursing in certain situations. For example, if I want to help a family learn to parent their child so that the disability does not worsen, I must be very careful in the terminology I use, in order to get reimbursement.

We work closely with Medicaid, and many times they are very helpful when we seek reimbursement, but they are still--

ASSEMBLYMAN WATSON: Are you employing the social standard of Medicaid?

MS. MILLER: No, we are dealing with health care: nursing, therapy, and so forth. Again, we are a health care organization; we are not a welfare board or a social service organization, despite our initials. And again, earlier I heard someone mention the personal care assistance program. I don't work with it, so I really cannot answer questions pertaining to it. Recently, however, many families have transferred to that program. It is supposed to be a cost-cutting mechanism, but it also removes some of the professional supervision, and that can create a very sticky situation in some families.

ASSEMBLYMAN WATSON: I noticed in your remarks that you were talking about an advisory board. Are you aware that, by law, there is a Medicaid Advisory Board already?

MS. MILLER: Yes. We were thinking, more specifically, of this kind of legislation.

ASSEMBLYMAN WATSON: Thank you. Yes, Dr. Villane?

ASSEMBLYMAN VILLANE: Mr. Chairman, if I may. Being from Monmouth County, I am acutely aware of the extremely successful job MCOSS is doing for there. There are tireless paid workers and many, many volunteers who provide a lot of quality health care in the home. This reduces the burden on government. I agree with your recommendation, Ms. Miller, and with the Chairman's permission, I think it is important for this Committee to have the opinions and experiences of nurses who have provided home care. It would be good information for us to look over, to see where we can help those people by treating them in the home atmosphere -- rather than subjecting them to hospital care. I want to thank you personally, as a resident of Monmouth County and as a State legislator, for the fine work you are doing.

ASSEMBLYMAN WATSON: Thank you, doctor. Are there any other questions for Ms. Miller? (negative response from Committee members) Then I would, once again, like to thank you for your appearance here today. We would like to get that information from you within a few days or in the near future, at your convenience. Would you address it to the Chair? (affirmative response from witness) Thanks a lot.

MS. MILLER: Thank you.

ASSEMBLYMAN WATSON: Our next speaker will be Mr. Ciro Scalera from the Association for Children of New Jersey.

CIRO SCALERA: Thank you, Assemblyman Watson. I will summarize my comments.

ASSEMBLYMAN WATSON: Thank you.

MR. SCALERA: I am the Director of the Association for Children, but I feel compelled, sitting here this morning, to sidetrack somewhat from my prepared statement. I would like to make some comments on some concerns I have about this whole process.

Before I do that, though, I want to at least summarize what is in my testimony. About two months ago, we conducted a children's health forum and we invited Dr. Robert Johnson from the University of Medicine and Dentistry of New Jersey to come to give us a speech specifically on the medically needy. What I have presented in my testimony is the full text of his speech. We have also summarized in our testimony his comparison of two chronically ill children, both aged

13, one from South Orange, one from Newark. The bottom line in terms of the preventive nature of what a medically needy program can do is spelled out very clearly. The one youngster -- who is now in college -- had total care costs of \$3,700, for one hospital visit. The other youngster had total care costs of \$65,850 over 40 hospital visits. The primary reason for the difference was that the one family could not afford to pay for routine clinic visits or prescriptions. If you read the doctor's testimony from our health forum, you will see that, number one, this is not an atypical situation, and number two, the consequences of not having the ability to provide for what we all may consider to be very routine medical practices can have some very bottom-line dollar results.

That is the summary of our testimony. I would request that the Committee take a look at that, and I know that they will.

I would like to express a couple of concerns about some things that have taken place this morning. First, I am really concerned that we have not seen the production of information that this Committee requested and generously gave time frames on in terms of allowing for the production of this. We are now at a point where we are still hearing very tentative kinds of statements, where we should be talking some of the specifics that we all knew three or four months ago that we would need to talk about.

Secondly, I am concerned specifically that the Department of Health, which is charged with taking a pro-active position in our State in defining the health needs of our children and our seniors, has not come out and said which of the specifics it deems -- since it is the primary health care agency in the State -- should be part of the specifics. Then, in terms of a specific Department, the Department of Community Affairs' Division on Aging-- Again, I was very dismayed to hear their comments and, also, not to have heard any comments in terms of what the health care needs of seniors are from the representative of the Division on Aging. I was somewhat dismayed -- sitting back as a citizen, as well as the Director of the Association for Children -- to see this take place.

Another concern involves the funding of this whole mechanism. As a representative of the Association for Children, I find myself in somewhat of an untenable position. If we say that casino funds are not to be touched, or used, that then means that the full cost would have to come from general State revenues. That would mean that the program, depending on the options selected, would be that much more costly, yet seniors would be given the services. I do not want to be in the position of having to say that because the seniors, whom we have been working very closely with from day one of this-- I do not want to say, "Well, pick an option that provides for pregnant women and children, say Option One, and forget about the seniors until we can get a consensus on what the senior health needs are." I will not make that statement, and I think it is untenable for us to try to pick and choose in that way.

We support this program going forward; we support it working together with the seniors. I think it is a health care issue for seniors. I think that Edith testified, and you will hear it from other representatives, that something can be done to address this in a comprehensive way, not excluding, or taking an option, that is going to be put aside.

Finally, on the question of the options, in an ideal world, we would prefer Option Four. As several of the witnesses said, if the DRG waiver is in jeopardy, that would be a viable option. It is a question-- We have all seen the commercial about you can pay now or you can pay later. That is certainly true, because the waiver would come up again in 1987. What will be the cost between now and 1987, however, if we do not begin to address that? So, Option Four, if we do lose the waiver, is certainly our preference. Short of that, we are realistic. Our position, as an agency, has been to support the development of this program now, even if it means picking an option that may not provide the fullest extent of range. I would say at this point that Option Three, which does include the parents, is the one we would prefer. However, at this point, we would support Option Two or Option Three.

That is the end of my formal comments. I would be happy to answer any questions the Committee members may have.

ASSEMBLYMAN WATSON: Thank you for providing us with your testimony this afternoon. I just want you to know that this Committee is grateful that you are as concerned as we are. We are going to continue to try to get the kind of information we requested in the beginning as soon as possible. We are very concerned about this, and we are going to make sure that our movement will be adhered to between now and the end of the month.

MR. SCALERA: I appreciate that.

ASSEMBLYMAN WATSON: Are there any questions from the members of the Committee? Assemblyman Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: I have a comment. I just want to commend you for the material you sent us.

MR. SCALERA: Thank you, Assemblyman Frelinghuysen. We sent everyone a copy of our health forum report.

ASSEMBLYMAN FRELINGHUYSEN: It was extremely informative. It would be nice if we had the material that is applicable to all age groups, as well as what you provided in terms of providing for young people. Thank you.

MR. SCALERA: Thank you, Assemblyman.

ASSEMBLYMAN WATSON: Mr. Scalera, do you have any comments on the reliability of the hospital data on indigent care?

MR. SCALERA: Not really. I don't have any data on that. I would share the comments of the nurse who preceded me that I can't imagine that to conduct that kind of a survey-- We conduct surveys all the time at the Association. We have not found that when you are polling people about potential programs or benefits they are going to get that they are unwilling or reluctant to share their income levels with you. So, I share her view that that should not pose a problem to doing that. Steps should be taken to ensure confidentiality. I mean, we do it. I would assume that any association doing research of that nature would take those steps.

ASSEMBLYMAN WATSON: Once again, I would like to thank you for your appearance here this afternoon.

MR. SCALERA: Thank you, Assemblyman Watson.

ASSEMBLYMAN WATSON: Our next speaker will be Mr. Grey Dimenna from the Department of Higher Education.

GREY DIMENNA: Thank you. My name is Grey Dimenna; I am from the Department of Higher Education. In the interest of not being repetitive, the Department is appearing here today in support of this bill, especially with regard to the effect it would have on University Hospital which, as you know, is part of the University of Medicine and Dentistry of New Jersey.

We support the bill not only for the purpose behind it, that of providing medical care to those who cannot afford it, but we also support it on the grounds of the effect it would have on University Hospital and the decreasing of State support for the unmet indigent care with the resulting Federal aid that would come about as a result of this bill.

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

ASSEMBLYMAN WATSON: I do not have any; how about the Committee members? (negative response) All right, thank you for your appearance this afternoon.

MR. DIMENNA: Okay, thank you.

ASSEMBLYMAN WATSON: Mr. George Hooper from the Essex County Council on Senior Citizens. Good afternoon, Mr. Hooper. In the interest of time, I would like you to summarize your position, if possible.

GEORGE HOOPER: I do not have a printed statement, and I will be brief. First, as to my identity, I have a couple of hats. I am also Chairman of the Tax Task Force of the New Jersey Federation of Senior Citizens, the same organization Edith Edelson represented, and I am a member of the Legislative Task Force, which has been mentioned here.

Basically, I would like to make a few remarks with reference to funding. I am particularly interested in that angle. In April, I presented a statement to the Joint Appropriations Committee, which contained a few points that are still applicable. One is that senior citizens are somewhere between 16% and 17% of the population of this State, if you consider persons over 60, and maybe between 11% and 12% if you consider persons over 65. Casino fund expenditures, although they vary, generally represent something around 2% of the State budget. Therefore, any concept that we are limited to casino funds for senior programs is, on the face of it, erroneous.

Second, it is our position that casino funds were designed for new or expanded programs for seniors under the constitutional uses permitted.

Third, as has been stated here several times, there is some question about the usable funds under casino funding. Although there is a surplus in this year's budget -- as has been pointed out by Assemblyman Kavanaugh -- there are bills in process and commitments that will use it up.

The chief problem with reference to the senior part of the priorities is in your lap. In other words, for two sessions we have been asking for a commission to get a consensus on priorities and to present it. For two sessions, there has not been such an operating commission. I live in Nutley and, unfortunately, there has been a death of one of the members appointed by the Speaker of the Senate, so now we have at least one -- and I understand two -- vacancies on the commission. I don't know that they have even had their first meeting. But, until such time as this is in order and functioning, we are going to have this split personality kind of thing. A good program is a good program. As Edith has said, there is no disagreement -- except where there is disagreement about some ranges and parameters -- that we have a good program here. The funding should be a matter of general funding, if necessary. If we have a surplus, to get it started, I see no reason why we cannot start with that. It is going to have to be considered as a good program.

As far as casino funding is concerned, each of the eight or nine organizations in this task force has its set of priorities and tries to get together on them. The Federation has its own priorities, among them, of course, the medically needy. They are changing; these things are not static. What I am suggesting is, we need to get that prioritization commission off the ground as rapidly as possible. Having done that, some of the difficulties that have been pointed out here by the Division on Aging about worries on funding might well be leveled off if we get a consensus.

Thank you.

ASSEMBLYMAN WATSON: Thank you for your testimony, Mr. Hooper. Are there any questions from the members of the Committee? (negative response) I hear none, so I just want to thank you for appearing this afternoon, and thank you for being patient.

MR. HOOPER: Thank you, Mr. Chairman.

ASSEMBLYMAN WATSON: I think Mr. Tergis from the New Jersey Council of Senior Citizens is the last on our list. Is Mr. Tergis here? (no response) I understand that we have Mr. Tergis' testimony, and we will make it part of the record.

I think that wraps up our hearing. Is there anyone else who would like to testify before we adjourn this afternoon? (no response) Okay, seeing no one come forward, would any Committee member like to make a statement? (negative response)

Then, I would just like to thank my Assembly colleagues for being with me today -- Assemblyman Kavanaugh, Assemblyman Weidel, Assemblyman Frelinghuysen, and Assemblyman Villane. Assemblyman Deverin was here this morning. I would also like to thank my staff, Jay Hershberg and Fred Butler. Thank you everyone for your attendance here today at this second public hearing.

We look forward to receiving Commissioner Albanese's specific recommendations. We are concerned about the lack of progress in completing the hospital survey. We are going to make sure -- Mr. Scalera, as you are -- that we do everything we can to obtain that information. Nonetheless, it is the Committee's intention to begin preparing amendments to A-608 which will detail the people to be served, the income and assets test to be used, services, administration, etc. We intend to begin preparing this bill for the Committee's release and for Assembly support.

Once again, thank you all for attending. This hearing is adjourned.

(HEARING CONCLUDED)

APPENDIX

**NEW JERSEY
DEPARTMENT OF HUMAN SERVICES**



**FACTS ABOUT THE
MEDICALLY NEEDY
PROGRAM**

Submitted by

Thomas M. Russo, Director

Division of Medical Assistance and Health Service

NOVEMBER, 1984

TABLE OF CONTENTS

<u>PAGE</u>	
1	Historical Overview of the Title XIX Medically Needy Program
4	*Chart - How Much Will It Cost?
5	Clients Covered Under a Medically Needy Program
7	*Chart - Maximum Service Expenditures
8	Scope of Medical Services
11	*Chart - Maximum Services
12	*Chart - Comparison of Costs
13	Medically Needy Income Level
19	Medically Needy Resource Standard
21	Budgeting Period
27	*Chart - Eligibility Periods for States with Medically Needy Program
28	Other Issues
35	Preliminary List of Program Activities Necessary to Implement a Medically Needy Program
39	*Chart - Preliminary List of Program Activities

APPENDICES

<u>PAGE</u>		
41	"A"	Medicaid Covered Services
46	"B"	Comparison of SSI and Medically Needy Income Levels
48	"C"	Cost Sharing Provisions
51	"D"	Federal Cost Share Regulations
52	"E"	New Jersey Title XIX Services
54	"F"	Resources Considered as Assets Under Categorical and Medically Needy Program
56	"G"	List of Agencies

HISTORICAL OVERVIEW OF THE TITLE XIX MEDICALLY NEEDED PROGRAM

The original Social Security Act, which was enacted in 1935, made no direct provision for medical assistance. However, it did establish a system of "categorical" public assistance that allowed the federal government to share with states the cost of providing maintenance payments to the needy aged and blind, and to needy families with dependent children. This assistance, which was subsequently extended to the permanently and totally disabled, could include the cost of some medical care in monthly assistance payments to recipients.

In 1950, public assistance under the Act was broadened to include federal sharing in "vendor payments," i.e., direct payments by a state to doctors, nurses, and health care institutions, rather than to the welfare recipient himself. Although federal sharing in vendor payments created an administrative framework for a welfare medical program, federal funding was so small that only a few states participated. Subsequent amendments to the Act made more federal funds available so that, by 1965, all of the states provided medical vendor payments in their federally aided categorical assistance programs. Many states also offered an allowance for some items of medical care in welfare payments to categorical assistance recipients.

Despite these expanded federal and state efforts, the need for medical assistance became so great that most states could finance only a few services. To help satisfy this need, Title XIX or "Medicaid" was enacted in the Social Security Amendments of 1965, providing grants to states for medical assistance programs beginning January 1, 1966. By January 1, 1967, more than half of the states had Medicaid programs, and by 1970, all of the states except Alaska (which later implemented one) and Arizona (which implemented an alternative to Medicaid in 1982) had programs. As a result, the federal financial participation in medical care that had been available through the categorical public assistance programs was ended because of the availability of federal Medicaid funds and the administrative advantages of offering medical care exclusively through Medicaid.

In general, categorically needy individuals who are given public assistance under the Social Security Act because they are poor, and are either aged, or blind, or disabled, or members of families with dependent children, are covered by Medicaid. Other categorically needy individuals who could generally qualify for such public assistance if they applied, or Medically Needy individuals who could qualify for such public assistance except for their slightly greater income and/or resources, may be covered at the option of the state. Eligible individuals are called categorically needy because of their relationship to categories of public assistance under the Act, or Medically Needy because they lack sufficient income and/or resources to pay their medical bills.

New Jersey implemented a Medicaid program, in January 1, 1970 to cover the categorical groups receiving, 1) Old Age Assistance; 2)

Disability Assistance; 3) Aid to Families with Dependent Children ; and 4) Assistance for the Blind.

A state's Medicaid plan must offer the categorically needy the following: (1) inpatient and outpatient hospital services, (2) rural health clinic services, (3) other laboratory and X-ray services, (4) skilled nursing facility services for individuals 21 or older, (5) early and periodic screening, diagnosis, and treatment for individuals under 21 (EPSDT), (6) family planning services for individuals of child-bearing age, (7) physicians' services, (8) home health services, (9) nurse-midwife services, and (10) transportation to receive medical care, and may offer the Categorically Needy any number of the optional services covered in the federal Medicaid law. (See Appendix A for a list of the mandatory and optional Medicaid Services.)

In 1974 a study was performed to calculate the costs of implementing a Medically Needy program in New Jersey. At that time there was far less flexibility in the program than there is today. States which wanted to expand their Medicaid coverage to include the Medically Needy population had to meet specific federal guidelines. The following basic services would have to have been offered: (1) inpatient hospital services, (2) outpatient hospital services, (3) laboratory and x-ray services, (4) skilled nursing home services, (5) physician services, (6) early and periodic screening and diagnosis of individuals under 21 years of age, (7) home health services, (8) transportation, and (9) family planning services and supplies. The State had the option of providing dental care and prescribed drugs as well as other Medicaid services, with the stipulation that the services offered to the Medically Needy had to be equal for all groups. They could, however, be different from the services offered to the Categorically Needy. In addition, Medically Needy benefits had to be extended to all client type groups covered under the State's categorical program.

The 1974 study estimated 136,600 new eligibles would be covered under a Medically Needy program (Old Age Assistance, 40,000; Disability and Assistance for the Blind, 12,000; Assistance for Dependent Children, 84,000). The cost was estimated at \$49.1 million for the required basic services and all the optional services covered by the existing Medicaid program.

The financial eligibility to receive Medically Needy benefits was set at 133 1/3% of the categorical AFDC program. That was then, as now, the maximum level permitted under federal regulations.

Now, ten years later the program is under consideration again. However, there are, in 1984, some substantial differences in the federal requirements for a Medically Needy program.

The enactment of the Omnibus Budget Reconciliation Act of 1981 (OBRA) brought about several changes in the Title XIX Medically Needy program. States now have the option to establish different medical care packages for the different groups that qualify as Medically Needy.

If the State implements a Medically Needy program, federal regulation requires that pregnant women receive prenatal and delivery services and that children under the age of 18 receive ambulatory care services. These two groups are the only mandatory groups that must receive medical care. Beyond these requirements optional services can be established for the aged, blind, disabled, and the parents of eligible children.

Federal funding can be received for these last four groups, however, each medical package cannot exceed the medical services offered to the categorically needy groups. A different medical package can be established for each of the optional groups to meet the needs of those individual categories.

The Omnibus Budget Reconciliation Act of 1981 was unclear about the definition of children. This created confusion at both the federal and state level in terms of who had to be covered. The rules and regulations, published September 30, 1981 in the Federal Register stated as follows:

"The State Plan may include under the optional categorically needy those individuals under age 21 (or at State option, under age 20, 17, or 18) who do not qualify as AFDC dependent children. In addition, States may limit coverage to reasonable classifications of these persons."

The regulations provided the following as examples of "reasonable classifications":

- 1) Individuals in foster homes or private institutions for whom a public agency is assuming a full or partial financial responsibility.
- 2) Individuals in adoptions subsidized in full or paid by a public agency.
- 3) Individuals in intermediate care facilities, if intermediate care facilities were to be provided under the State Plan.

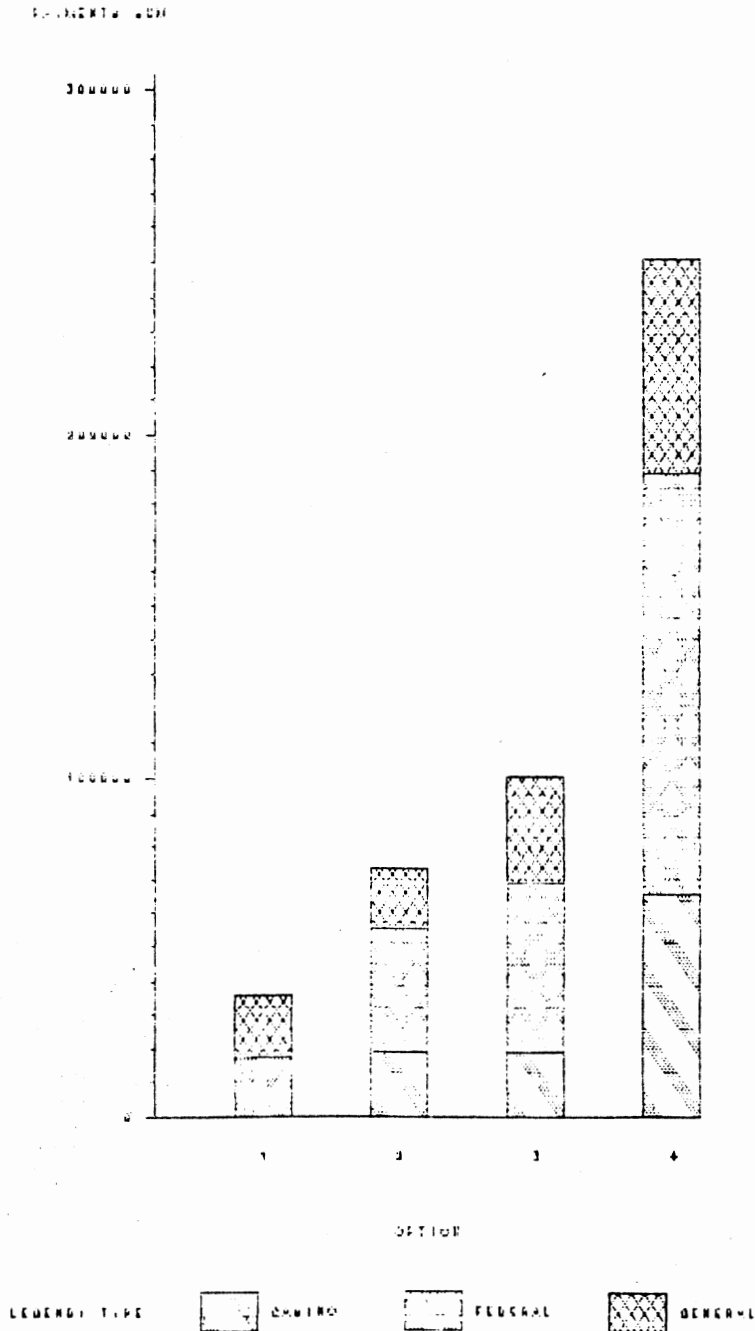
The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) included a number of technical amendments to clarify the definition of children contained in the Omnibus Budget Reconciliation Act of 1981 (OBRA). Under OBRA it appeared that the costs of providing medical care to children were minimal because of the narrow definitions used for "reasonable classifications" of children. TEFRA expanded the definition to include all Medically Needy children. However, regulations for TEFRA have not been published. Therefore, the existing federal regulations on the Medically Needy program conflict with the statute; however, the statute takes precedence.

MEDICALLY NEEDED PROPOSALS

HOW MUCH WILL IT COST?

4 OPTIONS APPORTIONED BY FUNDING SOURCE

EXPENDITURES



EXPENDITURES ARE IN THOUSANDS OF DOLLARS

CLIENTS COVERED UNDER A MEDICALLY NEEDED PROGRAM

If a State elects to establish a Medically Needy program, it must extend coverage to children and pregnant women. The State may elect to extend coverage to other groups such as aged, blind, or disabled clients as well as parents in families with dependent children.

In addition to providing Medicaid services to the categorically needy, under Title XIX of the Social Security Act, states may elect to provide coverage to the Medically Needy. Before the passage of the Omnibus Budget Reconciliation Act of 1981 (OBRA), this group consisted, in general, of all persons who, except for their income and resources, would have been eligible for either AFDC or SSI.

Sections 2171 and 2172 of OBRA revised Title XIX by giving the States flexibility in determining which groups of individuals would be included in their Medically Needy program. The intent of these provisions was to enable each state to target Medicaid services for the optional groups based on the States consideration of priorities, needs and resources.

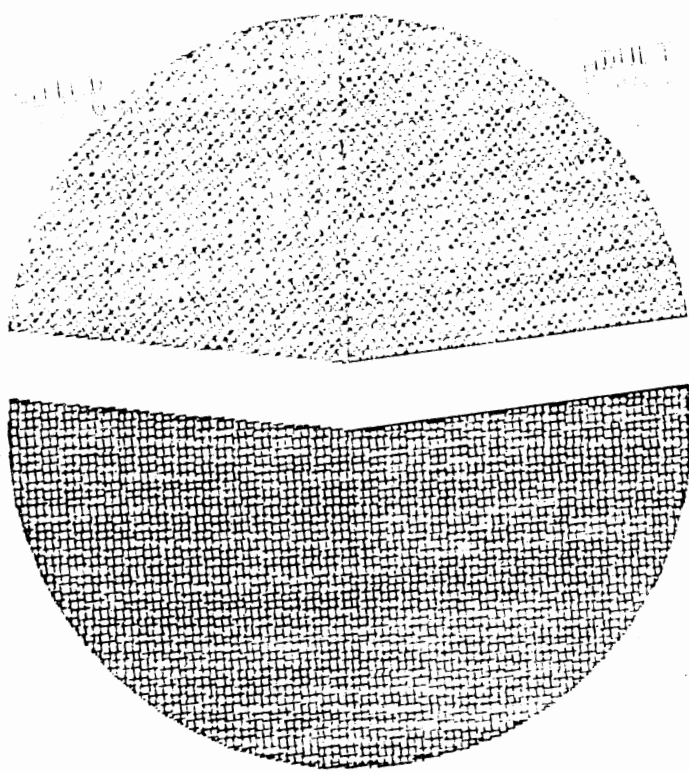
With the incorporation of the provisions of OBRA into the Social Security Act, the following guidelines applied to the coverage of clients in a Medically Needy programs:

- 1) If the State Plan provides Medicaid coverage to an individual in a group, the State must provide coverage to all members of the group.
- 2) Coverage must be extended to children under 18 who, except for income or resources, would be Categorically Needy individuals.
- 3) States are allowed, at their option, to extend Medically Needy coverage to children aged 18 to 21 who would be eligible for AFDC except for a school attendance requirement, or to any reasonable category of children between 18-21.
- 4) The State Medicaid plan must provide Medically Needy assistance to pregnant women during the course of their pregnancy if, except for their income or resources, they would be categorically eligible.
- 5) The State has the discretion to extend eligibility to any of the following groups:

- a. caretaker relatives in families with dependent children (these are generally considered to be the parent residing with the child);
- b. aged (individuals 65 and over);
- c. disabled;
- d. blind.

As indicated above, in addition to children and pregnant women, there are four optional client groups for which the State may elect to provide Medically Needy coverage. These include the aged, the blind, the disabled clients and/or parents in families with dependent children.

MEDICALLY NECESSARY PROVISIONS
MAXIMUM SERVICE EXPENDITURES
DISTRIBUTED BY RECIPIENT CATEGORY



PAYMENTS
(IN THOUSANDS OF DOLLARS)
EXCLUDES ADMINISTRATIVE COSTS

SCOPE OF MEDICAL SERVICES

As a result of provisions contained in the Omnibus Budget Reconciliation Act of 1981 (OBRA), states were allowed greater flexibility in the scope of services available to Medically Needy eligibles. While mandating a limited number of services to certain groups of eligibles, OBRA was designed to provide the states with maximum flexibility to structure their service packages to meet the needs of each type of client.

As a result of the provisions contained in OBRA, services do not have to be equal in amount, duration and scope for all groups. In addition, states no longer have to provide a mixture of institutional and noninstitutional services, and may offer one set of services for one Medically Needy group without being required to offer comparable services to another Medically Needy group. States are also permitted to offer Medically Needy coverage to some but not all of the groups formerly eligible.

However, the federal regulations do require a minimum number of services if a state provides a Medically Needy program. This includes ambulatory care services for individuals under the age of 18 and prenatal and delivery services for eligible pregnant women.

If the state elects to provide nursing home, mental hospital or Intermediate Care for the Mentally Retarded (ICF/MR), it is also required to provide the following services:

1. if a state provides skilled nursing home services to the Medically Needy population, it must also provide home health services to the same group of eligibles, and
2. if a state provides Medically Needy coverages for services in an institution for mental diseases (IMD's) or an intermediate care facility for the mentally retarded (ICF/MR's) for any group of Medically Needy eligibles, it must provide either a) the first five services listed below or b) any seven of these services. The services must be available, however, to all Medically Needy groups. The array of services are:
 1. Inpatient hospital services (other than services in an institution for tuberculosis or mental diseases).
 2. Outpatient hospital services.
 3. Laboratory and X-ray services.
 4. (i) Skilled Nursing facility services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older.

(ii) Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

(iii) Family planning services and supplies.

5. Physicians' services, whether furnished in the office, the patient's home, a hospital, a skilled nursing home or elsewhere.
6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.
7. Home Health Services. Nursing services, Home Health Aide services, and medical supplies, equipment and appliances suitable for use in the home must be provided.

Physical therapy, occupational therapy or speech pathology and audiological services, provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services, are optional.

8. Private duty nursing services. (We do not cover this service and could only provide this service in a Medically Needy program only if it was also available to categorically needy individuals.)
9. Clinic Services.
10. Dental Services
11. Physical therapy, occupational therapy, treatment of speech, hearing and language disorders.
12. Prescribed drugs, dentures and prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select.
13. Other diagnostic, screening, preventative and rehabilitative services.
14. Inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases.
15. Intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases) for individuals who are determined to be in need of such care (may include ICF/MR).

16. Inpatient psychiatric services for individuals under age 21.

17. Nurse-midwifery services.

See Appendix E for a list of services currently offered under the New Jersey Medicaid program.

In addition to the above requirements, the state has the option of providing any additional services it deems advisable to adequately meet the needs of the state's medically needy. The only proviso is that the state cannot provide more services to a Medically Needy eligible recipient than it does to a categorically eligible individual. The state does, however, retain the option of providing fewer services to the Medically Needy population.

For example, the state appears to have some flexibility in defining ambulatory care services for children. We have recommended a package of services for children that will meet their developmental needs as well as comply with federal requirements. This recommended package of services listed below, under recommendation number 1, can be expanded or reduced in certain circumstances.

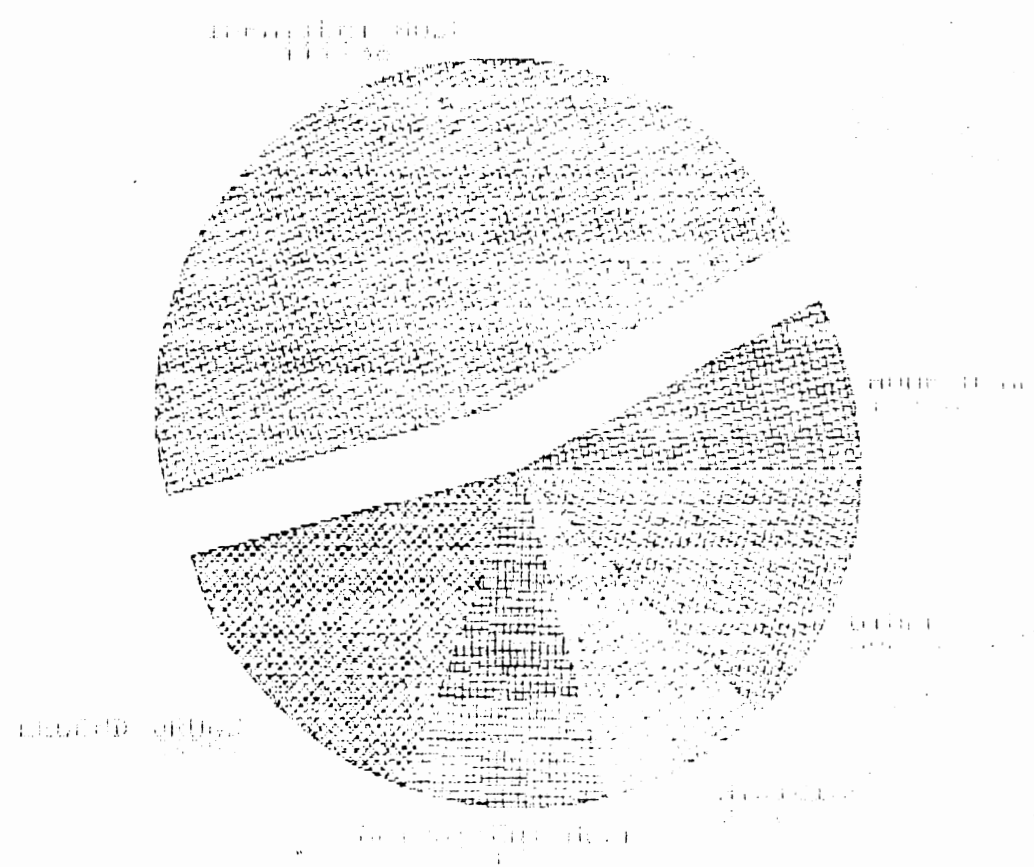
In the case of pregnant women, states are required to provide prenatal care and delivery services to pregnant women, who except for their income and resources, would be categorically eligible to receive assistance. The following is an illustration of how one state (Oregon) elected to provide this coverage. They selected 40 procedure codes related to antepartum, delivery, and six weeks postpartum care. These procedures are the only medical services Medically Needy pregnant women in Oregon are eligible to receive. Therefore, the program does not cover prescriptions, or treatment for any medical condition which may arise from the pregnancy which is not directly related to the antepartum, delivery or postpartum care.

Federal regulations do not require any Medically Needy coverage for aged, blind and disabled clients. States can elect to cover these groups and can design unique service packages for each type of client. The state may choose, for example, to provide physical therapy services to the disabled but not to the blind or aged. Home health care services could be considered in the package of services for the aged and blind, in another example, but not for the disabled.

As can be seen, the State is given a great deal of flexibility to establish a service package to meet the unique needs of each optional eligibility group.

MEDICAL SERVICES

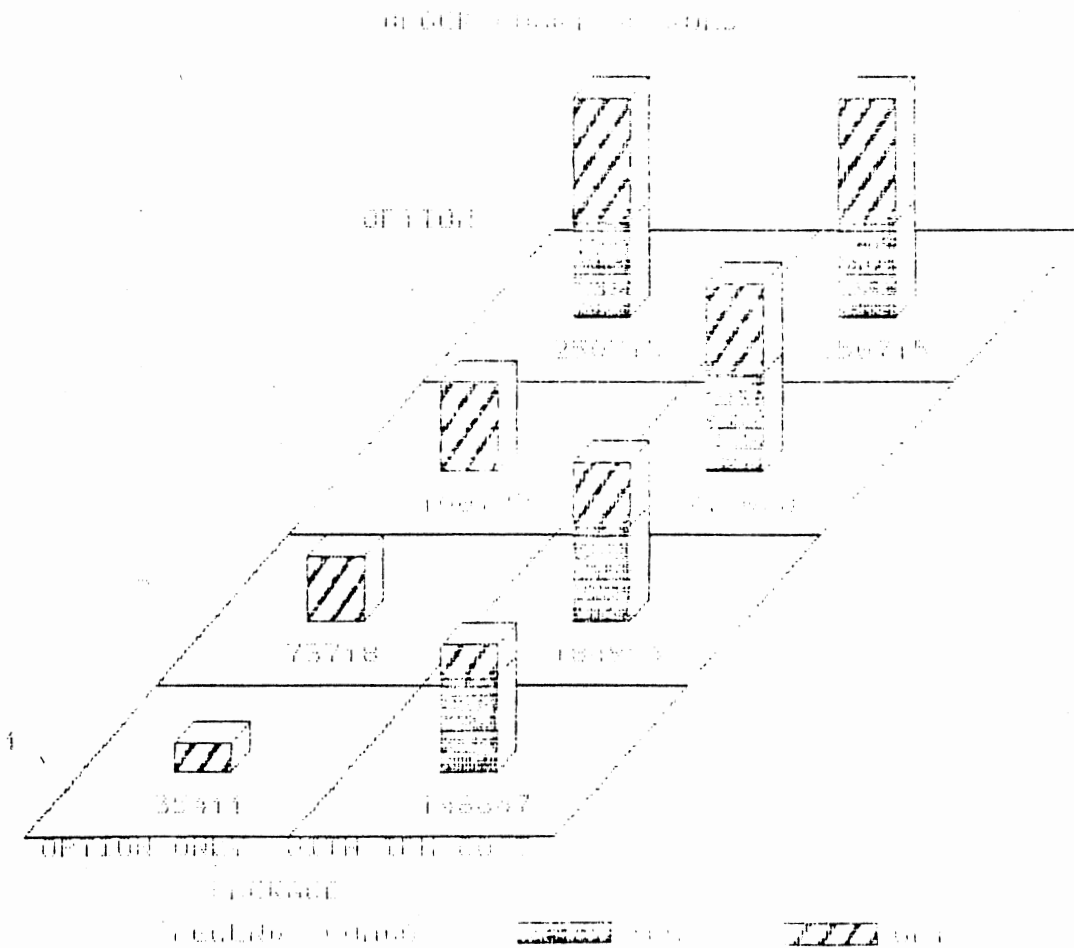
MAXIMUM SERVICES EXPENDITURES BY SERVICE



PAYMENTS
(IN THOUSANDS OF DOLLARS)

MEDICAL NEED PROPOSAL

COMPARISON OF COSTS WITH AND WITHOUT A COMPREHENSIVE INPATIENT HOSPITAL PACKAGE



COMPREHENSIVE IPH PACKAGE EQUALS IPH SERVICES TO ALL RECIPIENT CATEGORIES
 EXCLUDES ADMINISTRATIVE COSTS ASSOCIATED WITH IPH COSTS

MEDICALLY NEEDED INCOME LEVEL

Under federal regulations, the State must establish an income standard, known as the Medically Needy Income Level (MNIL), which applies to all individuals, regardless of age or situation, who establish eligibility as medically needy, and which must be adjusted by family size.

This differs from the categorical programs where different income standards are used to determine eligibility for the Aid to Families with Dependent Children (AFDC) and the Supplemental Security Income (SSI) clients.

Federal regulations require the Medically Needy program to establish a Medically Needy Income Level which is adjusted by family size and applies equally to all the medically needy applicants, regardless of the applicant's eligibility category.

Establishing a Medically Needy Income Level is a complex administrative process within the guidelines established by federal regulations (42 CFR 435.814, 435.816 and 435.1007). The process is as follows:

The State must set a Medically Needy Income Level which,

for individuals, and families of two persons, is the higher of the payment standard generally used to determine financial eligibility of one and two persons for cash payments available under the State AFDC or SSI program;

for families of three or more persons, is the level of the payment standard generally used by the AFDC program.

However, Federal Financial Participation (FFP) is not available for medical expenses on behalf of persons who qualify as Medically Needy or have an income level which exceeds 133 1/3% of the highest amount which would ordinarily be paid to a family of the same size in the AFDC program.

In those instances where the Medically Needy Income Level established above exceeds the income allowed for FFP, the State may establish a lower income standard which does qualify for FFP. In such cases, the income standard must not be less than the maximum level allowed for federal funding.

The following examples illustrate the process to be followed in establishing Medically Needy Income Level for New Jersey:

PAYMENT LEVELS IN NEW JERSEY FOR AFDC AND SSI

Family Size	1	2	3	4	5	6
AFDC	---	\$292	\$385	\$443	\$501	\$559
SSI	\$345.25	\$497.36				

Utilizing the process described above for a family of 4 with no income, the State would use the following process to establish a Medically Needy Income Level:

Current AFDC payment standard for a family of 4	\$443	This is the minimum income the State could set for a family of 4
133 1/3% of which is	<u>\$590.66</u>	
x 12 months	<u> x 12</u>	
	\$7,087.92	
Round to the nearest \$100	7,100.00	
Divided by 12 months	<u> ÷ 12</u>	
	\$591.66	This is the maximum income standard for a family of 4

In the above example, the State can establish the Medically Needy Income Level anywhere between \$443 a month to \$591.66 a month and receive FFP for the medical expenses paid by the State on behalf of this family. The only restriction is that the 4 person income standard must be higher than the 3 person income standard and less than the 5 person income standard.

Using the same process, the following is an example of the administrative complexities in establishing the Medically Needy Income Level for a family of two (2).

The State can use the SSI standard for a family of 2 and in New Jersey, for example, this would be \$497.36. However, FFP would only be available for those medical expenses paid on behalf of persons qualifying as Medically Needy based on an income level as computed below:

Current AFDC Standard for a family of 2	\$292.00
	x 133 1/3
133 1/3% of which is	<u>\$389.33</u>
times 12 months	x 12
	<u>\$4,671.96</u>
Rounded to the nearest \$100	\$4,700.00
divided by 12 months	<u>÷ 12</u>
for a monthly Medically Needy Income Level of	\$391.66

The federal regulations also require that if 133 1/3% of the AFDC standard is less than the SSI standard for the State, the Medically Needy Income Level must be set at 133 1/3% of the AFDC standard. In New Jersey, therefore, the Medically Needy Income Level cannot be lower than 133 1/3% of the AFDC standard.

It should be noted that the income calculations are based on the assistance payment, (such as \$292 for a family of 2 in the AFDC program), and not on any other standard; such as the 185% gross income level utilized by the AFDC program to determine if a family might be eligible for assistance.

In determining eligibility for a Medically Needy program, the State must establish the amount of available income (42 CFR 435.831). This includes the amount of income the individual/family receive on a regular basis or has control over. In addition to the amounts actually received, States also must take into account the financial responsibility of the spouse, for a spouse, and of parents for children who are under 21 or blind or disabled (42 CFR 435.602). Persons whose income is assumed to be available to the applicant are included in the household size to determine the appropriate income standard to be applied to the applicant. Once eligibility is established, the responsible relative is not eligible for benefits.

After determining available income (gross income), the client's income is reduced by disregards appropriate to that eligibility group. For families and individuals under age 21 disregards, such as work expenses and child care costs used in determining eligibility for the Aid to Families With Dependent Children (AFDC), would be deducted from gross income. For aged, blind or disabled individuals, the amounts that would be disregarded in determining eligibility for Supplemental Security Income (SSI) such as the disregard of the first \$20.00 of income would be deducted from gross income.

After disregards are determined, those with countable (net) income below the Medically Needy Income Level are eligible without cost to the individual. Those with countable (net) income above the MNIL must "spend-down" to establish eligibility by incurring medical expenses in an amount equal to their excess income.

If institutional services are provided under the Medically Needy program, most of the information above does not apply, including the 133 1/3% limitation. Applicants would have to incur medical expenses equal to net income, (after appropriate disregards), in excess of the 300% CAP higher income standard, currently \$882.00. After financial eligibility has been established, any available income above the amount allowed for personal needs allowance, currently \$25.00 per month, would have to be applied to the cost of medical care.

There appears to be a great deal of confusion concerning the Medically Needy Income Level (MNIL) used for aged, blind or disabled individuals and couples. Many of the Medically Needy advocate groups erroneously believe it is set at 133 1/3% of the State's SSI standard for aged, disabled and blind clients and 133 1/3% of the AFDC standard for children and pregnant women. However, as indicated above, the Medically Needy Income Level is set no higher than 133 1/3% of the appropriate AFDC standard for the family size for all client groups in order to receive federal funding.

As indicated in the examples in the background and in Appendix B, the federal regulations result in a MNIL for a two person household which can be less than the SSI standard, yet greater than the AFDC standard. In New Jersey, the Medically Needy Income Level for a two person household can be set at no lower than \$391.66 per month, which is \$103.62 less than the SSI standard and \$99.66 greater than the AFDC standard for a two person household. However, the Medically Needy program does not differentiate between client type in establishing an income standard. Thus, both mother and child, as well as an elderly couple, must meet the same income standard to qualify for the Medically Needy program.

As can be seen in Appendix B, New Jersey is not alone in having an SSI income standard substantially higher than the AFDC standard. Currently, 31 states have a Medically Needy program, and the majority of the states have Medically Needy Income Levels which are less than the state's SSI standard for a couple.

Under federal regulations, the state has the option of establishing a Medically Needy Income Level above 133 1/3% of the AFDC payment level; however, federal funding is not available for these costs. While some senior citizen groups may advocate setting a higher standard and funding these costs with casino dollars, this approach would result in numerous problems for the State.

First, since the State must set a single Medically Needy Income Level for all eligibles, many of the costs incurred would not be eligible for casino funding. Because a mother and child are eligible under the same standards that are used for an aged, blind or disabled couple, only a portion of the State's costs could be covered by casino funding.

Secondly, federal regulations also require that the Medically Needy Income Level must be adjusted by family size. Therefore, if the state established a Medically Needy Income Level for a two person household based upon the SSI standard, the income for a three and four person household would also have to be adjusted above the level for which federal funding is available.

The chart below illustrates this point. The first set of figures represent the maximum income level the state could utilize to receive FFP for all medical benefits, while the second line of figures illustrates a standard based upon SSI standards. These latter figures have been advocated by several groups supporting the implementation of a Medically Needy program.

DIFFERENCES IN INCOME STANDARDS BETWEEN FEDERAL
MEDICALLY NEEDED INCOME LEVEL AND
STANDARDS BASED ON SSI BENEFIT LEVELS

Family Size	1	2	3	4	5	6
Maximum Income for FFP	\$391.66	391.66	516.66	591.66	675.00	750.00
Standard Based on 133 1/3% of SSI Standard	<u>\$457.58</u>	<u>660.42</u>	<u>665.42</u>	<u>670.72</u>		
Difference	-\$65.92	-\$268.76	-\$148.76	-\$78.76		

As illustrated by the above chart, for a one person household, the state would have to fund the difference between the 133 1/3% SSI standard and the required Medically Needy standard (\$65.92) solely with State dollars for each eligible individual. In the case of the two person household, the State would have to fund, wholly, with State dollars, the first \$268.76 in medical benefits for each case.

Since the State is required to increase the income standard for each additional family member, the three person household income standard would have to be established in excess of \$660.42. Assuming a minimum \$5.00 increase, the State would have to absorb the first \$148.76 in benefits for a three person household and

\$78.76 of benefits in a four person household. Only when the State reached the five person household would FFP be available for all medical expenses. These numbers assume, however, that the State increases the standard by only \$5.00 for each additional member of the household.

Finally, if a state elects to establish a Medically Needy Income Level above the maximum allowable for FFP, the State must demonstrate its ability to track these costs to assure that federal funding is not claimed prior to each client's medical bills reducing their income to the federal MNIL. This need to track each client's income and medical bills would require a highly complex computerized system. Currently, the Division does not have a system capable of providing these requirements.

MEDICALLY NEEDY RESOURCE STANDARD

Under federal regulations, the State must establish a liquid resource standard which applies to all individuals and families, who establish eligibility as Medically Needy. This resource standard must be adjusted for family size.

The resource standards must be as high as those used for the highest cash assistance program. At the present time the AFDC Program has a \$1,000.00 family resource standard. The SSI resource standard is currently \$1,500.00/\$2,250.00 but under the Deficit Reduction Act of 1984 (DEFRA) that amount will be increased by \$100.00 for an individual and \$150.00 effective January 1985. Legislation allows for possible further increases in future years. (See Appendix F for a list of those items considered resources).

The resource standard could be set at the SSI level of \$1,500.00 (single)/\$2,250.00 (couples) and raised to the appropriate level based upon the DEFRA regulations, or set at any level above those figures. (Subject to Federal approval.)

However, based upon the Division's experience with the Community Care Program for the Elderly and Disabled (CCPED), the SSI resource levels appear insufficient to cover emergencies that might occur when the client is living in the community. It has been shown that some elderly and disabled clients do not participate in the CCPED program due to the stringent resource limitation.

States may elect to establish resource levels above those for the categorical programs, and may adjust these limits annually. However, Federal approval of the proposed asset limit must be obtained by the State.

A review of the resource standards for the Medically Needy programs in 28 states and the District of Columbia indicates that states have a wide variation in their resource eligibility standards for different types of assets. For liquid assets, many states have established a \$1,500 standard for an individual; \$2,250 for a two-person house, plus a range of \$25 to \$300 for each additional household member.

However, several states, use a higher federally approved standard. Some examples are Kansas (\$1,800 and \$2,400, respectively); Kentucky (\$1,500 and \$3,000); Maryland (\$2,500 and \$2,600); Massachusetts (\$2,000 and \$3,000); Minnesota (\$3,000 and \$6,000); New Hampshire (\$3,500 and \$4,000, that includes the equity value of

all life insurance policies); North Dakota (\$3,000 and \$4,500); Pennsylvania (\$2,400 and \$3,200); and Rhode Island (\$4,000 and \$6,000). New York State does not have a set figure for their Medically Needy resource standard. In New York, they utilize one-half of the appropriate yearly income exemption to establish the liquid asset level. Currently, for a one person household, the standard is \$2,100; for a two person household \$3,050 and \$50 for each additional household member.

The benefit of increasing the liquid resource limit in excess of the highest categorically related assistance standard would be to increase the number of eligibles for the Medically Needy program.

There are, however, several inequities in increasing the liquid resource limit above the level used for the categorically related programs.

Raising the resource standards would allow those with more income than the AFDC recipient to retain more assets than an AFDC or SSI eligible individual and still be eligible for certain Medicaid benefits.

In addition, an increase in the liquid asset limit standard for the Medically Needy program could discourage enrollment in the CCPED waiver since that program currently must utilize the SSI standard for resource eligibility.

However, it should be noted that at least ten (10) states and the District of Columbia have determined that these inequities are insufficient to outweigh the advantages of establishing the Medically Needy resource standards at a limit greater than the AFDC or SSI standard.

BUDGETING PERIODS

For the Medically Needy program, federal regulations require a State to establish a budget period for medical eligibility of not less than one month, nor more than six months in duration. After the budget period has expired, it is necessary to redetermine the applicant's eligibility for Medicaid. It must be noted, however, that whatever budget period the State has selected to utilize for a determination of eligibility, federal procedure requires that, in general, the State must apply the budget period consistently across all groups of recipients and for all types of services.

States have budget periods for their Medically Needy programs anywhere from one to three to six months for a variety of reasons. According to the data base maintained by the National Governor's Association, twenty of the states which have a Medically Needy program utilize a six month period of eligibility. Of the twenty states which use a six month accounting period, however, five noted they have exceptions, including one state which allows the applicant to elect the budgeting period applicable to his case. Arkansas, Kentucky, Louisiana and Montana utilize a three month budget period while California, Hawaii, North Dakota and Utah use a one month period to determine eligibility.

The following material outlines the advantages and inequities of establishing a one month or six month period for budgeting purposes for both the applicant and the administering agency.

. One Month Budget Period

Utilizing a one month budget period permits a State to closely monitor the eligibility process and the error rate. This is particularly true in instances where available income varies from month to month.

Administratively, however, it is more costly for a state to redetermine eligibility monthly. Several states have made a determination that the benefits of monthly budget periods outweigh the costs. For example, New York City has instituted a monthly budgeting period for their Medically Needy program as a corrective measure to reduce the Medicaid Quality Control error rate.

For the recipient, there is an obvious inconvenience in having their eligibility redetermined monthly. In addition, depending on the cash flow into the household, a monthly budgeting period could create an inequity for differing patterns of income.

For example, assume there are two households each with three persons and each household will receive \$2,700 income over

the next six months. One household will receive the income regularly over the six months but the other household's income will vary. Also assume that for this example, the Medically Needy Income Level is \$400 a month and there is a one month budgeting period.

ONE MONTH ACCOUNTING PERIOD VIEWED FOR SIX MONTH'S

	Countable Income	Spend- down Liability	Total Medical Expenses	Future Bills Covered by Medicaid	Client's Net Medical Expenses
Regular Income					
1st Month	\$ 450	\$ 50	\$100	Yes	\$ 50
2nd Month	450	50	25	No	25
3rd Month	450	50	150	Yes	50
4th Month	450	50	50	Yes	50
5th Month	450	50	75	Yes	50
6th Month	<u>450</u>	<u>50</u>	<u>30</u>	No	<u>30</u>
TOTAL FOR 6 Months	\$2,700	\$300	\$430		\$255

ONE MONTH ACCOUNTING PERIOD

	Countable Income	Spend- down Liability	Total Medical Expenses	Future Bills Covered by Medicaid	Client's Net Medical Expenses
Irregular Income					
1st Month	\$ 500	\$100	\$100	Yes	\$100
2nd Month	300	0	25	Yes	0
3rd Month	600	200	150	No	150
4th Month	400	0	50	Yes	0
5th Month	500	100	75	No	75
6th Month	<u>400</u>	<u>0</u>	<u>30</u>	Yes	<u>0</u>
TOTAL FOR 6 Months	\$2,700	\$400	\$430		\$325

As can be seen by this example, although both households received the same amount of countable income for a six month period of time, due to differences in the cash flow of the income and the use of a one month budget period, one household incurred more out-of-pocket medical expenses than the other.

However, there is an advantage to certain applicants if a one month budgeting period is utilized. This occurs for those applicants who have incurred large medical expenses in a short period of time. The example usually given is in the situation of a hospitalization, but could occur in the case of an unexpected illness, an accident or purchase of a large expensive item, such as dentures, a prosthetic device or a hearing aid. As a result of monthly budgeting periods, the individual could meet the spend-down limit for a month but would not be able to do so if the medical expenses were budgeted over a longer period of time.

. Six Month Budget Period

For the agency administering a Medically Needy program, a six month eligibility period can be less costly but also affords less opportunity for the agency to monitor for quality control accuracy. Many states advocate the six month budget period because they maintain that it provides eligibility to applicants who are truly medically needy and have ongoing and unmet medical needs. It does not, therefore, provide services to those individuals who are not medically needy, but have a one-time large medical expense.

For the recipient, a six month budget period can be advantageous because once eligibility is established, there is a longer period of time before a redetermination of eligibility is required to be completed.

In certain circumstances, a six month budgeting period can again be advantageous for the recipient in terms of the amount of expenses the applicant is responsible for, in addition to the medical coverage. The example below illustrates this point. In this illustration, it is assumed that the 3-person household has income which varies monthly and also that the Medically Needy Income Level is \$400. As can be seen, the six month budget period is more favorable than the one month budget period to the recipient with variable income because the recipient incurs \$25 less in net medical expenses over the same period of time.

SIX MONTH ACCOUNTING PERIOD WITH A SPEND-DOWN
LIABILITY OF \$300 FOR SIX MONTHS

	Countable Income	Remaining Spend- down Liability	Total Medical Expenses	Future Bills Paid by Medicaid	Client's Net Medical Expenses
Irregular Income					
1st Month	\$ 500	\$300	\$100	No	\$100
2nd Month	300	200	25	No	25
3rd Month	600	175	150	No	150
4th Month	400	25	50	Yes	25
5th Month	500	0	75	Yes	0
6th Month	<u>400</u>	<u>0</u>	<u>30</u>	Yes	<u>0</u>
TOTAL FOR 6 Months	\$2,700	\$700	\$430		\$300

ONE MONTH ACCOUNTING PERIOD VIEWED FOR SIX MONTHS

	Countable Income	Spend- down Liability	Total Medical Expenses	Future Bills Paid by Medicaid	Client's Net Medical Expenses
Irregular Income					
1st Month	\$ 500	\$100	\$100	Yes	\$100
2nd Month	300	0	25	Yes	0
3rd Month	600	200	150	No	150
4th Month	400	0	50	Yes	0
5th Month	500	100	75	No	75
6th Month	<u>400</u>	<u>0</u>	<u>30</u>	Yes	<u>0</u>
TOTAL FOR 6 Months	\$2,700	\$400	\$430		\$325

However, in another example, using the same six month total income, the same household size and the same medically needy standard, but using a different cash flow situation (in this case, a regular monthly income), it can be seen that a six month budgeting period would not be as equitable as a one month budget period to the applicant in terms of net medical expenses.

SIX MONTH ACCOUNTING PERIOD WITH A SPEND-DOWN
LIABILITY OF \$300 FOR SIX MONTHS

	Countable Income	Remaining Spend- down Liability	Total Medical Expenses	Future Bills Paid by Medicaid	Client's Net Medical Expenses
Regular Income					
1st Month	\$ 450	\$300	\$100	No	\$100
2nd Month	450	200	25	No	25
3rd Month	450	175	150	No	150
4th Month	450	25	50	Yes	25
5th Month	450	0	75	Yes	0
6th Month	<u>450</u>	<u>0</u>	<u>30</u>	Yes	<u>0</u>
TOTAL FOR 6 Months	\$2,700	\$700	\$430		\$300

ONE MONTH ACCOUNTING PERIOD VIEWED FOR SIX MONTHS

	Countable Income	Spend- down Liability	Total Medical Expenses	Future Bills Paid by Medicaid	Client's Net Medical Expenses
Regular Income					
1st Month	\$ 450	\$ 50	\$100	Yes	\$ 50
2nd Month	450	50	25	No	25
3rd Month	450	50	150	Yes	50
4th Month	450	50	50	Yes	50
5th Month	450	50	75	Yes	50
6th Month	<u>450</u>	<u>50</u>	<u>30</u>	No	<u>30</u>
TOTAL FOR 6 Months	\$2,700	\$300	\$430		\$255

There are other instances when a six month budget period can be inequitable for some applicants. Using an example of an individual applying for assistance who primarily receives ambulatory care services and has a large spend-down liability. Since the total liability for the six month budget period must be incurred prior to eligibility, a person who utilizes ambulatory services, such as pharmacy and physician, may find it more difficult to receive credit for the spend-down liability than another individual who received primarily institutional services, such as hospitalization during the same budget period.

Therefore, whatever budget period a state elects to utilize to determine eligibility for a Medically Needy program, there will be both costs and benefits to the administering agency, and both advantages and inequities to the applicants for such assistance.

In addition to reviewing the advantages and disadvantages of the different budget periods, the Division staff completed a statistical analysis of the error rate for each State with a Medically Needy program using the figures from Appendix D with each state's selected budget period. The analysis did not show any correlation between the accounting period and the State's Medicaid Quality Control error rates.

MEDICALLY NEEDY PROPOSALS

ELIGIBILITY PERIODS FOR STATES

WITH MEDICALLY NEEDY PROGRAMS



OTHER ISSUES

In addition to the major issues discussed in previous sections, there are other policy decisions which will affect the administration and implementation of a Medically Needy program. They include:

1. cost-share provisions
2. spend-down and "Incurred" medical expense requirements
3. Federal approval of the State Plan
4. Proposed Federal changes to the program and how it is effected by the Deficit Reduction Act of 1984 (DEFRA).

Each of these issues will be discussed below to provide a brief overview of the background and the problem areas.

1. COST SHARE PROVISIONS

In implementing a Medically Needy program, a state has the option to impose a cost sharing requirement for eligible individuals. The cost share payment may be an enrollment fee, premium, deductible, co-insurance, co-payment or similar cost sharing charges.

Federal regulations allow the states to impose a cost share payment on a Medically Needy individual within certain limitations. For example, the State may impose an enrollment fee based on family income with a minimum charge of \$1.00 a month for certain families and a maximum charge prescribed by federal regulations. For non-institutional services, the state may elect to impose a deductible not to exceed \$2.00 a month per family. Coinsurance on non-institutional services may be established if it does not exceed 5 percent of the agency's payment for the services. Copayments on non-institutional services are governed by a sliding scale established by regulation. (See Appendix D.) For institutional services the agency may impose a cost share which does not exceed 50% of the cost of the first day of care in the institution. Effective October 1, 1982, no cost share may be imposed in the following instances:

1. services provided to children under 18 or 21 at the State's discretion;
2. services related to pregnancy or any medical condition which may complicate the pregnancy;
3. services provided to patients in SNF's or ICF's;
4. family planning services; and
5. emergency services.

In addition to the federal restrictions on cost-share noted above, P.L. 1984, c.56 (N.J.A.C. 30:4D-6 et. seq.) a New Jersey statute, prohibits imposing any "copayment or other form of cost sharing" on any individual eligible for medical

assistance except as mandated by federal law as a condition of federal financial participation.

2. SPEND-DOWN AND INCURRED MEDICAL EXPENSES

In implementing a Medically Needy program, the state must allow for the deduction of incurred medical expenses if the client's income exceeds the income standard. This process of deductions is known as spend-down. Once the deduction of incurred medical expenses reduces the applicant's countable income to the Medically Needy Income Level, the individual is eligible for Medicaid for the balance of the eligibility period.

Federal regulations govern the type and order in which incurred medical expenses are deducted from countable income in order to establish eligibility. The order is as follows:

- a) Medicare and other health insurance premiums, deductibles and coinsurance charges. The state may set a reasonable limit on these incurred expenses.
- b) Incurred expenses for necessary medical and remedial services not covered under the Medically Needy program.
- c) Incurred expenses for necessary medical and remedial services covered under the Medically Needy program. The state may also establish a reasonable limit on these incurred medical expenses.

If the income of a family member or a financially responsible relative was considered in the determination of financial eligibility, their incurred medical expenses may also be considered, although they may not themselves be eligible for assistance.

The spend-down process is illustrated by the following:

Example 1: Assume a family of four with an annual countable income of \$10,000 or \$833.33 a month and a one month budget period.

\$833.33	Monthly income
<u>-591.66</u>	Maximum Medically Needy Income Level for family of 4
\$241.67	Family's spend-down liability for the month

Medical expenses:

a)	Family has health insurance coverage which costs \$50/month	\$ 50
b)	Mother has an emergency room bill (mother is not eligible for Medically Needy)	125
c)	Child has allergies and has a physician's office visit and medication	25 45
		<u>\$245</u>

From the time the family incurred the last medical bills totalling \$241.67, Medically Needy coverage would be available to the eligible family members until the end of the month. In this example, using a one month budgetary period, the family would have to reapply for assistance the first day of the following month and would have to incur an additional \$241.67 in medical expenses before they could receive benefits under the Medically Needy program again.

Example 2: Using the same family and a six month budget period

\$5,000.00	Semi-Annual Income
<u>-3,549.96</u>	Maximum Medically Needy Income Standard for six months
\$1,450.04	Spend-down liability

For this example, a family of four would be eligible for Medicaid after they have incurred \$1,450.04 in medical bills in the semi-annual period of eligibility. If they applied January 1 and they incurred \$1,450.04 in medical expenses by March 10, the clients would be covered under the Medically Needy program until June 30, then the eligibility determination process would begin again, and a new spend-down liability would be computed.

As part of the federal regulations, the state must insure that those incurred medical expenses counted towards the spend-down in one eligibility period are not counted in another period. In addition, the state must ensure that the incurred medical expenses are not subsequently paid by the Medicaid program.

Federal guidelines permit only unpaid medical expenses incurred prior to the date of application, which remain the liability of the applicant, to be applied toward the spend-down. At any time after the application has been filed, even prior to the date the application is approved, the applicant may pay outstanding medical bills and have them count as incurred expenses. This rule is applied as follows:

(1) PRIOR TO APPLICATION DATE

An applicant obtains medical services and receives a bill. In order to have this bill count toward spend-down in the initial period, the bill cannot be paid.

(2) APPLICATION DATE

The applicant submits all unpaid medical bills, and they are applied to the client's spend-down requirements.

(3) POST-APPLICATION

The applicant may now pay all outstanding medical bills, and all these bills, whether paid or remaining unpaid, can still be applied to the spend-down. Such bills, even if paid after the application filing date but before the application processing date, can be applied to the spend-down.

Due to these requirements, clients are encouraged to incur, but not pay for, medical care until eligibility has been established.

Once eligibility has been established, Medicaid will prospectively reimburse providers for the client's medical care. However, the bills used to meet the spend-down requirement remain the liability of the client. During each budget period providers will be required to bill the client for services prior to eligibility and then bill Medicaid for services after eligibility has been established.

For example, Mr. C. incurs medical expenses totalling \$500, equal to his spend-down liability, on February 25, as a result of medical services rendered by Dr. Z. The applicant, Mr. C., will be responsible for the \$500, but medical services rendered by Dr. Z. from February 25 to June 30 will be reimbursed by the Medicaid program.

On July 1, a new eligibility determination is required and a new spend-down liability will have to be incurred by Mr. C. In this second eligibility period, Mr. C. does not incur the \$500 in medical expenses until October 23. Dr. Z. will therefore have to bill Mr. C for medical services from July 1 through October 23, at which time Mr. C. will again be eligible for the Medicaid program and Dr. Z. can again begin submitting bills for any further medical services to the Medicaid program for reimbursement.

The changing liability for reimbursement of medical services will be confusing to the provider community and to recipients.

3. FEDERAL APPROVAL OF THE STATE PLAN

Prior to the effective date of a Medically Needy program, the State Plan must be prepared and forwarded to HCFA officials for their approval.

Federal Medicaid law describes the requirements that State Medicaid Plans must meet if they are to be approved by the Secretary of Health and Human Services. The plan must be amended whenever necessary to reflect any change in State law, organization, policy or State agency operation. If approved, Federal Financial Participation (FFP) is available for additional expenditures resulting from an amended provision of the State Plan as of the first day of the calendar quarter in which an approvable amendment is submitted or the date on which the amended provision becomes effective in the State, whichever is later.

As a result of several provisions contained in the Omnibus Budget Reconciliation Act of 1981, States were given increased flexibility to establish the eligibility requirements for a Medically Needy program. For several requirements, the federal regulations indicate the state must establish reasonable standards. These standards must be approved by the Secretary in order to receive federal matching funds.

4. PROPOSED FEDERAL REGULATIONS

The Department of Health and Human Services in the September 2, 1983 issue of the Federal Register published proposed rule revisions for the Medically Needy program. These proposed rules are tentatively scheduled to be finalized in December, 1984.

On September 2, 1983 the Health Care Financing Administration published proposed rules which would amend 42 CFR 435 and 42 CFR 436. The proposed rules would revise the spend-down process by which medical expenses are considered in determining eligibility for the Medically Needy program. According to the Department of Health and Human Services' semi-annual regulatory agenda, published in the Federal Register of April 19, 1984, the tentative date for publication of the final rules is December, 1984.

The issues covered by the proposed rules include:

- .Medically Needy budget period;
- .Exclusion from incurred medical expenses those bills for services rendered more than three months prior to a Medicaid application;

- .Application of incurred medical expenses to the spend-down period in chronological order;
- .Limiting deductible medical expenses to services covered under the State Plan, and
- .Consideration of projected institutional expenses at the Medicaid rate as incurred medical expenses.

The following is a synopsis of the current regulations and the proposed changes for each of the above mentioned issues:

Medically Needy Budget Period. Current regulations allow the State to establish a Medically Needy prospective budget period of between one and six months. Incurred medical expenses are deducted from countable income, and when the individual's income reaches the Medically Needy Income Level, eligibility is established. In addition to this prospective period of eligibility, Medicaid regulations require that Medicaid benefits must be provided up to three months prior to the month in which the application is filed if the individual would have been eligible for Medicaid at the time services are rendered.

Although federal regulations require these separate eligibility periods, there is no statutory requirement to use separate budget periods. States which currently are administering Medically Needy programs indicate that the present regulations create administrative difficulties and allow individuals to avoid the application of budget periods of more than one month by applying monthly for retroactive eligibility.

The proposed rules revise the current regulations to allow states to use a Medically Needy budget period of no more than six months but which may include all or part of the three month retroactive period.

Exclusion from Incurred Medical Expenses those bills for services rendered more than three months prior to a Medicaid application. Current regulations provide that any bills incurred prior to the period for which eligibility is determined may be applied to the spend-down only if they are unpaid, and remain a current obligation of the individual. This creates administrative problems for states because, a) the State must insure the bills are counted towards spend-down only once; b) the State must verify that the applicant remains liable for the bill; and c) an incentive is created for applicants not to pay their medical bills.

The proposed regulations would allow states to exclude from incurred medical expenses any bills older than three months except for current payments on older bills not previously

applied towards a spend-down liability. The regulations would also propose that bills not deducted in one budget period must be carried over and deducted in the immediate subsequent eligibility period.

Application of incurred medical expenses to the spend-down period in chronological order. Current regulations require that States deduct incurred medical expenses from an individual's countable income in a prescribed order. This requirement creates administrative difficulties because presently bills are not counted in the order in which they are incurred. In addition, the current regulation increases Medicaid expenditures because expenses which are included in the State plan are deducted subsequent to medical expenses not covered in the plan.

The proposed regulations would allow States the flexibility of using the current order of deductions or implementing a system which deducts incurred expenses in either the order in which they occur or the order they are presented to the agency that determines eligibility.

Limit deductible medical expenses to services covered under the State plan. Current regulations require that a state deduct from countable income all medical expenses including those not covered under the State plan. States have argued that this is an indirect subsidy for those services and also that it results in earlier eligibility and increased Medicaid costs.

The Department of Health and Human Services has requested comments on changing this provision. They note, however, that the Department would still require deductions for health insurance premiums, deductibles and copayments. The current requirement that states would not be allowed to limit the amount, duration and scope of the deductible services would continue.

Consideration of projected institutional expenses at the Medicaid rate as incurred medical expenses. Current policy requires that in the case of an institutionalized individual whose income exceeds the Medically Needy Income Level, the state must deduct incurred institutional expenses at the institution's private pay rate. In addition, a state may project these costs to determine eligibility.

The proposed revised regulations would allow states to project the institutional expenses at the Medicaid rate if they also elect to authorize Medicaid eligibility on the first day of institutionalization in any budget period.

Because we do not anticipate including institutional care as one of the services included in the Medically Needy program, this section of the proposed revisions would not have an impact at this time.

PRELIMINARY LIST OF PROGRAM ACTIVITIES NECESSARY
TO IMPLEMENT A MEDICALLY NEEDED PROGRAM

1) Policy Planning

At least three months will be required to review recommendations and develop policies for a Medically Needy program. Timely implementation of a program of this magnitude will require extensive cooperation between all agencies in State and County government.

2) Obtain Cooperation of Other Governmental Agencies

Implementation of a Medically Needy program will affect many other agencies within the State government. In order to implement a program of this magnitude, a clear directive from the Governor's Office will be needed to assure cooperation of Civil Service, the Department of Treasury and all the other Agencies and Departments with which the Division must interact in order to implement this program. A list of these agencies is contained in Appendix G.

3) Revision of Eligibility File and Modification of the Fiscal Agent Claims Processing System

A minimum of one year will be required to complete the system modifications needed to assure timely processing of Medically Needy claims. A mechanism will have to be established to identify each client group to assure collection of data used to charge costs to the Casino and the State Aid Accounts. Edits will be developed to assure each client group receives only those services provided for in the State plan.

Currently, staff from both the Division and the Hospital Service Plan of New Jersey (Blue Cross) have begun a major revision of the Medicaid Eligibility File. At the same time, Divisional staff are in the process of developing the REDI system. This system will allow providers to verify a client's eligibility using their office telephone. Both these projects represent a major undertaking by the Division to improve its ability to provide services to its clients. It is unlikely that the revision of the eligibility file will be completed in less than eighteen months unless massive resources are devoted to this project. We cannot, however, use the existing Eligibility File and must reprogram in order to have a usable system. However, we have been advised by the fiscal agent that just reprogramming the existing Medicaid eligibility file will not provide the required data for the special requirements of a Medically Needy program. This will necessitate devoting additional resources to develop a revamped system.

Currently, the County Welfare Agencies (CWA) utilize the CODES system at the Division of Public Welfare (DPW) to input AFDC data to the Medicaid Eligibility File. The proposed successor to CODES, the FAMIS system also will only accommodate data on AFDC clients. Therefore, the Division will require a system to allow the counties

to have direct input from the CWA to the Medicaid Eligibility File. This will require terminal installation in each county office.

4) Amend Fiscal Agent Contracts

The Division will be required to amend the contracts with its Fiscal Agents, the Hospital Service Plan of New Jersey and the Prudential Insurance Company. Approximately six months will be required to amend these contracts to include a Medically Needy program.

5) Reprogramming Existing Computer Generated Reports

Currently over 100 management and surveillance reports are produced monthly for the Division. All of these reports will have to be modified. The on-line data base maintained for the Division by the Treasury Data Center will require modifications to accommodate the Medically Needy population. In addition to additional system analysts in the Division, the Medicaid Fiscal Agents and the Treasury Data Center will require additional staff to reprogram the entire Medicaid reporting system.

The primary objective of the Fiscal Agent's programming efforts will be directed toward modifying the claims processing system in order to assure timely payment of claims. Therefore, changes to the reporting systems may not be completed before clients begin receiving services. Approximately eighteen months will be required to complete the system changes to the Medicaid reporting system.

6) Develop New Jersey Register Proposals

Proposed regulations and numerous changes to the Provider Manuals and the eligibility manuals on file in the Administrative Code will be required for publication in the New Jersey Register.

Approximately six months will be required to develop and publish the initial proposals. An additional three months will be required to review the comments received on the announcement and to adopt the final regulations.

7) Develop Newsletters Bulletins, Procedural Directives and Forms

The Division will be required to develop new forms for the new client groups such as worksheets to be used to record incurred medical bills. Newsletters and revised Manuals will have to be sent to all provider groups to familiarize them with the service packages for each client group. At least eight months will be required to develop forms and draft newsletters, and manual revisions and to print and disseminate them.

8) Identify, Establish and Fill New Positions

Implementation of a Medically Needy program will require numerous additional positions within the Division of Medical Assistance and Health Services.

Additionally, there will be a significant staff impact on the Fiscal Agents, the various data centers and other organizations which will be affected by a major program like Medically Needy. Currently, standards to be used in developing the Division's additional staffing requirements are being refined. A complete list of titles and duties will be prepared and submitted to the Commissioner as soon as major decisions are made and the focus of the major functions is determined.

A task force should be established comprised of staff from the Division of Medical Assistance and Health Services, the Division of Public Welfare and the County Welfare Agencies to identify the positions that would be required in the County Welfare Agencies if a Medically Needy program is implemented. The Department will also require the full support of the Department of Civil Service, the Department of Treasury, and the Office of Management and Budget to establish the required positions in a timely manner.

9) Obtain Additional Space

The addition of new positions will require the Division to obtain additional office space. The exact amount and locations of this space will be completed following the staffing review currently in progress. The Department will require the complete cooperation of the Department of Treasury in order to obtain the required space in a timely manner.

10) Amend State Plan

The establishment of a Medically Needy program requires an amendment to the New Jersey Title XIX State plan. The amendments must include information regarding the scope of services and eligible clients, the eligibility standard, the resource limits, and other information. Federal approval of the amendments to the State Plan is required to receive federal funding for the program. Preparation and submission of the State Plan amendments will require approximately six months.

11) Develop Manual of Operations

A manual defining the administrative procedures to be followed for a Medically Needy program must be developed. This manual will include information on Divisional policies, scope of services, eligible client groups, etc. Approximately six months will be required to complete the operations manual.

12) Train New and Existing Employees

Implementation of a Medically Needy program will have a major effect on Divisional operations. Training will be required in order

for all staff to become familiar with the requirements of a Medically Needy program. In addition, the CWA staff will require extensive training on the eligibility determination activities which are unique to the Medically Needy program.

13) Revise Interagency Agreements

The Division will be required to revise its agreements with other state agencies to accommodate the Medically Needy population. For example, the agreement with the Division of Criminal Justice will require a modification to assure the Medically Needy population is included for fraud and abuse reviews.

14) Outreach the Public and Providers

The Division may be required to outreach potential clients, educate the provider community and provide information on the program to the legislature and other public officials. Included in this outreach, The Division will develop a mechanism to outreach the PAAD population through a mailing to that client group.

The Division will be required to publish brochures on the Medically Needy program for distribution in State and county offices throughout the State.

The Division's provider groups will require information on the Medically Needy population. In addition to the previously mentioned newsletters, the Division will be required to provide additional information on issues such as scope of service for each client group and the client's responsibility for the "spend-down" bills. etc.

It should be noted that most of the activities described above will require additional resources to initiate and complete, therefore it should be understood that the time frames begin (in most instances) after the staff has been recruited to perform these new duties.

APPENDIX

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

STATES WITH MEDICALLY NEEDY PROGRAMS:	LIQUID ASSETS			ELIGIBILITY BUDGET PERIOD	ELIGIBLE GROUPS COVERED										MEDICAL COVERED SERVICES:										MOQ ELIGIBILITY PAYMENT ERROR RATES		REVIEW PERIODS																											
	INDIV.	COUPLES	EACH ADD'L MEMBER		PREGNANT WOMEN	INDIVIDUAL < CITED AGE	CHILDREN < CITED AGE	UNBORN CHILD	CARETAKER RELATIVES	AGED, BLIND, DISABLED	BLIND/DISABLED (12/73)	INPATIENT HOSPITAL	OUTPATIENT HOSPITAL	RURAL HEALTH CLINIC	OTHER LABORATORY & X-RAY	SNF & HOME HEALTH (> 21)	EPSDT (< 21)	FAMILY PLANNING	PHYSICIAN	PODIATRIST	CRTOMETRIST	CHIROPRACTOR	OTHER PRACTITIONERS	PRIVATE DUTY NURSING	CLINIC SERVICES	DENTAL SERVICES	PHYSICAL THERAPY	OCCUPATIONAL THERAPY	SPEECH/HEARING/LANG. DIS.	PRESCRIBED DRUGS	SENTUPES	PROSTHETIC DEVICES	EYEGLASSES	DIAGNOSTIC SERVICES	SCREENING SERVICES	PREVENTIVE SERVICES	REHABILITATIVE SERVICES	IP HOSP	SNF	ICF	OVER 65 OR IN TB INST.	IP HOSP	SNF	ICF	OVER 65 OR IN MENTAL INST.	INTERMEDIATE CARE FACIL.	ICF/MR	IP PSYCHIATRIC (< 22)	CHRISTIAN SCIENCE (NURS)	CHRISTIAN SCIENCE (SANIT)	SNF (< 21)	EMERGENCY HOSPITAL	PERSONAL CARE	10/82 - 3/83
MICHIGAN	\$1,500	\$2,250	\$200	6 MONTHS	X	21		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	2.39	1.95
MINNESOTA *	\$3,000	\$6,000	\$200	6 MONTHS	X	21		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	1.72	1.92
MONTANA	\$1,500	\$2,250	\$100	3 MONTHS	X	21		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	1.82	1.24	
NEBRASKA *	\$1,500	\$2,250	\$25	6 MONTHS	X	21		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	0.56	4.66	
NEW HAMPSHIRE *	\$2,500 INCLUDES EQUITY VALUE OF LIFE INSURANCE	\$4,000	\$100	6 MONTHS	X	18		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	0.90	2.39	
NEW YORK	\$2,100	\$3,050	\$50	1 MONTH	X	21		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	2.70	2.83		

45X

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

46X

STATES WITH MEDICALLY NEEDY PROGRAMS:	LIQUID ASSETS			ELIGIBILITY BUDGET PERIOD	ELIGIBLE GROUPS COVERED										INDICATED COVERED SERVICES:										MQC ELIGIBILITY PAYMENT ERROR RATES.																												
	INDIV.	COUPLES	EACH ADD'L MEMBER		PREGNANT WOMEN	INDIVIDUAL < CITED AGE	CHILDREN < CITED AGE	UNBORN CHILD	CARETAKER RELATIVES	AGED, BLIND, DISABLED	BLIND/DISABLED (12/73)	INPATIENT HOSPITAL	OUTPATIENT HOSPITAL	RURAL HEALTH CLINIC	OTHER LABORATORY & X-RAY	SNF & HOME HEALTH (> 21)	EPSDT (< 21)	FAMILY PLANNING	PHYSICIAN	PODIATRIST	OPTOMETRIST	CHIROPRACTOR	OTHER PRACTITIONERS'	PRIVATE DUTY NURSING	CLINIC SERVICES	DENTAL SERVICES	PHYSICAL THERAPY	OCCUPATIONAL THERAPY	SPEECH/HEARING/LANG. DIS.	PRESCRIBED DRUGS	DENTURES	PROSTHETIC DEVICES	EYEGLASSES	DIAGNOSTIC SERVICES	SCREENING SERVICES	PREVENTIVE SERVICES	REHABILITATIVE SERVICES	IP HOSP	SNF	ICF	IP HOSP	SNF	ICF	INTERMEDIATE CARE FACIL.	ICF/NR	IP PSYCHIATRIC (< 22)	CHRISTIAN SCIENCE (NURS)	CHRISTIAN SCIENCE (SANIT)	SNF (< 21)	EMERGENCY HOSPITAL	PERSONAL CARE	REVIEW PERIODS	
																																																				FOR AGED \$1,000 MAXIMUM:	UNMARRIED: \$3,050 BLIND, \$1,100 \$2,000
NORTH CAROLINA *	\$1,500	\$2,250	\$100	6 MONTHS	X	19	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	1.55	1.39
NORTH DAKOTA	\$3,000	\$4,500	\$25	1 MONTH	X	21	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	0.93	1.27
OKLAHOMA *	\$1,500	\$2,250	\$100	6 MONTHS	X	21	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	4.27	2.63	
OREGON **				6 MONTHS	L	14	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	0.81	2.86	
PENNSYLVANIA	\$2,400	\$3,200	\$300	6 MONTHS	X	21	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	1.92	3.54	
RHODE ISLAND	\$4,000	\$6,000	\$100	6 MONTHS	X	19	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	4.14	3.87		

APPENDIX B

DEPARTMENT OF HUMAN SERVICES
 DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

COMPARISON OF SSI AND MEDICALLY NEEDY INCOME LEVEL (1)

<u>STATE</u>	<u>SSI - STANDARD (1)</u>		<u>MEDICALLY NEEDY LEVEL (2)</u>	
	<u>1 Person</u>	<u>- 2 Person</u>	<u>1 Person</u>	<u>- 2 Person</u>
Arkansas	314	472	175	183
California Aged/Disabled Blind	477 535	886 1041	459	709
Connecticut	466.10	585.30	341	466
D.C.	329	502	300 (Net figures)	314
Hawaii	318.90	480.80	300	400
Illinois	budgeted individually		238	333
Kansas	314	472	310	410
Kentucky	314	472	192	225
Louisiana	314	472	167	192
Maine	324	487	270	325
Maryland	314	472	267	309
Massachusetts Aged Blind Disabled	442.82 463.74 428.39	673.72 927.48 652.06	333	425
Michigan	338.30	508.40	309	463
Minnesota	349	538	313	393
Montana	314	472	314	375
Nebraska	381	572	375	375
New Hampshire	328	473	252	346
New York	374.91	548.03	350	508

<u>STATE</u>	<u>SSI - STANDARD (1)</u>		<u>MEDICALLY NEEDY</u>	
	<u>1 person</u>	<u>- 2 person</u>	<u>LEVEL (2)</u>	<u>1 person - 2 person</u>
North Carolina	314	472	183	241
North Dakota	314	472	265	385
Oklahoma	383	616	265	327
Oregon	315.17	472	327	415
Pennsylvania	346.30	520.70	350	366
Rhode Island	365.98	570.30	408	450
Tennessee	314	472	117	135
Utah	324	492	287	385
Vermont	364	535.50	332	514
Virginia	314	472	325	366
Washington	352.30	508.40	343	493
West Virginia	314	472	200	225
Wisconsin	413.70	633	404	575

(1) Source - National Governor's Association

(2) Source - Commerce Clearing House - In some instances more current information was available in State Medically Needy Manuals.

APPENDIX C

Table I

COST-SHARING PROVISIONS
COPAYMENT, COINSURANCE, DEDUCTIBLES
AS OF DECEMBER 1983

State	Procedure/Service for which Copayment is Imposed	Charges Imposed on Recipients		Extended Exemptions of Optional Provisions Under TEFFA
		MN	CN	
Alabama	-Prescription Drug Refills		\$7.25 or less-\$5.50	
		*	7.26-22.25 1.00	
			22.26-47.25 2.00	
			47.26 or more 3.00	
Arizona	-Prescription Drugs	\$ 1.00	\$.50	
	-Nonemergency Surgery	15.00	5.00	
	-Doctor's Office or Home Visit	1.00	.50	
California	-All Medical Services	\$ 1.00		
	-Prescription Drugs	1.00 (over \$10)	*	
	-Nonemergency ER Services	5.00		
Florida	-Dentures	*	5% Coinsurance	-Under age 21
	-Hearing Aids			-Services to Pregnant Women
DC	-Prescription Drugs	\$.50	\$.50	
	-Eyeglasses	2.00	2.00	
Illinois	-Inpatient	*	\$3 - \$325/day & up	
			2 - 275-\$325	
			None - Below \$275	
Iowa	-Podiatrist	*	\$1.00	
	-Optometrist		2.00	
	-Chiropractor		1.00	
	-Psychologist		2.00	-Under Age 21
	-Dental Services		3.00	-Services to Pregnant Women
	-Prescription Drugs		1.00	
	-Medical Equipment		2.00	
	-Orthopedic shoe Services		2.00	
	-Hearing Aid		3.00	
	-Optician Services		2.00	
	-Rehabilitation Agency Svc		2.00	
	-Physical Therapy		1.00	
Kansas	-Prescription Drugs	\$1.00	\$1.00	
	-Dental Services	1.00	1.00	
	-Physician Services	1.00	1.00	
	-Optometrist Services	1.00	1.00	
	-Psychologist Services	1.00	1.00	
	-Chiropractor Services	1.00	1.00	
	-Ambulance (Non-ER)	1.00	1.00	
Maine	-Prescription Drugs	.50	.50	-Under age 21
				-Services to Pregnant Women
Michigan	-Prescription Drugs	.50	.50	
	-Dental Services	3.00	3.00	
	-Podiatrist	2.00	2.00	-Under age 21
	-Chiropractor	1.00	1.00	-Services to Pregnant Women
	-Hearing Aid	3.00	3.00	
	-Vision	2.00	2.00	
Missouri	-Prescription Drugs		10.00 or less, \$0.50	
			10.01 to \$25.00 1.00	
			25.01 or more 2.00	
	-Dentures		5% Coinsurance	
	-Dental		10.99 or less, \$0.50	
	-Audiology		11.00 to 25.99 1.00	
	-Optical Services		26.00 to 50.99 2.00	
	-Podiatry		51.00 or more 3.00	
	-Inpatient Hospital Services (per Hospitalization)		10.00	
	-Outpatient Clinic/ER		2.00	
	-Physician Services		1.00	
Montana	-Prescription Drugs	.50	.50	

Source: Intergovernmental Health Policy Project

Table I continued

State	Procedure/Service for which Copayment is Imposed	COST-SHARING PROVISIONS COPAYMENT, COINSURANCE, DEDUCTIBLES As of December 1983		Extended Exemptions of Optional Provisions Under TEPPA
		Charges Imposed on Recipients		
		MN	CN	
Nevada	-Prescription Drugs		\$1.00	
	-Dentures		3.00	-Under age 21
	-Dental Services		2.00 (Initial Exam)	-Services to Pregnant Women
	-Chiropractic Services		1.00	
	-Clinic Services		1.00 (MH-OPT)	
	-Eyeglasses		3.00	
	-P.T., O.T., Speech Hearing Therapy		1.00	
	-Podiatric Services		1.00	
	-Prosthetic Services		3.00	
	-Transportation			
	•Ambulance		3.00	
	•Medi-van		2.00	
	•Taxi		1.00	
New Hampshire	-Prescription Drugs	\$0.75	\$0.75	
North Carolina	-Prescription Drugs	.50	.50	
	-Dentists	2.00	2.00	
	-Chiropractors	.50	.50	-Services to Pregnant Women
	-Podiatrist	1.00	0	
	-Optometrist	1.00	0	
	-Optical Supplies	2.00	2.00	
	-Clinic (Except Rural Health)	1.00	1.00	
	-Hospital Inpatient	2.00	0	
	-Hospital Outpatient	1.00	0	
	-Nonhospital Dialysis Facility	2.00	0	
-Physician	1.00	0		
North Dakota	-Eyeglasses (2nd or Subsequent Pairs)	3.00	3.00	
South Carolina	-Prescription Drugs		.50	-Under age 21
	-Eye Examination		1.00	
	-Podiatrist		1.00	
	-Emergency Dental		1.00	
South Dakota	-Prescription Drugs		1.00	
	-Chiropractic Visit		.50	
	-Prosthetic Device		5% of Allowable Reimbursement	
	-Medical Supply		1.00	
	-Medical Equipment		5% of Allowable Reimbursement	
	-Mental Health Center Services		5% of Allowable Reimbursement	
	-Dental			
	•Tooth Extractions		1.00	
	•Surgical Procedures		1.00	
	•Setting of Fractures		1.00	
	•Full Dentures		3.00	
	•Relining of Dentures		3.00	
	-Optometric/Optical Services		\$ 1.00	
	-Physician Services		1.00	
	-Nonemergency Outpatient Hospital		5% of total charge	
-Hospital Admission (non-ER)		25.00		
-Rehabilitation Hospital Inpatient Services		25.00		
-Outpatient Services		5% of total charge		
Utah	-Nonemergency use of ER		3.00	
Vermont	-Prescription Drugs	1.00	1.00	
Virginia	-Prescription Drugs		10.99 or less, .50 11.00 or more, 1.00	
	-Clinic Visits	1.00	1.00	
	-Eye Examinations	1.00	1.00	
	-Physician Visits	1.00		
	-Admission (Deductible)	30.00		
	-Outpatient Visits (Except Medical Emergencies)		2.00	
West Virginia	-Prescription Drugs		10.99 or less, .50 11.00 or more, 1.00	

Table I continued

COST-SHARING PROVISIONS
COPAYMENT, COINSURANCE, DEDUCTIBLES

State	Procedure/Services for which Copayment is Imposed	Charges Imposed on Recipients		Extended Exemption of Optional Provisions Under TEFRA
		MN	CN	
Wisconsin	-Hospital (Inpatient)	\$ 3.00/day, not to exceed 75.00 per stay		
	-Hospital (Outpatient)	2.00 per visit		
	-Rural Health Clinics	2.00 per visit		
	-Chiropractic Services	.50 per procedure		
	-Community Care Organization	3.00 per month		
	-Medical Day Treatment	.50 per day		
	-Dental Services			
	●Diagnostic services	.50 per service		
	●Prosthodontic Services (Full Denture)	3.00 per approved Service		
	●Other Covered Dental Services (nonemergency)	1.00 per service		
	-Orthodontic Services (EPSDT Referral Required)	2.00-\$3.00 per approved service		
	-Drugs and Disposable Medical Supplies	.50 per new and refill prescription		
	-Durable Medical Equipment (purchase)	1.00 per item		
	-Eyeglasses	3.00 per pair		
	●Frame, Temple or Lens Replacement	2.00 per procedure		
	●Repair Service	.50 per service		
	-Optometric Services			
	●Annual exam	2.00 per procedure		
	●Supplemental Testing, Follow-up Exam	.50 per procedure		
	●Vision Training & Therapy or Low Vision Services	1.00 per approved procedure		
	●Contact Lens Service	3.00 per approved procedure		
	-Hearing Aids	3.00 per item		
	-Occupational or Physical Therapy Services	.50 per 15 minutes		
	-Psychotherapy/Alcohol and other Drug Abuse Therapy (outpatient)	.50 per 15 minutes		
	-Speech, Hearing and Language Disorder Services, Individual or Group Therapy	.50 per 15 minutes		
	-Audiological Testing	1.00 per service		
	-Transportation, Ambulance (non-emergency)	2.00 per trip		
-EPSDT	1.00 per screening			

* No Medically Needy Program

APPENDIX D

MEDICALLY NEEDY
FEDERAL COST SHARE REGULATIONS

Institutional Services

- . Under waiver, states can impose a copayment up to twice the maximum allowable for nonemergent services provided in an emergency room.
- . Cost share cannot exceed 50% of the cost of the first day of care.

Noninstitutional Services

- . Deductible not to exceed \$2.00 per month per family.
- . Coinsurance not to exceed 5% of the agency payment for the service.
- . Copayments not to exceed:

<u>State Payment For Service</u>	<u>Maximum Copayment</u>
\$10.00 or less	\$0.50
\$10.01 to \$25.00	\$1.00
\$25.01 to \$50.00	\$2.00
\$50.01 or more	\$3.00

APPENDIX E

NEW JERSEY MEDICAID (TITLE XIX) SERVICES

BASIC SERVICES REQUIRED BY FEDERAL REGULATION:

Inpatient Hospital Services (other than services provided in an institution for tuberculosis or mental diseases)
Outpatient Hospital Services
Rural Health Clinic Services
Other Laboratory and X-ray Services
Skilled Nursing Facility Services (other than an institution for tuberculosis or mental diseases) and Home Health Services for individuals 21 and older
Early and Periodic Screening, Diagnosis and Treatment for individuals under 21 (EPSDT)
Family Planning
Physician and Psychiatric Services provided in the office, patient's home, hospital long term care facility or in any other setting
Transportation for Medical Services

OPTIONAL SERVICES OFFERED IN NEW JERSEY:

Podiatrists' Services
Optometrists' Services
Chiropractors' Services
Psychologists' Services
Clinic Services (including ambulatory surgical centers, community health care centers, partial care and partial hospitalization centers, family planning, and drug abuse clinics)
Dental Services
Physical Therapy
Occupational Therapy
Speech, Pathology and Audiology Services
Prescribed Medication
Dentures
Prosthetic and Orthotic Devices, including hearing aids, artificial limbs, braces and orthopedic shoes
Eyeglasses and other Optical Appliances
Diagnostic Services, such as CAT scans
Screening Services, such as screening for lead poisoning

OPTIONAL SERVICES (continued):

Preventive Services, such as immunizations and well-child visits
Durable Medical Equipment, such as wheelchairs and hospital beds
Medical Services including nursing services; home health aide
services; medical supplies, equipment and appliances suitable
for use in the home; physical therapy, occupational therapy,
speech therapy and audiological services.
Services for age 65 or older in Mental Institutions
 Inpatient hospital services
 SNF services
 ICF services
Intermediate Care Facility Services, including services for the
mentally retarded
Inpatient Psychiatric Services for individuals under age 21
Christian Science Sanitoria
Skilled Nursing Facility Services for individuals under the
age of 21
Emergency Hospital Services
Personal Care Services
Medical Day Care Services

OTHER OPTIONAL SERVICES NOT OFFERED IN NEW JERSEY:

Private Duty Nursing
Services for age 65 or older in TB Institutions
 Inpatient hospital services
 SNF services
 ICF services
Christian Science Nurses

APPENDIX F

RESOURCES CONSIDERED AS ASSETS UNDER
CATEGORICAL AND MEDICALLY NEEDY PROGRAM

	<u>Amount Considered As An Asset</u>
<u>SSI</u> (Categorical Asset Limit - \$1,500 individual/\$2,250 couple)	
1) Home owned and used as principal place of residence	-0-
2) Automobile	
a) used for employment, or	-0-
b) used as transportation to receive medical care for a specified problem, or	-0-
c) modified for the transportation (or operation) of a handicapped person	-0-
d) Other	value above \$4,500
3) Personal effects and household goods	value above \$2,000
4) Wedding and engagement rings	-0-
5) Certain medical equipment (e.g. prosthetics, hospital beds, wheel chairs, etc)	-0-
6) Life insurance	cash surrender value only if face value exceeds \$1,500
7) Non home income producing property	if equity exceeds \$6,000 and property not producing a net return of 6% of equity
8) Tools and equipment of an employee	-0-
9) Inaccessible resources	-0-
10) Burial Spaces and burial funds (must be clearly designated and set aside for expenses connected with an individual's funeral arrangements)	funds may not exceed \$1,500 per individual

	<u>Amount Considered As An Asset</u>
11) Liquid assets (savings/checking accounts, bonds, etc.)	full value
 <u>AFDC (Categorical Asset Limit - \$1,000)</u>	
1) Home owned and used as principal place of residence	-0-
2) Automobile	equity value above \$1,500
3) Personal effects and household furnishings in regular use	-0-
4) Livestock, machinery tools, equipment used to produce net income	-0-
5) Savings	amount exceeding the total of 3 months public assistance allowance standard for that eligible unit
6) Other liquid assets	full value

APPENDIX G

LIST OF AGENCIES

The following Federal, State, County and Local Agencies will have significant roles to play in the implementation of a Medically Needy program in New Jersey:

Federal Agencies

Department of Health and Human Services
Health Care Financing Administration
Social Security Administration

State Agencies

Department of Human Services
Division of Medical Assistance and Health Services
Division of Public Welfare
Division of Youth and Family Services
Division of Information Systems
Training Office
Office of Personnel
Office of Budget Planning
Department of Treasury
Budget and Accounting
Purchase and Property
Real Estate
Data Processing
Department of Civil Service
Division of Classification and Compensation
Division of Examinations
Job Content Committee
Department of Law and Public Safety
Division of Law
Division of Criminal Justice
Division of Professional Boards
Department of Health
Various units depending upon increase in Medicaid providers
for inspection and certification, licensing and rate setting.

County Agencies

County Welfare Agencies

Local Agencies

Municipal Welfare Boards

OFFICIAL STATEMENT

MR. CHAIRMAN, I AM ANN ZAHORA, DIRECTOR OF THE NEW JERSEY STATE DIVISION ON AGING. THANK YOU FOR THE OPPORTUNITY TO SPEAK ON ASSEMBLY BILL NO. 608.

THE MEDICALLY NEEDY CONCEPT HAS BEEN AROUND FOR QUITE SOME TIME AND WE FAVOR THE CONCEPT.

NO ONE CAN DISPUTE THE FACT THAT CERTAIN GROUPS, AMONG THEM THE ELDERLY, GO WITHOUT PROPER MEDICAL CARE. THIS IS DUE TO THEIR LOW INCOMES AS WELL AS TO THE ESCALATING COST OF HEALTH CARE.

WE SADLY AGREE THAT MEDICAL CARE IS OFTEN UNAVAILABLE TO PEOPLE JUST ABOVE THE POVERTY LEVEL AND SOMETIMES BEYOND; HOWEVER, WE DO NOT BELIEVE THAT PASSING A-608 IN ITS PRESENT FORM WILL SOLVE THIS PROBLEM.

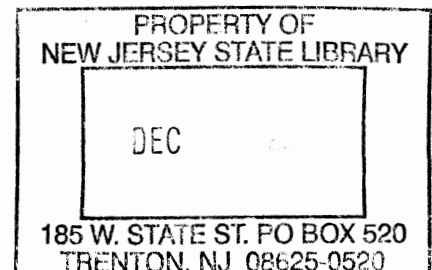
MR. CHAIRMAN, LET ME OUTLINE FOR YOU A FEW REASONS WHY WE FEEL THIS WAY.

- 1) THE COST ESTIMATES FOR THIS PROGRAM ARE EXTREMELY SOFT. THE RANGE OF ESTIMATES INCREDIBLE, INDICATING THAT BUDGETING WOULD BE A NEXT TO IMPOSSIBLE TASK. THIS IS NOT ONLY DUE TO AN INABILITY TO ESTIMATE COSTS UP FRONT BUT DUE TO YEAR TO YEAR VARIATIONS. CERTAINLY, SOUND BUDGET PRACTICES REQUIRE BUDGETING FOR THIS PROGRAM AT THE HIGHEST RANGE, AND IN OUR OPINION, THIS IS EXTREMELY EXPENSIVE. IN ADDITION, THE ESTIMATED COSTS OF ADMINISTRATION ARE EXORBITANT. THIS BILL IS ENTIRELY TOO LOOSE IN ITS PRESENT FORMAT, AND I WAS PLEASED TO HEAR EARLIER TODAY THAT YOU ARE ACCEPTING AMENDMENTS.

- 2) CASINO REVENUE FUNDS ARE THE PROPOSED FUNDING SOURCE FOR ELDERLY AND DISABLED RECIPIENTS, AND I WAS GLAD TO HEAR ASSEMBLYMAN DEVERIN SAY THIS MIGHT BE CHANGED. THERE IS NOT ENOUGH MONEY IN THIS FUND TO SUPPORT A PROGRAM WITH SUCH BROAD PARAMETERS AND CERTAINLY PROGRAMS CURRENTLY FUNDED THROUGH CASINO DOLLARS SHOULD NOT BE CUT BACK OR ELIMINATED IN ORDER TO ESTABLISH THIS NEW ONE, AND FINALLY,

- 3) THE MOOD IN WASHINGTON IS TO CUT SPENDING, AND ANY CUTS IN FEDERAL SPENDING AFFECTS AID TO THE STATES. MR. CHAIRMAN, THE 50-50 STATE FEDERAL MATCH CONTAINED IN THIS BILL IS A PRECARIOUS NOTION, GIVEN THE CURRENT ATMOSPHERE. IT'S QUITE CONCEIVABLE THAT THE STATE OF NEW JERSEY COULD BE LEFT HOLDING THE FINANCIAL BAG, RESPONSIBLE FOR THE LIONS SHARE OF THIS VERY EXPENSIVE PROGRAM. THIS CERTAINLY MUST BE EXAMINED QUITE CLOSELY.

NOW THAT I HAVE EXPRESSED TO YOU THE REASONS WHY WE HAVE PROBLEMS WITH THIS LEGISLATION AS IT EXISTS LET ME OUTLINE FOR YOU SOME OTHER CONSIDERATIONS. FIRST, AND FOREMOST, REAL EFFORTS NEED TO BE MADE TO CONTROL THE RISING COST OF MEDICAL CARE. THESE COSTS ARE AS MUCH, AND PROBABLY MORE, TO BLAME FOR THIS SITUATION AS IS LOW INCOME. SECOND, WE SHOULD EXPAND THE HOME HEALTH CARE PROGRAM. CERTAINLY THE NEED FOR HOME HEALTH CARE KNOWS NO BOUNDS. THE ELDERLY WILL BE SERVED IF HOME HEALTH CARE IS MORE READILY AVAILABLE TO ALL.



MR. CHAIRMAN, THE DIVISION ON AGING, IN THE DEPARTMENT OF COMMUNITY AFFAIRS AND THE TASK FORCE ON ELDERLY CONCERNS, MADE UP OF NUMEROUS SENIOR ORGANIZATIONS, QUESTIONS THIS LEGISLATION IN ITS PRESENT FORMAT WHILE FAVORING HOME HEALTH CARE. IN SUMMARY WE ARE CONCERNED ABOUT ITS EFFICIENCY, ITS COST, AND ITS EFFECT ON OTHER VALUABLE PROGRAMS SERVING THE SENIORS OF OUR STATE. I WOULD HOPE THAT COMMISSIONER ALBANESE'S REPORT TO YOU WILL ADDRESS THESE CONCERNS.

THANK YOU VERY MUCH.



NEWS

STATE OF NEW JERSEY
DEPARTMENT OF COMMUNITY AFFAIRS
JOHN P. RENNA, Commissioner



JEFFREY M. BRINDLE • PUBLIC INFORMATION OFFICER • CN 800, TRENTON, N. J. 08625 • (609) 292-6055
RICHARD E. HARPSTER • PUBLIC INFORMATION ASSISTANT

FOR IMMEDIATE RELEASE

December 5, 1984

Ann Zahora, director of the state Division on Aging, told an assembly committee today she is opposed to the medically needy bill on the grounds New Jersey cannot afford such a program.

"Budgeting would be next to impossible. This is not only due to an inability to estimate costs up front, but due to year to year variations. Certainly, sound budget practices require budgeting for this program at the highest range, and in our opinion, New Jersey could not afford such a program. In addition, the estimated costs of administration are exorbitant," she told the committee.

Hearings on A-608 were chaired by Assemblyman George D. Otlowski, D-19 of the corrections, health and human services committee.

Zahora, former director of the Cape May County Office on Aging, further told the committee that real efforts are needed to control the rise of medical care.

"These costs are as much, and probably more, to blame for this situation as low income. Second, we should expand the home health care program...the elderly will be served if home health care is more readily available to all," she testified.

She also told the committee that the New Jersey Task Force on Elderly Concerns, made up of numerous senior organizations, is also opposed to the proposed legislation.

-end-



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

LEGISLATIVE
MEMORANDUM

WILLIAM C. PELSTER,
Chairman, Public Affairs Committee

WERNER WEINSTOCK,
Vice-Chairman, Public Affairs Committee

DORIS B. NASH
Public Affairs Director

One Park Avenue
New York 10016
212 679-5700

Long Island Office
20 Crossways Park North
Suite 304
Woodbury, N.Y. 11797
516 364-8130

New Jersey Office
466 Old Hook Road
Suite 18
Emerson, N.J. 07630
201 261-2003

12/5/84

TO: Assemblyman John S. Watson, Vice Chairman
New Jersey Assembly Revenue, Finance and
Appropriations Committee.

RE: A.608 - To allow "Medically-Needy" Persons
to Qualify for Medicaid.

Board of Trustees

PAUL H. BRIGER
President

MRS. HIRAM D. BLACK
Chairman, Executive Committee

MRS. DOUGLAS C. LYNCH
Vice President

WILLIAM C. PELSTER
Vice President

JAMES B. SWIRE
Vice President

FRED D. FINE
Treasurer

PETER F. MACKAY
Assistant Treasurer

WILLIAM D. DOINO
Secretary

Mrs. Donald R. Carse
Richard M. Clark
Lyman Delano
Mrs. Frederick I. Ehrman
James P. Erdman
Mrs. Alexander P. Federly
Mrs. Hobart C. Gardiner
Mrs. James H. H. Jenkins
George A. Kellner
Mrs. William Lebenfeld
Mrs. John D. Lind
Kenneth J. Ludwig
James T. Parkinson
Mrs. David M. Resnik
Mrs. Joan H. Russell
Maurice V. Russell, Ed.D.
Mrs. John E. Saladino
John R. Schoemer
Ms. Jan A. Sneed
Mrs. Florence T. Stein
Mrs. Gertrude Steinberg
Marguerite P. Sykes, M.D.
Mrs. William Tall
Mrs. Robin R. Weck
Werner Weinstock
John W. Wingate, D.C.S.

DONALD E. CARRINI
Executive Director

I am William C. Pelster, Chairman of the Public Affairs Committee and a member of the Board of Trustees of Cancer Care, Inc. We are pleased to have the opportunity to address you today concerning A. 608, the concept of which we heartily support.

Especially since this marks the first time we have presented public testimony in the State of New Jersey, a brief introductory description of our organization seems necessary.

For over 40 years, Cancer Care has provided social work counseling to cancer patients and their families. Our professional staff helps families through the crises of cancer by providing individual and group counseling to patients, relatives, and concerned friends. Bereavement counseling is also available.

Our social workers also assist families in planning for the patient's care at home, when this is medically feasible. Some financial assistance is available, when appropriate, to help self-supporting families maintain a care-at-home plan for the patient. Our goal is to strengthen the family's ability to cope with the patient's illness and to enhance the quality of life for the patient.

Cancer Care receives no government funds or 3rd-party reimbursements. We rely solely on contributions from the public at large, foundations, fund raising events, volunteer chapters, and bequests, to finance our services.

We have traditionally offered direct services to those areas of New Jersey near New York City. However, in order to reach more New Jersey residents, we opened a part-time office in October '82, and fairly soon after, July '83, we opened a full-time office in Emerson. These offices have enabled us to serve 14 New Jersey counties. We started with one part-time social worker, and now have four working full time, so rapidly has our patient-load increased.

And now, I would like to introduce Helene Feldman, the Social Work Supervisor at our New Jersey branch. Miss Feldman came to Cancer Care after over 15 years with the Hospital Center at Orange where she was Director of Social Services. She will be able to offer a more graphic description of our work in New Jersey and explain why a medically needy category is so essential.

Miss Feldman: As Mr. Pelster stated, the volume of our work in New Jersey has rapidly increased. A vivid way of describing this to you would be to present statistics starting with our '82-'83 fiscal year during which a total of \$87,437 was given to share with New Jersey patients/families the cost of home care plans. This made up 12.7% of the agency's total disbursements. Our '83-'84 year disbursements of \$152,640 represent 19% of total disbursements. The figures for July 1, 1984 thru November 16 are \$71,292, given to 107 patients/families, now as high as 24% of Cancer Care's total disbursements.

The statistics we have offered could easily be a reflection of the desperate situation of so many New Jersey cancer patients. And at least some of these situations can be attributed to the lack of a medically-needy category which would allow for Medicaid assistance. We have been finding that approximately 23% of the patients we are serving in New Jersey have monthly incomes of \$600.00 or less! Some of these patients may be eligible for nursing home placements, but they want to stay home and should be helped to realize that wish.

Needless to say, our social workers and the families they serve are constantly coping with the harsh realities--both financial and emotional -- which frequently accompany a catastrophic illness such as cancer. The most heartrending situations are those families whose incomes are extremely low -- particularly the under - \$600 a month group -- and/or those whose assets have been severely drained because of the illness. These families often need at-home care for the patient but can't possibly afford it on their own. We assist them but the needs out there are much greater than a voluntary community agency can fully satisfy.

Many of the families we see are so impoverished by the illness that the remainder of their incomes approach the defined welfare level which actually is below the poverty level. Many of them are the patients described by the Home Health Agency Assembly in their testimony at the first hearing: patients who no longer qualify for Medicare home health benefits, or other 3rd-party reimbursements. We pick up many of these patients and frequently home health agencies make referrals to us in advance of the need because they can forecast how far the reimbursed benefits will go.

Permit me to offer some situations for which a medically needy category would be very helpful:

The first household consists of a couple in their late-seventies. The woman has bone cancer with metastasis to the pelvis and hip, as well as osteoarthritis, and she is in severe pain. The man has emphysema and can not be of help to his bedridden wife. Their income is \$724 a month from Social Security; they have Medicare, and Blue Cross/Blue Shield Supplemental Coverage.

The couple's children, although weighed down with many other familial responsibilities, are taking turns staying with the couple overnight and generally overseeing the situation. Medicare is helping with 9 hours of home health aide services a week because the woman is deemed to need skilled nursing supervision. We are helping the family pay for more hours of care which are desperately needed.

The second household consists of a 42 year old woman, operated on for cervical cancer, as a clinic patient, her 15 year old son, and her 73 year old father. He has a colostomy because of colon cancer, is somewhat paralyzed because of a stroke and has chronic heart failure. He receives \$359 from Social Security; the daughter's take home-pay as a waitress in a diner is only \$500 a month. She has no health insurance coverage. She is paying off the cost of the operation in an arrangement with the hospital.

The father needs daily help with his colostomy bag, and the daughter had always performed this function. Since Medicare does not consider this and his other needs as requiring a skilled service, he was ineligible for home health care visits. We helped them pay for some home care during the severe period of the daughter's illness.

Another situation -- A 73 year old widower with colon cancer who also suffered from diabetes, arteriosclerotic heart disease and osteoporosis. His income was only \$437 a month. He has \$6000 in medical debts.

His son and daughter-in-law took him to their home, but their work schedules meant that some help with home care services was needed. We shared the cost of this with them, and eventually there were some Medicare-covered home health visits when the patient became terminally ill.

These and other very poor patients should be given the opportunity to receive assistance from Medicaid. And, home care services should be made available to them since this is so frequently a crying need. The lack of availability of Medicaid for these marginal-income families is usually accompanied by less frequent medical care, particularly on an out-patient basis, and an exacerbation of the many problems with which these patients and families are already struggling. And it is also important to mention that the DRG prospective reimbursement system has led to earlier hospital discharges, increasing the need for appropriate home care services.

New Jersey's Medicaid program should be commended for its home health, personal care services, and now the Community Care Program for the Elderly and Disabled. However, what is so very necessary is a medically needy category for those marginal-income families who desperately need medicaid assistance.

It is our understanding that 30 states have some form of a medically-needy category. New York's program (including the possibility of extensive home care services) has been in place for many years. Our New York offices have frequently helped patients during the waiting period after the Medicaid application has been filed on the basis that the patient/family has spent down to the Medicaid eligibility level. And, we can feel comfortable about discontinuing financial assistance because Medicaid in New York will help with adequate home care.

We are aware that several versions of a medically-needy program are under consideration by you and the New Jersey Division of Medical Assistance. We are also aware that there is concern, justifiably, about costs. We do not consider ourselves qualified to comment on costs except to remind the committee that society must assume responsibility for its sick poor -- and that this responsibility can not be met without the expenditure of money. We would also like to highlight the strong possibility that a medically needy category can be expected to prevent further personal and family breakdown which could eventually cost society much more.

While we can not speak to the fiscal ramifications of a medically - needy category, we trust we have adequately described the immense need there is for it in the community. A voluntary agency such as ours can deal with only some of this need, and rightfully we should assist those with middle incomes who are trying desperately to make ends meet, what with the many expenses created by the illness. The public sector should extend Medicaid to those who are close to the Medicaid level and are contending with severe illness. This represents a just public - voluntary partnership in the best interest of those who need help because of illness. We are pleased that we can provide some financial assistance to needy cancer patients. But, the reality is that we are currently disbursing \$1,000 a week over our budget and we are now confronted with the possibility of having to cut back on our assistance.

A.608 - Page 7.

We urge you, therefore, to amend A.608 to mandate (as does S.1718) a medically needy category, and to choose Option 4, described by the Division of Medicaid Assistance and Health Services as all medical services for all categories: children, pre- and post-natal care, the elderly and disabled.

Thank you for this opportunity to express our views. We would be pleased to respond to any questions you may have.

DBN:rb



New Jersey Federation of Senior Citizens, Inc.
A NON PARTISAN ACTION COALITION
439 MAIN STREET, ORANGE, NEW JERSEY 07050
(201) 677-3750

TESTIMONY

on MEDICALLY NEEDED LEGISLATION A 608

by

EDITH EDELSON, CHAIRPERSON
HEALTH/WELFARE TASK FORCE

DEC. 5, 1984

TESTIMONY IN FAVOR OF A 608

By Edith Edelson

The New Jersey Federation of Senior Citizens has been working for the enactment of a Medically Needy Program for about 10 years, ever since Assemblyman Herman introduced such a bill at our request. We have now reached the point where practically everyone recognizes that such a program is needed. We have the co-sponsorship of 42 Senators and 21 Assemblypersons. A 608 has been endorsed by dozens of organizations representing varied constituencies. The Department of Health and Commissioner Albanese have lent their support to such a program. Governor Kean in the past has made statements pointing to the need for extending medical assistance to the Medically Needy.

So what's holding up the passage of A 608 and S 1718, which would provide Medicaid coverage to people with incomes not low enough to be eligible for AFDC or SSI but who cannot afford to pay for the health care they need? It seems to be concern about the sufficiency of funding sources to cover the cost. In the past, setting aside money from the General Fund for this was difficult because budgets were very tight. But now the General Fund is in a healthy state. In fact, I understand that even in the recent depression, the economy in New Jersey was doing well. And in the past year the General Fund was able to accumulate a substantial surplus. Moreover, New Jersey will be getting an additional \$12 million from the federal government in the form of Medicaid reimbursement.

And now, unlike in the past, we have available the Casino Revenue Fund for new and expanded programs for seniors and the disabled. Some legislators have raised the question of depletion of the Casino Revenue Fund, but at the same time they keep introducing bills drawing upon this fund. It is true that priorities have to be established for its use, but we can't wait forever for a Casino Revenue Fund Commission to be established. We have waited for over 1½ years for this. We congratulate Assemblyman Kavanaugh for calling hearings

to resolve the question of priorities. Our position is that the very top priority for use of the Casino Fund is HEALTH -- a Medically Needy program without which there is irreparable damage to the health of thousands of people.

Among the groups that desperately need such a program are the widows age 60 - 64. While they may be eligible for Social Security benefits, they cannot get Medicare before age 65. Thus they have no medical insurance to cover their medical needs.

From a humane point of view, we are obligated to provide health care for people who cannot afford it. From a financial point of view, the program is cost effective: the hospitals need a Medically Needy program to reduce the bad debts that they are saddled with, the State needs it because it saves the State money in the long run -- Being a preventive program, it reduces the use of emergency rooms and the need for hospitalization.

We should not overlook the fact that federal money will be returned to our State if a Medically Needy program is carried out.

Your Committee has been holding on to the bill for a very long time. We urge you to amend A 608 to make it mandatory for the Commissioner to carry out a Medically Needy program and then report the bill out for a vote.

Attached to this statement is our Fact Sheet Explaining a Medically Needy Program and also a list of the co-sponsors of these bills.

oo0oo

It is important that an advisory committee (composed of seniors & others) be appointed to participate in the plan of the dept to set up a program.



New Jersey Federation of Senior Citizens, Inc.

A NON PARTISAN ACTION COALITION

439 MAIN STREET, ORANGE, NEW JERSEY 07050

(201) 677-3750

November 30, 1984

FACT SHEET EXPLAINING A "MEDICALLY NEEDY" PROGRAM

WHO ARE MEDICALLY NEEDY?

They are some of the poorest people and some people of moderate income, all of whom cannot afford the health care they need. They are people who meet the eligibility requirements - except for their income - of the federal categorical programs, "Aid to Families with Dependent Children" (AFDC) and "Supplementary Security Income" (SSI). These two programs set the income guidelines below the poverty level. According to the Census, the poverty level for a family of 4 in 1982 was \$9,862. AFDC benefits for such a family is just about half of this level; it is \$4,968. SSI is also below the poverty level because for several years in the past, the State absorbed the social security cost-of living increase (COLA) instead of passing it along to the recipients. And while the State no longer does this, the Social Security COLA applies only to the federal part of the benefit and not to the State supplement.

HOW WOULD A MEDICALLY NEEDY PROGRAM WORK?

Under the Federal Medicaid Law, income eligibility for the Medically Needy Program is tied by formula to the AFDC guidelines. In accordance with this, the State Department of Human Services has set the income standards of eligibility as follows:

FAMILY SIZE:	1	2	3	4	5	6
* Medically Needy Standard	\$391.66	\$391.66	\$516.66	\$591.66	\$675.00	\$750.00

*Note: The Medically Needy standard equals 133% of AFDC rounded up to the nearest \$100. of the annual amount.

The above are the maximum income standards allowed if the federal government is to reimburse N.J. for about half of the Medicaid payments made on behalf of the eligible persons - those who meet the eligibility requirements for AFDC or SSI with the exception of income.

In determining eligibility

For aged, blind or disabled persons: \$20. of the gross income would be disregarded;

For individuals under 21, the amounts deducted from gross income would be work expenses, child care costs, etc.

WHEN INCOME EXCEEDS THE MEDICALLY NEEDY STANDARD

A "spend-down provision makes a person with higher income eligible for Medicaid when the deduction of incurred medical expenses reduces their income to the Medically Needy income standard.

Example: Mr. A's countable monthly income is \$500; his total incurred medical expenses equal \$110. He would be eligible under a Medically Needy Program since his countable income of \$500 has been reduced below the Medically Needy Standard of \$391.66 by \$110 of incurred medical expenses.

WHO AND WHAT SHOULD BE COVERED?

The Department of Human Services has drawn up several alternative service packages. Option II of these packages would provide as follows:

For Children: ambulatory care (outpatient hospital, lab/x-ray, clinic, drugs, physician, dental, optometric, optical appliances, prosthetics and medical transportation).

For Pregnant Women: prenatal, delivery and postnatal care.

For Aged and Disabled Persons: selected services (home health, lab/x-ray, clinic, medical day care, physician, medical transportation and medical supplies and equipment.)

Some vital health care needs remain unmet. We urge that dental, podiatric and optometric services as well as optical appliances be included in the selected services for seniors and the disabled.

It is estimated that Option II would cover about 100,000 aged and disabled persons, 100,000 children and 3,000 pregnant women.

WHO WOULD PAY FOR A MEDICALLY NEEDED PROGRAM?

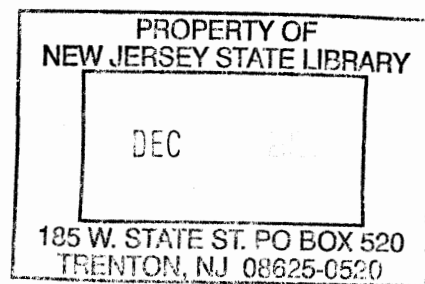
The Federal Government would pay about half of the cost, and the State would pay the rest, using the Casino Fund for Seniors and the Disabled, and the General Fund for all the others.

The estimated cost of Option II is \$73,718,000. Of this, the Federal share would be about \$36 million; the State's share would be \$37 million of which \$18 million would come from the General Fund and \$19 million would come from the Casino Fund. If the selected services for seniors and the disabled would include dental, podiatric and optometric services and optical appliances, the Casino Fund would be tapped for an additional \$2.1 million.

While we have focused on Option II, we strongly favor inclusion of the parents of the eligible children. New Jersey could well afford to provide for selected services to these parents because the State has become eligible for an additional \$12 million from the Federal Government for Medicaid services.

A Medically Needy bill is pending in each house -- A 608 by Assemblyman Deverin in the Assembly, and S 1718 by Senator Bassano in the Senate.

In view of the great need for a Medically Needy program and the availability of \$36 million of federal matching funds, we think it would be inexcusable for the State to refuse to adopt such a program.





New Jersey Federation of Senior Citizens, Inc.
A NON PARTISAN ACTION COALITION
439 MAIN STREET, ORANGE, NEW JERSEY 07050
(201) 677-3750

MEDICALLY NEEDY COALITION

The following is a complete list of legislators who informed us of their co-sponsorship:

Assemblypersons

<u>Dist</u>		<u>Dist</u>		<u>Dist</u>	
2	Kline	14	Patero	27	Garvin
3	Herman	15	Naples	30	S. Aduato
4	Marsella & Riley	16	Kavanaugh	31	Doria Jr.
5	Bryant & Gorman	17	Perun & Schwartz	32	Cuprowski & Vainieri
6	Shusted	18	Paterniti & Pelly	35	Pellechia & Girgenti
7	Foy & Kalik	19	Karcher	37	Baer & Mazur
9	Rod	20	Long	38	Shuber & Kosco
10	Doyle & Ford	21	Gill	39	Rooney
13	Flynn & Walker	22	Ogden	40	Felice

We also received a commitment of support from Assemblymen Palaia (11) and McEnroe (27).
Legislative News reported that Assemblymen LaRocca (33) and Littel (24) are co-sponsors.
Total = 42

Senators

1	Hurley	13	Van Wagner	31	O'Connor
4	Dalton	14	McManimon	33	Jackman
5	Rand	17	Lynch	36	Hirkala
6	Laskin	18	Garibaldi	37	Feldman
9	Connors	22	DiFrancisco	39	Cardinale
10	Russo	24	Dumont	40	Hagedorn
11	Pallone	30	Orechio	7	Costa

Total = 21

PUBLIC HEARING - WEDNESDAY 12/5/84 - TRENTON, N.J.

As professional nurses from MCOSS Nursing Services, the largest home health organization in New Jersey, we support the development of a medically needy program. At this time, we would like take the opportunity to share our perspectives with you.

It is our understanding that the nine selected services in option II ^{option Two} were arbitrarily chosen and are therefore at risk of being changed and/or excluded. We are interested in ensuring that home health remain one of the selected services. With DRG's limiting the admission and length of stay in hospitals, the elderly are increasingly forced to manage their chronic care needs in the community. In view of the fact that over 80 percent of the elderly have at least one chronic condition which necessitates long term management, care in the home is both the necessary and cost effective alternative.

Furthermore, it is imperative that home health be defined in such a way that the elderly in need are actually allowed access to services. For example, the current medicare structure provides reimbursement for acute illness rather than chronic care. Once a patient is defined as status quo, even when bed-bound, that patient is no longer eligible for reimbursed services. Therefore, patients with ALS, MS, post-stroke, Alzheimers Disease or other chronic diseases are not eligible for service in the home. Consequently, they exist marginally in the community until such time as they expire or are institutionalized. Certainly this represents a greater cost to society than would home care.

Children with chronic illness also have needs that can be met in the home. Without such service, significant health problems arise which can lead to costly hospitalization and/or non-functional family units. A recent example

of this situation is a toddler with severe diabetes whose mother is a blind diabetic. Home care needs include nursing visits to teach parenting skills and to monitor the relationship between blood glucose levels and insulin administration. Home health aides assist the mother to structure her environment and implement the parenting skills demonstrated biweekly by the registered nurse.

Many high-risk pregnant women and children have health care needs that can economically and satisfactorily be met in the home. Examples of pregnant women who would benefit from such home health services include those with labile diabetes, hypertensive disease of pregnancy and the women at significant risk for preterm delivery. Follow-up home care for the premature infant facilitates the prevention of physiological and emotional illness and complications. The fact that home health care is not even an option for pregnant women and children is a gross oversight.

Many home care programs are being implemented throughout the country, many of which have limited and/or excluded the participation of professional nurses. Nurses, with their backgrounds in all aspects of health care needs, physio and psychosocial, are uniquely qualified to service the consumer group. Nurses have been managing and coordinating the multi-faceted needs of clients for many decades. Therefore, the case management and home health service provision aspects of the medically needy program are inherently nursing functions.

During a previous public hearing in Trenton on July 12, 1984, Commissioner Albanese stated "...we all needed to get the input of the citizens of New Jersey in formulating this program." We think it is likewise essential that the implementation of this legislation be accompanied by ongoing input from a

multi-disciplinary advisory committee. As nurses have had a history of providing services to clients in their own environment, it is essential that nursing have the opportunity to represent the needs of the program's recipients. We recommend that nurses with the following areas of expertise be included on the aforementioned advisory committee: Community health, maternal child, gerontology and rehabilitation. We further recommend that the New Jersey State Nurses Association be consulted in such selection.

Thank you.

→ Judith L. Miller, MS, RN
Manager of Ambulatory Services

Mary Ann Christopher, RN, MSN
Manager of Ancillary Services

New Jersey Council of Senior Citizens

STATE HEADQUARTERS

16 Commerce Drive, Cranford, N. J. 07016

Telephone: (201) 272-4200

PRESIDENT

MARY E. JOHNSON
JERSEY CITY

EXECUTIVE SECRETARY
RICHARD DePALMA

November 10, 1984

VICE-PRESIDENTS

HUGH MAGUIRE
HAMILTON TOWNSHIP

REV. KELMO C. PORTER
NEWARK

JOSEPH MASTRIANI
SPRING LAKE HEIGHTS

RICHARD SANFILIPPO
CRESSKILL

JOHN VOLOSIN
LINDEN

KITTY V. TAYLOR
NEWARK

SECRETARY

MARY NOLAN
HAMILTON TOWNSHIP

TREASURER

MARJORIE PRUMATICO
PATERSON

BOARD MEMBERS

A. KELLY BUFFARDI
CRANFORD

HAROLD DAYES
BERKELEY TOWNSHIP

DAVID GROSSMAN
ORANGE

JAMES GYLE, JR.
METUCHEN

DAVID KEISERMAN
MANALAPAN

TED KOWALSKI
MANVILLE

JOHN LORDEN
LINDENWOOD

HENRY RALL
BRICK TOWNSHIP

LEON B. SCHACTER
PENNSAUKEN

JACK SCHLESINGER
LIVINGSTON

JOHN SMITH
CLIFTON

JOHN P. TERGIS
MARLBORO

JOHN WILSON
WILLINGBORO

Memorandum to Members of the Assembly Revenue, Finance and Appropriations Committee

In our testimony before the finance committee on July 12, 1984, we suggested that you await the recommendations of the Commission which will review the disbursement of casino revenue funds, according to SCR-97, before any further funds are expended, particularly in view of the fact that the fund seemed to be leveling off.

Since our testimony, the enclosed study of the fund, dated October 10, 1984, and prepared by Gerald D. Silliphant, Legislative Budget Officer, has come to our attention.

The study bears out the present generally accepted view that the fund is reaching a peak and that a major new expenditure could reduce the surplus to zero in a few years.

There is now more reason than ever to make sure needs of the highest priority are incorporated in the fund before it is too late.

The legislature devised the idea of a commission to study the resources of the fund and prioritize needs. We believe the decision of the legislature was a good one and again we respectfully request the finance committee to await the findings of the study commission before proceeding.

JOHN P. TERGIS
Legislative Chairman

JPT/ds

ACNJ

ASSOCIATION FOR CHILDREN OF NEW JERSEY

17 Academy Street, Suite 709
Newark, New Jersey 07102

December 4, 1984

TO: Assemblyman John Watson, Vice Chairman
Members, Assembly Revenue, Finance and Appropriations Committee

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

We are here today on behalf of the Association for Children of New Jersey (ACNJ) to present testimony in support of Assembly Bill 608 which proposes a Medically Needy Program for New Jersey. ACNJ is a statewide citizen-based advocacy organization dedicated to bettering the lives of New Jersey's children through the improvement of policies and programs that affect them. We, along with the Federation of Senior Citizens and other organizations, strongly support the enactment of a Medically Needy Program for the children, seniors and disabled citizens of New Jersey.

In prior testimony before this Committee, we documented the need for a Medically Needy Program. The approximately 110,000 children living in poverty in New Jersey today who do not have health coverage, the high cost of uncompensated care to hospitals that the medically needy now use to obtain health services, and the strong financial incentives from the Federal Government to implement a program are all sound reasons to enact a Medically Needy Program now.

Our focus here today, however, is to examine the cost-effectiveness of a Medically Needy Program and the availability of medical services elsewhere to those without health coverage. We also will explore what services we feel should be included in a Medically Needy Program for New Jersey's children.

1. A Medically Needy Program is Highly Cost-Effective and Results in Both Immediate and Long-Term Benefits.

As preventive health care, a Medically Needy Program can be highly cost-effective with both immediate and long-term benefits. Preventive treatment can avoid the need for costly hospitalization as well as result in long-term savings related to education, employment and child protective services.

The impact of such cost-savings can be seen in an example used by Dr. Robert Johnson, Director of Adolescent Medicine, University of Medicine and Dentistry of New Jersey, in a speech he delivered at the recent ACNJ Health Forum, a copy of which is attached. Dr. Johnson described a five-year comparison of David and Vincent, two adolescents who developed asthma at age 13. David's family had a hospitalization and prescription drug plan while Vincent's family was among the working poor who have no health insurance. They were not eligible for Medicaid even though their income was below the poverty level.

David's asthma was diagnosed after an initial hospitalization at age 13. He was referred to the Adolescent Clinic for monthly visits and was maintained on medication. By age 18, David had learned to control his asthma and was away at college. He had had no further hospitalizations, had missed no school, and did not view his disease as a disability. Total cost of David's health care for that five year period was \$3,775 which was covered by his parents' hospitalization plan.

Vincent's asthma was also diagnosed at age 13 and he, too, was referred to the Adolescent Clinic. His visits were infrequent, however, because his parents could not afford the cost of the clinic. They also could not afford to maintain Vincent on his medication and he used it only when absolutely necessary.

Comparably, Vincent's clinic and medication costs were less than those of David. But because Vincent could not afford to manage his asthma, his need for acute care was greater. He averaged monthly visits to the Emergency Room for treatment when his asthmatic attacks became severe. In addition, over that five year period, Vincent was hospitalized 40 times, three times in Pediatric Intensive Care when his asthma became advanced. Total cost of his health care was \$65,850 as compared to David's bill of \$3,775. Because Vincent's family had no health coverage, his bill was ultimately paid by the State of New Jersey. Had Vincent's preventive health care been paid, the state could have saved \$62,075.

But Vincent's story does not end here. The seriousness of his asthmatic attacks will lead to chronic lung disease and emphysema as he becomes an adult. His repeated hospitalizations and illnesses caused him to miss a great deal of school so that he dropped out in the tenth grade. His employment opportunities are seriously restricted both by his medical disability and lack of educational skills. Society will most likely be supporting Vincent for the rest of his adult life.

Stories like Vincent's and David's are not unique. The 1981 Federal budget cuts caused at least 18,500 children in New Jersey to lose their Medicaid benefits. In Middlesex County, for example, 49% of those families who lost their Medicaid benefits could not afford care for severe health problems of their children.

The cost of prevention is far less than the cost of treatment. National estimates suggest that preventive health care saves an average of \$8 for every \$1 spent. New Jersey, which has an infant mortality rate above the national rate, could benefit from pre-natal and perinatal intervention. Childhood diseases, such as measles and mumps, which are on the rise in New Jersey in contrast to a general national decline, can be prevented through early inoculations and immunizations.

In reality, children comprise only a small percentage of the recipients who use the Medically Needy Programs in other states. In Massachusetts, for example, where in-hospital care is included in the Medically Needy Program, children and their adult caretakers represent only 10% of the total Medically Needy expenditure. In Pennsylvania and Maryland, children spend 9% of the Medically Needy dollars.

The Medically Needy Program can be seen as an investment for the state. As evidenced by David and Vincent, a small investment in preventive health care now will result in significant long-term savings. But it is also an investment in a future that can see the potentially disabled, like Vincent, become productive, self-supporting members of society.

2. ACNJ Supports Option III as the Plan That Would Provide the Most Comprehensive Services for the Greatest Number of People.

To ensure that the most comprehensive health services are available for the children of New Jersey, ACNJ supports Option III. Option III, which would require a \$32 million appropriation from the General Fund, would provide ambulatory care, such as clinic visits, drugs, dental and optometric services for children and their parents; prenatal, delivery and postnatal care for pregnant women; and selected services for the elderly and disabled.

Should Option III not be possible due to fiscal constraints, Option II may be a realistic alternative. Any option that is chosen, however, must provide a full range of Medicaid services including EPSDT. While we realize that most options deal with ambulatory care, serious consideration should be given to in-hospital, non-ambulatory care if, as we suspect, New Jersey is in danger of losing its DRG waiver.

3. The Health Services That the Medically Needy Program Would Provide Are not Otherwise Available to the Children of New Jersey.

An inventory of ambulatory medical services for children completed by ACNJ indicates that there are not enough alternative facilities with sliding scale fees for poor children to satisfy the need. Of 105 general hospitals in NJ, only 49 were identified as offering out-patient care for children on a sliding-scale fee basis. Clinics which are operated by the State Department of Health and funded by Maternal and Child Health Block Grant Funds to give comprehensive pediatric care to poor children can not continue beyond 1984 because of the exhaustion of one-time federal funding. Other pediatric services, such as Child Health Conferences, do not give care to children who are sick or only address specific illnesses such as lead poisoning.

A similar lack of services exists for prenatal care as well. Of 70 maternity hospitals in NJ, only 50 offer prenatal care on a sliding-scale basis. There are 17 Prenatal Clinics and 7 Community Health Centers with prenatal care services which are funded by the federal government. Despite these facilities, infant mortality increased in New Jersey in 1982 and, though it decreased slightly in 1983, it was still above the national average.

Nor are the public schools a resource for health services. Although immunizations are required for school admission, they are not given in school. General screening for hearing, vision, and scolioses may be conducted by the schools, but follow-up treatment is left to the parents and depends on their ability to pay for care. School nurses are not authorized to give inoculations or medication, other than that which is sent from home.

This is the second time in the last six years that a Medically Needy Program has been proposed for New Jersey. No action was taken in the past. In the interim, serious health consequences have resulted for the State's children, senior citizens and disabled.

The time for a Medically Needy Program is now. The need for a program is clear. The state is in a period of economic stability and growth and we have an opportunity to take the lead in preventive initiatives. In addition, other programs may now be in jeopardy if the DRG waiver is lost. Administrative start-up costs should be included in the FY86 budget and we have written to Commissioner Albanese on this issue. We stand ready to support this proposal and hope that the Committee will release this bill with recommendation as soon as possible.

CASE HISTORY SHOWS COST EFFECTIVENESS
OF A MEDICALLY NEEDY PROGRAM

By: Edith Edelson

At a meeting called by the Association for Children of New Jersey, Dr. Johnson who is on the staff of the Rutgers Medical School and a member of our Coalition, gave the case histories of two youths who were cared for in the Adolescent Medicine Clinic.

Both youths had onsets of asthma at the age of 13 and are now 18 years old.

DAVID

His family was well off financially; had complete medical insurance including coverage for drugs.

Hospitalized only once for 4 days.

Visited clinic regularly once every month.

Took prescribed medicine regularly.

Graduated High School

Medical condition: under control

Present Occupation: Enrolled in College

Social Prognosis: Contributing member of society.

Total cost in 5 years = \$3,500

VINCENT

His family was poor but stable; not poor enough for Medicaid; had no medical insurance.

Hospitalized 40 times in the 5 years, an average of 8 days a year.

Visited clinic only when absolutely necessary. Visited Emergency Room once/mo.

Did not take medication regularly; only when the family could pay for it.

Absent from school 40-50 times a year because of illness. Had to repeat a number of grades. Dropped out at the 10th grade.

Medical condition: not controlled

Present Occupation: Unskilled worker in fast food restaurant where asthma is aggravated by working conditions.

Social Prognosis: Recurrent unemployment, Probable disability and recipient of government benefits.

Total cost in 5 years = \$65,850

HEALTH CARE NEEDS OF LOW-INCOME CHILDREN

Dr. Robert Johnson
Director, Adolescent Medicine
U M D N J

Speech before Children's Health Forum, September 25, 1984 at the
Center for Health Affairs
Sponsored by the Association for Children of New Jersey

Thank you and good morning. I'm delighted to be invited to come and share some of my experiences with you this morning. I was given the task of trying to talk to you about the medical needs that poor children have and I think that answers to this question are fairly self evident. Poor children have all of the needs of any children in this country and this world. We have plenty of statistics that convince us that we are not doing an adequate job in taking care of the poor children in our country. What I chose to do, however, was to make an attempt to put some flesh and blood on the dry bones of statistics.

Therefore, In preparing for this talk I went to the files in our Adolescent Clinic and chose the records of two individuals who attend our clinics. I compared the cost, both financial and human, to these two individuals as result of their diseases, and what I quickly realized is that even in our own health care facility we have two levels of care.

The first level of care is administered to a young man named David. David comes from a very stable family in one of the more affluent communities in Essex County. If you are familiar with Essex County you know that there are very poor areas that are within five miles of extremely affluent areas. Even though our health care facility is in the center of Newark, we draw from a population that has income that goes from nothing all the way up to people who are presidents of corporations. Well, David lives in this affluent community and he comes from an affluent family and very importantly, that affluent family has good health care. They have hospitalization provided by Blue Cross/Blue Shield. They have coverage for out-patient visits, coverage for laboratory tests and very importantly, they have that little blue prescription card that allows you to get almost anything that your physician can prescribe for about \$2.50. Now, I don't know - that may have gone up to \$3. But, in any case, the cost is minimal.

David developed asthma when he was 13 years of age. That was five years ago. During those five years he had one hospitalization that was concurrent with the initial diagnosis of his disease. He stayed in the hospital for four days, and that left him with a hospital bill of \$600 that was paid by Blue Cross.

In Adolescent Medicine we consider it very important for young people to visit us on a very frequent basis. We find that these frequent

visits help the young person to take charge of their disease. We decrease the level of medical indigency as a result of these visits and we increase the level of compliance. David was able to keep just about all of his monthly visits. Over five years his cost for physician care, visits to our clinic, came to \$1,350. That included a yearly physical examination as well as chronic disease counseling. He also had medication to take, and as best as I can estimate, over the five years the cost of his medications came to \$1,825. He was extremely compliant and our records indicate that there was never an occasion when David was either out of medication or did not take his medications. So in five years his asthma has cost him \$3,775.

David is now away at college. He has no medical disability as a result of his illness. He had an illness that required one hospitalization. He took his medication on a regular basis and he missed no time in school. In fact, he did rather well in school, and more importantly, he did not see his disease as something that impaired his life. He had no psychosocial disability as result of his asthma. Now, that's a very nice story, and that's certainly the way we would like to deliver care to anyone with a chronic illness or anyone with any illness at all.

The second individual is Vincent. Vincent lives exactly 3 1/2 miles from David. Vincent also comes from a stable family, but they are working poor. They live in a very poor community and because of the nature of the employment of his father and his mother, they have no hospital insurance at all - no health insurance - non. They are not poor enough for Medicaid. No hospitalization, no coverage for outpatient visits, and very importantly, no prescription card.

Well, Vincent developed asthma at 13 years of age also, and he is now 18, and we are also going to look at five years of his illness. Now you remember that David was hospitalized one time. Vincent has been hospitalized, so far, 40 times. Over those years he averaged eight hospitalizations a year. At least three of those hospitalizations were in the Pediatric Intensive Care Unit in our hospital, because he had something called status asthmaticus where he would not respond to the traditional therapies we deliver in the Emergency Room. The cost for Vincent's hospitalization over five years was \$59,000 as compared to \$600 for his neighbor David.

In addition to that, Vincent frequently visits the Emergency Room, and so far he averages one visit per month. That's excluding the visits where he is admitted to the hospital. There are times when he comes in and receives a shot of Adrenalin and his asthma clears up. Then there are other times when he has to come back. That's an average of once a month, although I must admit its fairly seasonal. During periods of time when there is an excess of pollen in the air, he has more frequent visits. Well, over five years the bill comes to \$4,800 as compared to no cost at all for emergency visits for David.

Vincent came very irregularly to the clinic. As a matter of fact, it only cost him \$700 as compared to \$1,350 for David. And he came less frequently because the parents cannot pay the bills that the hospital submit to them. And even though we have very unofficial systems for young people who can't pay their hospital bill, he and his parents

didn't feel that they should come in and keep avoiding the system of registration and be seen without records being kept. So he would frequently miss his visits and would come only when he absolutely had to.

In addition to that, the records that we have on Vincent indicate that he was frequently non-compliant. In other words, when he would come to the Emergency Room either for a visit or for admission we would find that the level of the medication that was being used to control his asthma was very low. He would tell us that the reason he didn't take it was not because he didn't want to, but because his family couldn't afford it. The cost for his medication over five years was \$1,350 as compared to \$1,825 for David. And because he was not able to afford the medication, he went into asthmatic attacks more often. As a result of that, he had to come into the Emergency Room and was frequently admitted to the hospital. That one item - that little blue prescription card - or some method of getting medication - was the answer to this riddle. Yet because we live in a system that did not provide that, we find that Vincent's cost for his illness over five years so far was \$65,850 as compared to \$3,775 for David.

Now that is just incredible. The costs are staggering. I know for those of you interested in money, you can see a tremendous difference in cost to all of us, because the state of New Jersey picks up the bill for this particular hospital. Otherwise the hospital would be bankrupt.

But there are more important outcomes for Vincent. Vincent has a significant medical disability. Everytime he went into the Pediatric Intensive Care Unit there was a real chance that he would die. And over the years we have had at least two or three adolescents that I'm familiar with who have died because of their inability to comply with therapy for their asthma. Vincent fortunately has not yet reached this end. In addition to that there's a chance for infection, because of the poor compliance with asthma. All of these things will have certainly affected his growth and he will very soon develop chronic lung disease and emphysema as he becomes an adult. So he has a significant medical disability that is a direct result of our inability to treat him properly. We have all the skills to prevent this medical disability and to prevent the tremendous cost that his disease will carry for him as he goes into adulthood; yet we didn't have the ability to give him money to afford his medications.

In addition to that, there's the educational disability. Vincent was absent from school 40 to 50 days per year because of his illness.

You add the hospitalizations, the Emergency Room visits, the times when he is not feeling well because the level of medication is too low and you come up with that number of missed days. Needless to say, he had to repeat a number of grades, a very frustrating type of thing to go through, and as a result of that Vincent dropped out of school just about when he had gotten through the 10th grade. So now we add into the equation all of the economic costs of the poor education and the fact that now as an adult, he cannot get a job that will give him enough money to pay for the medications that he needs.

Finally, there is a psychosocial disability. I already referred to the fact that there are restricted employment opportunities. As a matter of fact, one of the current problems we have is that the only type of job that Vincent can qualify for is one in fast food alley where he is on the stove. He has to cook those hamburgers and grease gets into his nose, which causes him to have asthmatic attacks. We think that he's going to lose his job. It certainly is worsening his disease. And even more important than that, he has an image of himself as an individual who is decidedly abnormal, different from his peers, someone who has an extremely bleak and limited future that is a direct result of his illness.

Now that is a striking example of the two levels of care we have with chronic illness. The story can be repeated over and over again with the thousands of asthmatics and diabetics and other youngsters with chronic illnesses that we have throughout our state and indeed throughout our country. We not only see this two-level system striking in the area of chronic care, but routine medical care as well. We recommend yearly physical examinations for children above five years of age. Below that there are the routine health care programs that are recommended, such as immunization and well-baby care. That is again restricted for those individuals who fall into this category where their medical needs are not sufficiently provided.

One of the interesting things is when it comes to catastrophic care. That's the area where we get all the press. Usually we get an idea that there is some equality. Over and over again we see stories in the paper of individuals who are medically needy who need heart transplants for example, and corporations will intercede and provide funds for their operations. And in the case of one of our adolescents, the governor interceded to get the money to pay for the heart transplant for this very needy young man. That sort of thing makes us feel good and gives us the idea that we are really doing a wonderful job. But this is just one individual compared to the thousands of individuals for whom we are doing a very inadequate job.

Well; I hope that these brief remarks have put some life into the task that is facing you. It is one that is vital for the future of our young people and indeed vital for the future of our country. Thank you.



STATE OF NEW JERSEY
DEPARTMENT OF HEALTH

CN 360
TRENTON, 08625

J RICHARD GOLDSTEIN, MD
COMMISSIONER

(609) 292-7837

December 14, 1984

Honorable John S. Watson
Assemblyman, District 15
240 West State Street
Suite 825
Trenton, New Jersey 08618

Dear Assemblyman Watson:

I was pleased that Scott Crawford had an opportunity to represent the Department of Health at the public hearing, which the Assembly Revenue, Finance, and Appropriations Committee held on the medically needy legislation this past December 5th.

It has been brought to my attention that you and other members of the Committee expressed concerns and frustrations over the fact that the Committee has not received previously requested information concerning the number of people who use inpatient and outpatient hospital services, who may meet medically needy income and asset standards.

Following the Department's appearance before your Committee at the first public hearing on the medically needy bill, you asked the Department and the Hospital Association to try to ascertain this information concerning the population covered by the medically needy bill, which would be responsible for uncompensated care in the hospital. Following this request, Department of Health staff prepared a Charity Care Survey Form, which was broken up into several categories, such as patient's income, number of dependents, age, sex, race, type of services rendered, and the cost of services.

On September 27th, we sent this Survey Form to the Hospital Association as a suggested format which could be used by the hospital to obtain the requested information, and which would not create an undue burden to the hospitals. You may recall that I also provided you with a copy of the Survey Form in my letter of September 27th (copy enclosed).

December 14, 1984

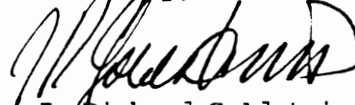
On November 16th, we provided the Hospital Association with a revised Charity Care Survey Form. It has been our understanding that the Hospital Association, through the use of this Survey Form, has not been able to gather the information which your Committee requested from various hospitals throughout the State.

My staff does not believe that the Department has access to data at the level of detail which would provide us with estimates as to the extent that the population coverage by the medically needy bill would be responsible for uncompensated care in the hospitals. In an attempt to provide the Committee with its requested information, members of my staff will be meeting with the staff from the Hospital Association to see if, through a joint effort, we can come up with some estimates regarding this issue. My staff will be asking Jay Hirshberg, from your Committee, to take part in this meeting.

If this effort should prove unsuccessful, I will immediately bring this to your attention, so that the Committee would be fully informed and could proceed in another manner.

I will be in further touch with you on this matter in the very near future.

Sincerely,



J. Richard Goldstein, M.D.
State Commissioner of Health

lt
Enclosure

cc: Assemblyman Rodney P. Frelinghuysen
Assemblyman Walter J. Kavanaugh
Assemblyman Anthony M. Villane, Jr., D.D.S.
Mr. Charles F. Pierce, Jr.
Mr. Joseph Morris
Mr. Louis P. Scibetta
Mr. Jay A. Hershberg



STATE OF NEW JERSEY
DEPARTMENT OF HEALTH

CN 360
TRENTON, 08625

J. RICHARD GOLDSTEIN, MD
COMMISSIONER

(609) 292-7837

September 26, 1984

Honorable John Watson
Assemblyman, District 15
Suite 825
240 West State Street
Trenton, New Jersey 08618

Dear Assemblyman Watson:

Thank you for your letter of July 17, 1984, concerning the Department of Health's testimony before the Assembly Revenue, Finance and Appropriations Committee on Assembly Bill 608. In your letter you asked the Department to provide the committee with certain additional information which arose out of the Department's testimony which was presented by Assistant Commissioner Joseph Morris. One such request was from Assemblyman Frelinghuysen, concerning how the Department planned to allocate certain funds for prenatal services to high-risk women as it related to Resolution 166.

Through the implementation of Resolution 166, which provided an appropriation of \$625,000 to the Department of Health, the Department proposed to address the infant mortality and prematurity problem in identified high-need areas by developing a community based initiative to provide greater access to prenatal care. Specifically, seven high-risk area projects were planned. The start up of these projects was projected to need \$525,000. The funds would have provided prenatal care to approximately 1,500 women. This would be in addition to the 9,000 served by existing clinics funded through the Maternal and Child Health Block Grant. The areas which would have received funding would have been Atlantic City, Trenton, Camden, Newark, New Brunswick, Jersey City and Paterson.

None of the 1,500 women the program planned to serve would have benefited from the proposed medically needy program. The funds were to be targeted to provide prenatal services to women who do not have Medicaid or insurance coverage.

The remaining \$100,000 was to be used to develop and implement a uniform statewide obstetrical and newborn system in conjunction with the New Jersey Medical Society and the state's maternity service hospitals. This system would improve the care for the 95,000 women who are pregnant each year. The system would have improved the monitoring of care provided by clinics with Department funds.

September 26, 1984

In your letter of July 17, you also asked the Department to work with the Department of Human Services and the New Jersey Hospital Association to devise a method by which New Jersey hospitals could perform a one-time, one-week survey of hospitals to try and determine the number of people utilizing inpatient and outpatient services who may meet medically needy income and asset standards. My staff has prepared the enclosed form as a suggested format which could be refined by the Department of Human Services through both the Medicaid office and Department of Human Services' Data Center. The method is very similar to the test survey that most all populations are familiar with. The amounts in our illustrative example, or the amounts of charges, can be readily altered by the Department of Human Services to those categories which best meet their needs. Our focus was to provide a simple tool which would not create an undue burden to the hospitals, yet provide fairly reliable information in a cost effective manner. We have made available to Mr. Tom Russo, Director of Medical Assistance and Health Services at the Department of Human Services, a copy of this form. We have also provided a copy of this form to Mr. Scibetta of the New Jersey Hospital Association.

Lastly, you asked the Department to review the estimates prepared by the Department of Human Services concerning the cost of providing the medically needy with inpatient and outpatient hospital services. We believe these figures, which estimated the cost of providing inpatient services to the medically needy at \$111.3 million and the costs of outpatient services at \$23.2 million, represent reasonably reliable figures.

I hope this information is of assistance to you and the members of your committee. If the Department of Health can be of further assistance in this matter, please do not hesitate to contact me.

Sincerely,



J. Richard Goldstein, M.D.
State Commissioner of Health

JRG:JM:af

Enclosure

cc: Hon. Rodney Frelinghuysen
Hon. Thomas J. Deverin
Hon. Jacqueline Walker
Jay Hershberg
Commissioner Albanese
Thomas Russo
Lou Scibetta
Ollie Hawkins, Esq.

Hospital _____

City _____

County _____

CHARITY CARE SURVEY

	Less Than \$7,500	\$7,500 - \$15,000	\$15,000 - \$25,000	Over \$25,000
Income	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# of Dependents	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	Over 3 <input type="checkbox"/>
-----------------	----------------------------	----------------------------	----------------------------	----------------------------	---------------------------------

N.J. Resident	Yes <input type="checkbox"/>	No <input type="checkbox"/>
---------------	------------------------------	-----------------------------

Inpatient <input type="checkbox"/>	Outpatient <input type="checkbox"/>
------------------------------------	-------------------------------------

Amount of Charges	Less Than \$100 <input type="checkbox"/>	\$100 - \$500 <input type="checkbox"/>	Over <input type="checkbox"/>
-------------------	--	--	-------------------------------

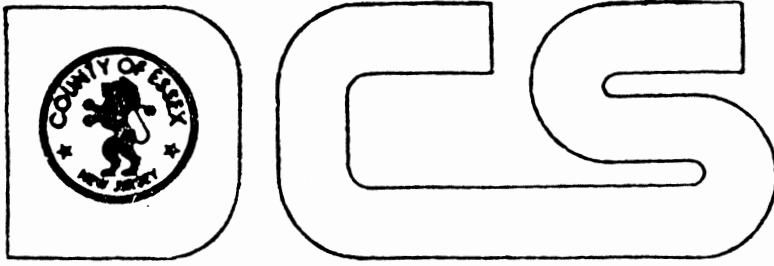
Type of Service	E-Room <input type="checkbox"/>	Clinic <input type="checkbox"/>	Acute Care <input type="checkbox"/>	Other <input type="checkbox"/>
-----------------	---------------------------------	---------------------------------	-------------------------------------	--------------------------------

94X

Age	Less than 10 <input type="checkbox"/>	10 - 20 <input type="checkbox"/>	21 - 35 <input type="checkbox"/>	36 - 55 <input type="checkbox"/>
	56 - 65 <input type="checkbox"/>	Over 65 <input type="checkbox"/>		

Sex	Male <input type="checkbox"/>	Female <input type="checkbox"/>
-----	-------------------------------	---------------------------------

Race	White <input type="checkbox"/>	Black <input type="checkbox"/>	Hispanic <input type="checkbox"/>	Other <input type="checkbox"/>
------	--------------------------------	--------------------------------	-----------------------------------	--------------------------------



DEPARTMENT OF
CITIZEN SERVICES

PETER SHAPIRO
COUNTY EXECUTIVE

REBECCA DOGGETT ANDRADE
DIRECTOR

TESTIMONY OF REBECCA DOGGETT ANDRADE

TO

REVENUE, FINANCE & APPROPRIATION COMMITTEE
NEW JERSEY GENERAL ASSEMBLY

December 5, 1984

Assemblyman Watson, Members of the Revenue, Finance & Appropriation Committee:

I am Rebecca Doggett Andrade, Director of the Essex County Department of Citizen Services, New Jersey's largest social services agency in its most economically depressed area.

Among the myraids of programs we administer, my department is responsible for determination of eligibility for Medicaid for all persons in Essex County applying for participation.

Although county government does not share in Medicaid payments, we as the agency responsible for eligibility determinations have a major role to play in the current program, and therefore we believe we have a certain amount of expertise to contribute to the current dialog.

May I first state unequivocally that extension of eligibility for participation in this program, to the medically needy is long over due. New Jersey cannot claim to be in the forefront of states caring for its needy children, aged and disabled, and continue to refuse medical care to those whose incomes are \$1 to \$200 per month above the extremely low levels we establish for eligibility for Assistance to Families with Dependent Children and for Supplemental Security Income to the Aged, Blind and Disabled. Few would expect a mother of two children with a gross income of less than \$400 per month to be able to utilize any of income for medical care for herself or those children. Few would expect a disabled or elderly person with any income over \$350 per month to be able to meet the costs of health care on today's market.

An investment in medical care for these groups of citizens is not only an obligation for this state, with its third highest per capita income in the country, it is

Ad 1 Testimony

a basic investment in its future.

There are legitimate questions of coverage of services, of spenddowns, of eligibility limits, and of state budgetary constraints, but the thrust of the argument remains the urgent need to extend health care coverage to as many of those marginally excluded as can be covered within the constraints of federal policy. Certainly with the availability of federal dollars, and with casino funding available for meeting the non-federal costs of services to all but our children, we must move forward in this area.

You are asking for comments on administrative provisions. Our county Department of Citizen Services administers the eligibility determination program now for about 26% of the statewide total of Medicaid eligibles. We have administered this program from the start under a contract with the state that sets our reimbursement rate at \$10 per case.

Since establishment of the program there has been no adjustment in the rate. There have been adjustments however, in the coverage, and we now determine eligibility not only for all AFDC cases and SSI households, but also for all of the elderly seeking Medicaid eligibility for admission to nursing homes, and for all of these hundreds of first-time pregnant women in need of help to meet the costs of prenatal care and delivery.

Needless to say, eligibility determinations cost our agency far more than \$10 per year per case, and we are hopeful now that the State Department of Human Services will provide additional funding. Eligibility determinations for one of the most expensive entitlement programs in the state, far more expensive than AFDC, demand the best and should be adequately reimbursed.

We are not interested in a two-tier approach to eligibility determination, we do not believe in shuttling applicants from one agency to another, we do believe in

Ad 2 Testimony

quality programs from the point of view of the state as well as of the participants. We believe we have provided that quality service and are prepared to expand to provide the eligibility determinations for an extended program. We ask only that you in the Legislature assure that the reimbursement to the county welfare agencies is adequate for a quality job.

We now have a professional staff of 12 involved in eligibility determination for nursing home admissions. We have an additional clerical staff of 12 involved in issuing the monthly determinations. We believe that we do an effective job, from the point of view of consumers and of the providers of service. We are prepared with adequate resources, to continue to do the job with any expanded constituency.

AOF/ep

12/3/84

cc: Peter Shapiro, Essex County Executive

MONMOUTH COUNTY BOARD OF SOCIAL SERVICES

A comprehensive program of

Social Services

Nursing Home Care

Public Assistance

Food Stamps

MAILING ADDRESS
P.O. BOX 3000
FREEHOLD, N.J. 07728



Kozloski Road Freehold Township, N.J. 07728

REPLY TO: _____

PHONE NO.: _____

November 29, 1984

Mr. Michael J. Basarab
Legislative Services
State House Annex Room 425
Trenton, NJ 08625

Dear Mr. Basarab:

At its November meeting the Monmouth County Board of Social Services voted unanimously to express support for including a Medically Needy Program in the array of services available to the poor of this state. The Board believes that such a program would serve a population in serious need of subsidized medical services and has directed me to express their support for the passage of legislation enacting the Medically Needy Program in New Jersey.

The Board particularly favors the concept of furnishing medical assistance to those persons who would currently be eligible for Medicaid Services if their incurred medical costs were considered. The opportunity to tailor a program to the special needs of our state while taking advantage of federal matching should not be overlooked. Furthermore, the experience of nearby states with the program should be of significant help in designing an appropriate service for the medically needy.

The Monmouth County Board of Social Services and I sincerely hope to see the establishment of a Medically Needy Program by the end of this legislative session.

Very truly yours,


Louis Armour, Director

cc: Audrey Harris
Thomas Russo

H: 200

HOME HEALTH AGENCY ASSEMBLY OF NEW JERSEY, INC.

760 Alexander Road CN-1 • Princeton, New Jersey 08540

Center for Health Affairs
(609) 452-9280


December 14, 1984

The Honorable Barbara Faith Kalik
Laino Bldg., Route 130 North
Delran, NJ 08075

Dear Assemblywoman Kalik,

As requested by the Revenue, Finance and Appropriations Committee on December 5, 1984, enclosed is specific data regarding home health care in New Jersey. We hope that this data will be of assistance in developing a Medically Needy program for New Jersey.

Sincerely,

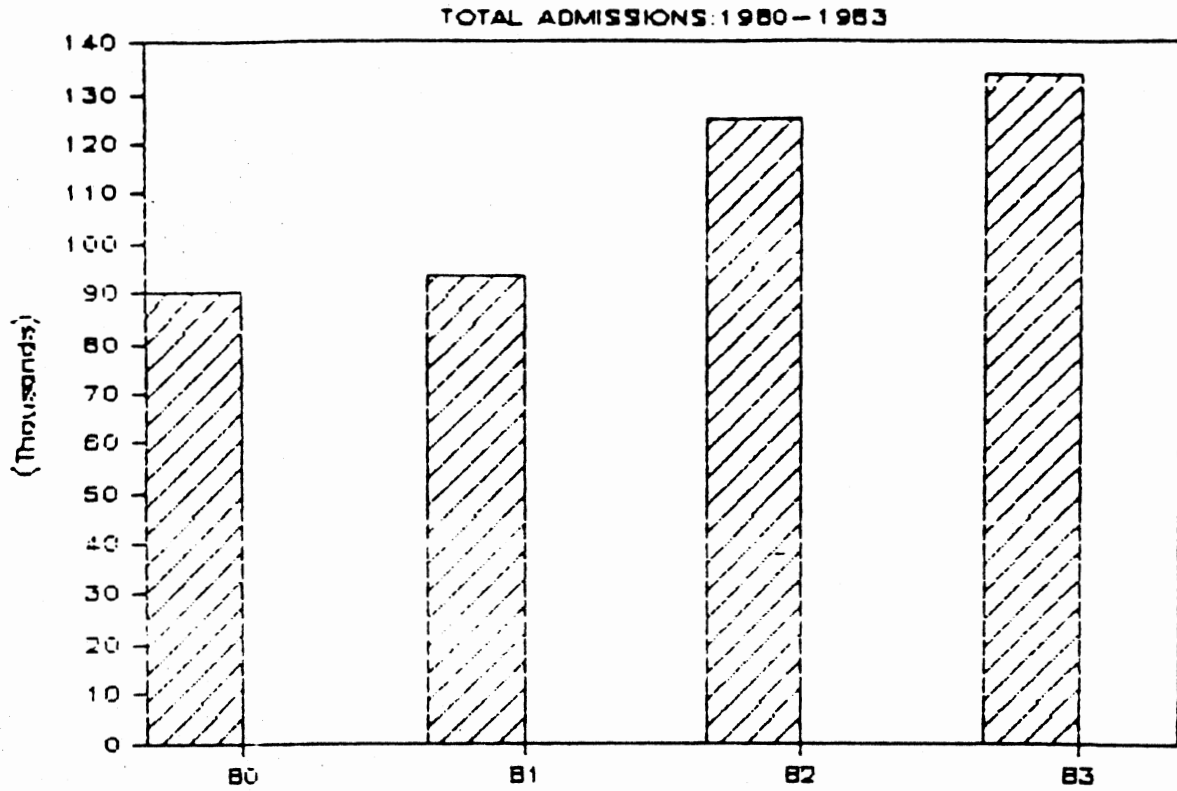

John Paul Marosy
Executive Director

JPM/cr
ENC: 1983 Data Survey

SUMMARY 1983 HOME HEALTH AGENCY DATA

1. GROWTH IN HOME HEALTH ADMISSIONS

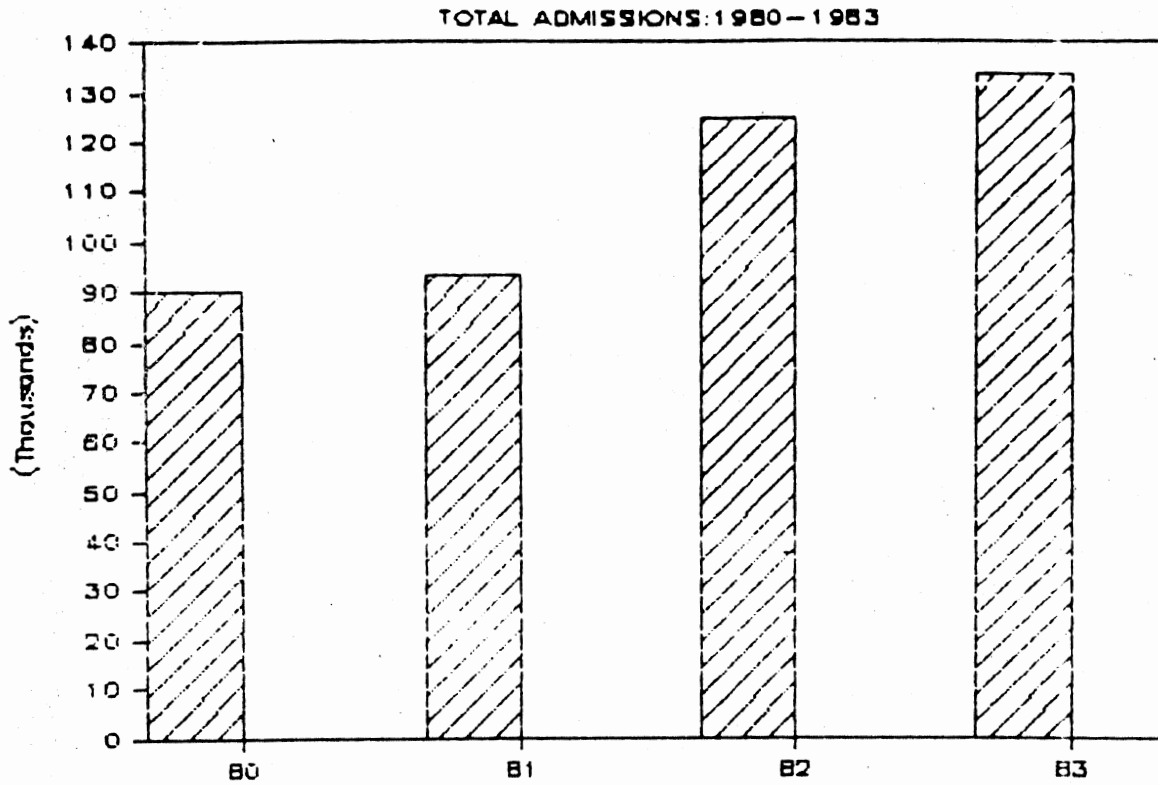
Between 1980 and 1983, home health service to New Jersey residents from certified home health agencies increased from 90,000 to 133,000 admissions per year - a growth of 48% over the four year period.



SUMMARY 1983 HOME HEALTH AGENCY DATA

1. GROWTH IN HOME HEALTH ADMISSIONS

Between 1980 and 1983, home health service to New Jersey residents from certified home health agencies increased from 90,000 to 133,000 admissions per year - a growth of 48% over the four year period.



2. AGENCY SPONSORSHIP

Certified home health agencies in New Jersey are based in a variety of sponsoring organizations. Many have developed from traditional community-based Visiting Nurse Associations or other non-profit community nursing agencies. Another large group are divisions of municipal or county public health departments. A third large group are departments within community general hospitals. Proprietary (for-profit) agencies, usually franchises of national chains, make up another category of sponsorship type. In 1983, there were 2 proprietary agencies. Two more for-profit agencies received certification in 1984 and will be reporting data in the 1984 annual survey.

TYPE OF AGENCY, BY SPONSORSHIP AUSPICE (1983)

	NUMBER	PERCENTAGE
Non-Governmental		
Hospital-based	10	19.6
Community-based	25	49.0
Proprietary	2	3.9
Governmental		
County Boards of Health	7	13.7
Municipal Boards of Health	7	13.7
		(combined total percentage 27.4)

TOTAL AGENCIES	51	100.0%

3. SERVICES PROVIDED

All agencies provide six core services to sick patients in the home - nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social work. Over 2.5 million home health visits were provided to patients in the home in 1983.

In addition to care of the sick in the home, home health agencies are involved in a number of community health programs such as well child care, disease screening, health education, and senior citizen health promotion. Over half of the agencies have contracts for the provision of school health programs. Other frequently offered programs are special children's care and hospital coordination/discharge planning.

Most agencies (82%) schedule admissions and visits seven days per week, and virtually all agencies provide emergency phone and referral service around the clock.

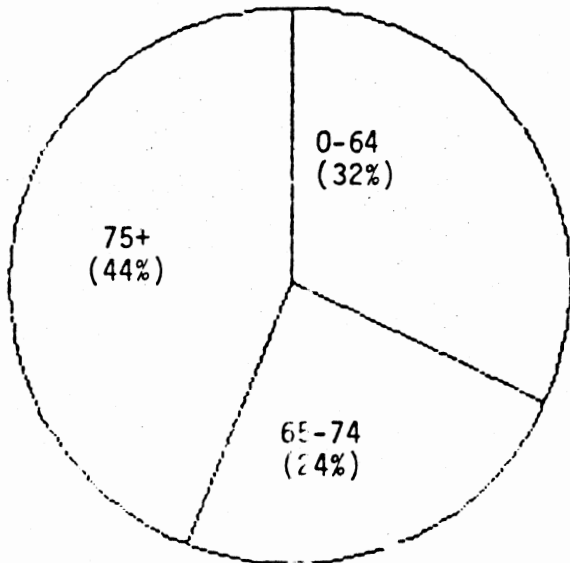
TYPES OF PROGRAMS AVAILABLE (1983)

	NUMBER	PERCENT
Home Catheter Care	50	98.0
Tracheostomy Care	45	88.2
Well Child Care	40	78.5
Hospice		
Comprehensive	16	31.4%
Elements	24	47.5%
Disease Detection/Screening	38	74.5
Health Education	36	70.6
Senior Citizens Health Screening/Counseling	35	68.6
Hospital Coordination/Discharge Planning	33	64.7
Special Children's Care	31	60.8
Immunization	32	62.7
Maternity	30	58.8
School Health	28	54.9
Intravenous Therapy	26	51.0
Abused Children/Adults	22	43.1
Respiratory Therapy (MAI Respirator)	17	33.3
Private Duty: Homemaker/Home Health Aide	16	31.4
Bi-Lingual Intrepreter	15	29.4
Mental Health	14	27.5
Chemotherapy	13	25.5
Family Planning	11	21.6
Other	10	19.6
Private Duty: Nurses	10	19.6
Mental Retardation/Developmentally Disabled	8	15.7
RHCF Health Maintenance and Monitoring	6	11.8
Industrial Program/Occupational Health	6	11.8
Private Duty: Separate Corporation	4	7.8

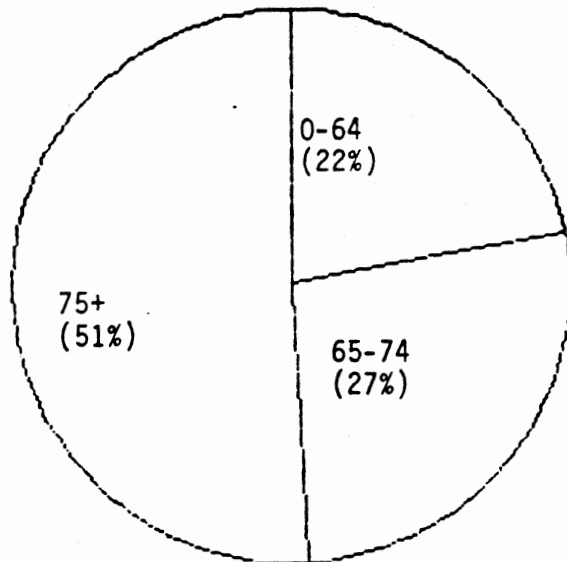
4. AGE DISTRIBUTION

The elderly are the most frequent users of home health care. Persons over 65 make up 68% of all nursing patients served, and 78% of all nursing visits.

NURSING PATIENTS, BY AGE (1983)



NURSING VISITS, BY AGE (1983)



HOME HEALTH USE RATE, BY AGE

AGE	% DISTRIBUTION BY AGE*	HH ADMISSIONS BY AGE (1983)**	NJ POPULATION BY AGE (1985)	USE RATE
0-64	0.3178	42,415	6,507,600	0.0065
65-74	0.2431	32,446	573,600	0.0566
75-84	0.2892	38,598	283,600	0.1316
85 +	0.1500	20,020	84,600	0.2366
TOTAL	1.0000	133,479	7,449,400	0.0179

* From Table 8.1

** Home health admissions, by age, determined by applying age distribution percentages to total client population (133,466) (see page 10).

The projected growth in the oldest age group - persons over 85 years of age - has important implications for home health. The number of persons over 85 is expected to more than double by the year 2000. Assuming the need for home health care remains constant in this age group, the demand for service will increase proportionally. Demand would increase significantly if the reimbursement barriers to chronic care were eliminated (or moderated).

5. COSTS

Charges for professional visits of one to two hours in length are in the mid-forties. The average charge for a home health aide visit of approximately three hours is \$32.

CHARGES BY VISIT, BY DISCIPLINE: STATEWIDE AVERAGES (1983)

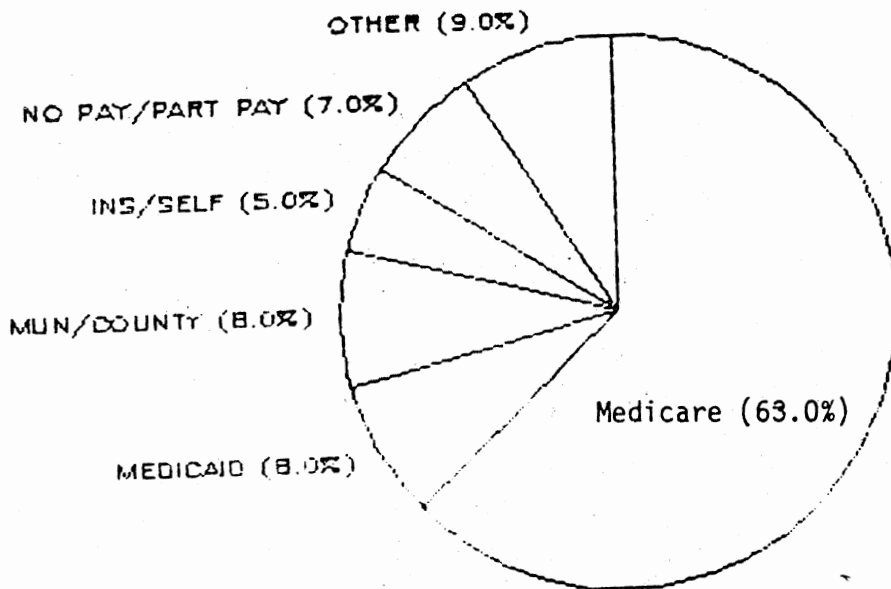
	AVERAGE CHARGE	LOW	HIGH
Skilled Nursing Care	44.41	29.00	80.00
Physical Therapy	41.67	25.00	72.00
Occupational Therapy	41.58	30.00	60.00
Speech Therapy	42.27	30.00	74.00
Social Worker	47.83	25.00	67.00
Home Health Aide (visit)	32.29	14.00	54.00
(per hour)	11.12	7.50	19.00

(Average number of hours per visit 2.90)

6. PAYMENT SOURCES

Home health services are paid for predominantly by Medicare and Medicaid. Medicare is the principle source of payment for 63% of nursing patients and 72% of all nursing visits.

NURSING PATIENTS, BY PAYMENT (1983)



NURSING VISITS, BY PAYMENT (1983)

