THE CAPITOL FORUMS
On Health and Medical Care

Data Book:
Medicaid Funding of Chronic and Long Term Care

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background information for the discussion at the

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MEDICARE

Co-payment: The portion of Medicare (of other third-party) charge that is paid by the beneficiary. Also referred to as coinsurance or as an out-of-pocket expense. Different copayments are required under Medicare Parts A and B.

Part A: In Medicare coverage of Skilled Nursing Facility (SNF), the beneficiary is responsible for a coinsurance amount or copayment that is equal to one-eighth of the inpatient hospital deductible for each day after the 20th and before the 101st day of services furnished during the spell of illness. The inpatient hospital deductible is equal to the national average Medicare rate per hospital day. In 1992 the hospital deductible equals $652 and the SNF daily copayment is $81.50 (or 1/8 * $652). It is possible for the Medicare daily SNF copayment to exceed the approved Medicare daily rate so that no funds are received from Medicare for days 21 to the end of coverage in the SNF. Medi-gap coverage frequently pay the SNF copayment.

Part B: The beneficiary is responsible for 20 percent of the Medicare approved charge for services covered under Part B. Medigap coverage frequently pays the copayment amount, for those persons who have Medigap policies.

Deductible: A specified amount paid by the patient (or resident) for covered services before reimbursement from a third party begins. Under Medicare Part A, there is no deductible for Medicare SNF coverage. In 1992, there is a deductible of $652 for inpatient hospital expenses in a benefit period. Under Medicare Part B, the deductible is $100 in each calendar year for all covered services. Private long-term care insurance policies may also have deductibles, often called "waiting periods." There are no deductibles for nursing home care paid by Medicaid.

Medicare — Title XVIII: An acute health insurance program for persons 65 or older who are eligible for Social Security, persons under 65 who are receiving Federal disability benefits, and certain individuals with end-stage renal disease. Medicare eligibility and scope-of-benefits are not subject to any income test and are uniform throughout the country. Actually composed of two programs: **Part A** and **Part B.**

Part A — Coverage is automatic under Medicare. Part A coverage includes up to 100 days in a SNF for persons admitted within 14 days of a discharge from a hospitalization with a minimum stay of three days. The SNF stay is covered if skilled care or rehabilitation associated with recuperation is warranted.

Part B — Also called Supplementary Medical Insurance. Coverage is voluntary, although virtually all persons who are eligible to participate do so. Medicare Part B is financed from premiums paid by individuals (or by States under the Medicaid program in the individual is eligible for Medicaid) and additional funds appropriated from general Federal tax revenues. In addition, the program requires payment of deductibles and cost-sharing. Part B covers physician and medical services for all Medicare enrollees in a nursing home. Also covers therapy services, durable medical equipment, medical supplies, and nutritional supplements or formula for Medicare enrollees in a nursing home who are not covered under Part A for that stay.

Medicare payment rate: Amount paid by Medicare Part A to cover SNF care. The rate is comprehensive. It covers all services received while the patient is in the facility, except physician care. The Medicare rate is determined retrospectively based on actual costs incurred subject to certain limits or ceilings.

Chart 1

NATIONAL MEDICARE/MEDICAID EXPENDITURES - ACTUAL AND PROJECTED

(with Percentage Comparison to Total National Expenditures and Total Program Expenditures)

	1990		1991		1993		1995		2000	
	Medicare	Medicaid	Medicare	Medicaid	Medicare	Medicaid	Medicare	Medicaid	Medicare	Medicaid
Amount In Billions										
Health Services and Supplies	$111.2	$75.2	$122.9	$98.2	$152.9	$150.6	$191.0	$202.2	$327.6	$359.8
Personal health care	108.9	71.3	120.3	94.1	150.0	145.2	187.8	195.5	323.3	348.6
Hospital care	68.3	28.5	74.3	40.6	90.7	67.2	113.6	91.8	191.0	162.1
Physician services	30.0	5.2	33.9	6.7	44.0	9.8	55.7	13.5	104.1	24.9
Dental services	-	0.7	-	0.9	-	1.4	-	1.7	-	2.5
Other professional services	3.1	2.0	3.5	2.8	4.4	4.3	5.5	6.1	9.0	12.5
Home health care	2.9	2.2	3.6	2.6	5.0	4.3	5.9	6.8	9.0	15.8
Drugs & other medical non-durables	-	4.9	-	6.1	-	8.4	-	11.1	-	19.5
Vision products & other medical durables	2.2	-	2.4	-	3.1	-	3.8	-	5.8	-
Nursing home care	2.5	24.1	2.6	28.7	2.9	38.4	3.2	46.9	4.4	72.1
Other personal health care	-	3.6	-	5.7	-	11.4	-	17.6	-	39.2
Program administration	2.3	3.8	2.6	4.2	2.9	5.4	3.2	6.6	4.3	11.2
Percent of National										
Health Services and Supplies	17.3	11.7	17.2	13.8	17.5	17.2	17.8	18.9	19.3	21.2
Personal health care	18.6	12.2	18.5	14.5	18.7	18.1	19.0	19.8	20.6	22.2
Hospital care	26.7	11.1	26.1	14.2	25.3	18.7	25.8	20.8	27.2	23.1
Physician services	23.9	4.2	24.6	4.8	26.3	5.9	27.0	6.5	30.2	7.2
Dental services	-	2.2	-	2.5	-	3.4	-	3.6	-	4.0
Other professional services	2.8	2.7	2.8	2.9	9.9	9.5	9.9	11.1	10.9	15.2
Home health care	2.6	2.9	3.0	2.7	40.4	35.1	35.9	41.5	29.5	51.9
Drugs & other medical non-durables	-	6.6	-	6.2	-	11.8	-	13.2	-	15.6
Vision products & other medical durables	17.8	-	19.4	-	22.2	-	23.2	-	23.9	-
Nursing home care	2.2	32.1	2.1	29.2	3.9	51.6	3.5	50.5	3.0	49.0
Other personal health care	-	31.9	-	41.4	-	56.1	-	63.0	-	72.4
Program administration	2.1	5.1	2.1	4.3	5.9	11.2	5.7	11.8	5.1	13.3
Percent of Program										
Health Services and Supplies	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Personal health care	97.9	94.9	97.9	95.7	98.1	96.4	98.3	96.7	98.7	96.9
Hospital care	61.5	37.9	60.4	41.3	59.3	44.6	59.5	45.4	58.3	45.0
Physician services	27.0	7.0	27.6	6.8	28.8	6.5	29.2	6.7	31.8	6.9
Dental services	-	1.0	-	0.9	-	0.9	-	0.8	-	0.7
Other professional services	2.8	2.7	2.8	2.9	2.9	2.8	2.9	3.0	2.7	3.5
Home health care	2.6	2.7	2.8	2.9	3.2	2.9	3.1	3.4	2.8	4.4
Drugs & other medical non-durables	-	6.6	-	6.2	-	5.6	-	5.5	-	5.4
Vision products & other medical durables	1.9	-	2.0	-	2.0	-	2.0	-	1.8	-
Nursing home care	2.2	32.1	2.1	29.2	1.9	25.5	1.7	23.2	1.3	20.0
Other personal health care	-	4.8	-	5.8	-	7.6	-	8.7	-	10.9
Program administration	2.1	5.1	2.1	4.3	1.9	3.6	1.7	3.3	1.3	3.1

Source: Health Care Financing Review/ Fall 1992/ Volume 14, Number 1

Chart 2

MEDICARE AND MEDICAID - SUMMARY BY STATE, 1991

(data are preliminary estimates)

	Medicare Enrollment (1,000)	Medicaid Recipients (1,000)
All areas	34,870	28,280
Northeast	7,541	5,721
N.E.	1,918	1,368
ME	186	151
NH	141	60
VT	76	71
MA	879	651
RI	161	164
CT	476	272
M.A.	5,623	4,353
NY	2,529	2,462
NJ	1,109	614
PA	1,985	1,277
Midwest	8,548	6,026
South	11,780	9,331
West	6270	5,989

Source: U.S. Health Care Financing Administration, unpublished data

Chart 3

MEDICAID - RECIPIENTS AND PAYMENTS, BY BASIS OF ELIGIBILITY AND TYPE OF SERVICE: 1990, 1991

Basis of Eligibility and Type of Service	Recipients (1,000) 1990	Recipients (1,000) 1991	Payments (mil.dol.) 1990	Payments (mil.dol.) 1991
Total	25,255	28,280	64,859	77,048
Age 65 and over	3,202	3,359	21,508	25,453
Blindness	83	85	434	475
Disabled	3,635	3,983	23,969	27,798
AFDC program	17,230	20,194	17,690	22,129
Other and unknown	1,105	658	1,257	1,193
Inpatient services in --				
General Hospital	4,593	5,072	16,674	19,891
Mental Hospital	92	65	1,714	2,010
Intermediate care facilities:				
Mentally retarded	147	146	7,354	7,680
Nursing facility services	1,461	1,500	17,693	20,709
Physicians	17,078	19,321	4,018	4,952
Dental	4,552	5,209	593	710
Other practitioner	3,873	4,282	372	437
Outpatient hospital	12,370	14,137	3,324	4,283
Clinic	2,804	3,511	1,688	2,211
Laboratory	8,959	10,505	721	897
Home health	719	813	3,404	4,101
Prescribed drugs	17,294	19,602	4,420	5,424
Family planning	1,752	2,185	265	359

Source: Health Care Finance Administration, Health Care Financing Review, quarterly

Chart 4

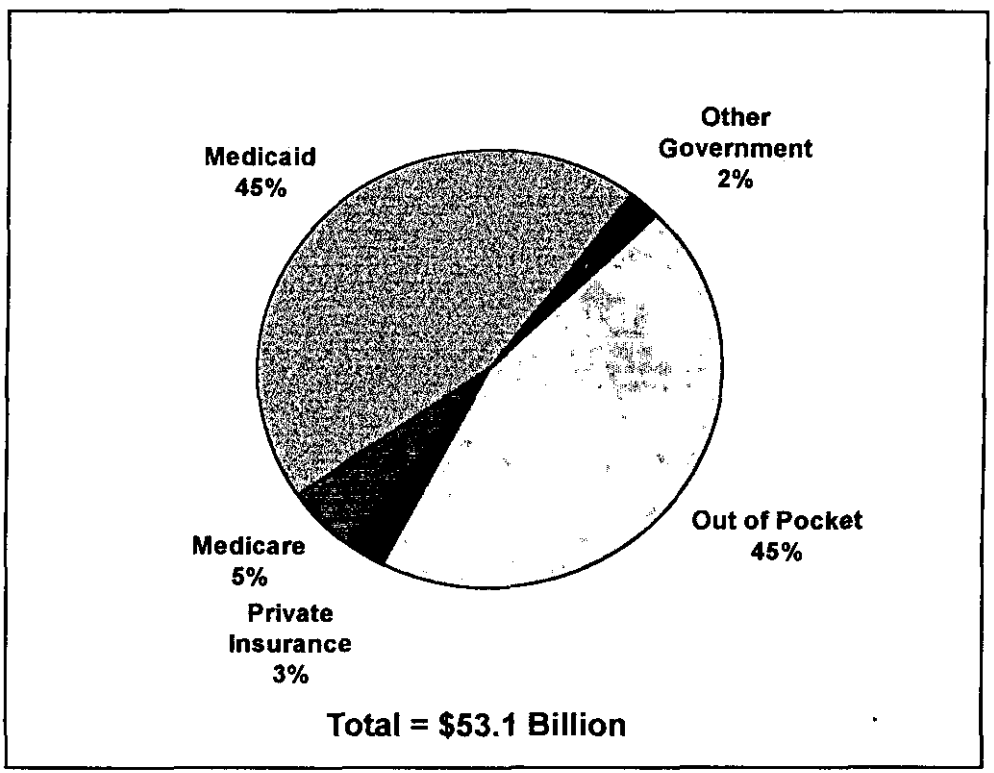
Major Federal Programs Supporting Long-Term Care Services for the Elderly and Disabled

Program	Objectives	Eligibility Requirements	Administration	Long-Term Care Services
Medicare/Title XVIII of the Socical Security Act	To pay for acute medical care for the aged and selected disabled	Persons 65 and over, persons under 65 entitled to federal disability benefits, certain persons with end-stage renal disease	Federal: HCFA/ HHS State: None	Home health visits, extended hospital stays, limited skilled nursing facility care
Medicaid/ Title XIX of the Social Security Act	To pay for medical assistance for certain low-income persons	Aged, blind, disabled persons receiving cash assistance under SSI; others receiving cash assistance under Aid to Families with Dependent Children at state option; those who qualify as "medically needy"	Federal: HCFA/ HHS State: State Medicaid Agency	Nursing home care, home- and community-based health and social services, out-patient care, facilities for the mentally retarded, chronic care hospitals
Social Services Block Grant/Title XX of the Social Security Act	To assist families and individuals in maintaining self-sufficiency and independence	No federal requirements; state may require means tests	Federal: Office of Human Development Services/ HHS State: State Social Services or Human Resources Agency; other state agencies may administer part of Title XX funds for certain groups; for example, State Agency on Aging	Services provided at the state's discretion, may include long-term care
Older Americans Act	foster the development of a comprehensive and coordinated service system to serve the elderly	Persons 60 years and older; no means tests, but services are targeted to those with social or economic need	Federal: Administration on Aging/ Office of Human Development/ HHS State State Agency on Aging	Nutrition services, home- and community-based social services, protective services, and long-term care ombudsman
Supplemental Security Income/ Title XVI of the Social Security Act	To promote an income floor for the needy aged, blind, and disabled persons	Aged, blind, and disabled persons who meet federally established income and resources requirements; states may make payments to other state-defined eligibility groups	Federal: Social Security Administration/ HHS State: State supplemental payment program may be state or federally administered	SSI awards to persons in licensed rest homes may be retained by providers to help offset long-term care costs
Related veterans' health services	To provide health care services to eligible veterans	Eligibility varies by program: generally, veterans meeting certain services, disability, and/ or income criteria	Federal: Veterans Health Administration/ VA State: State veterans' agency for some programs	Nursing home, respite care, domiciliary care, hospital-based home care, adult day health care, and psychiatric care

Source: General Accounting Office 1993 Report. GAO/ HRD-93-22R, Massachusetts Long-Term Care

Chart 5

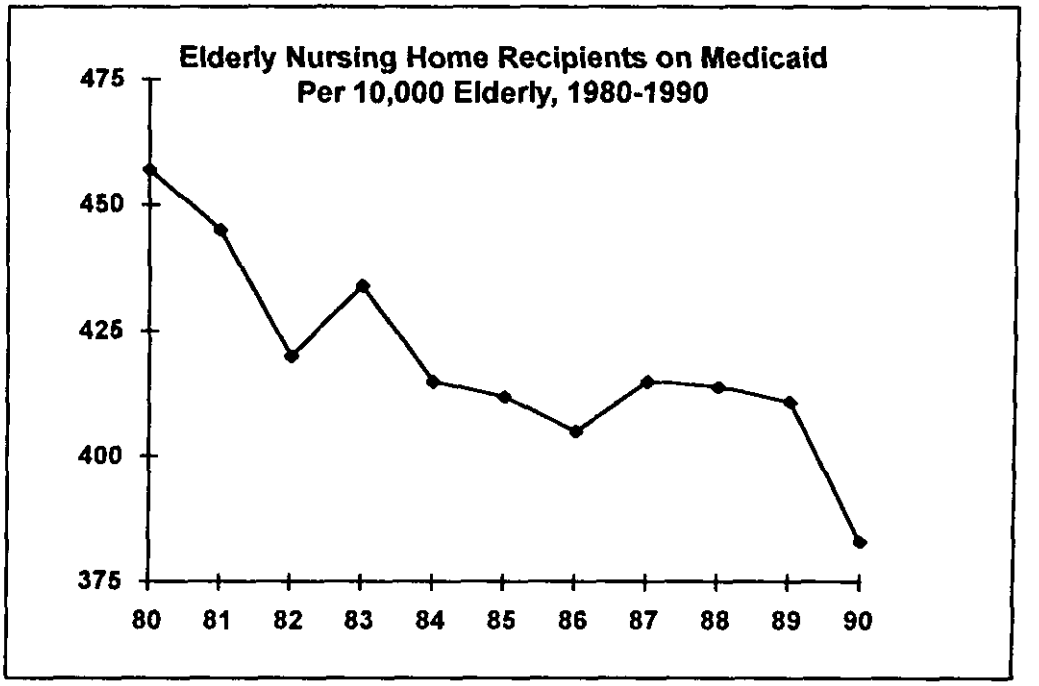
National Expenditures for Nursing Home Services, 1990



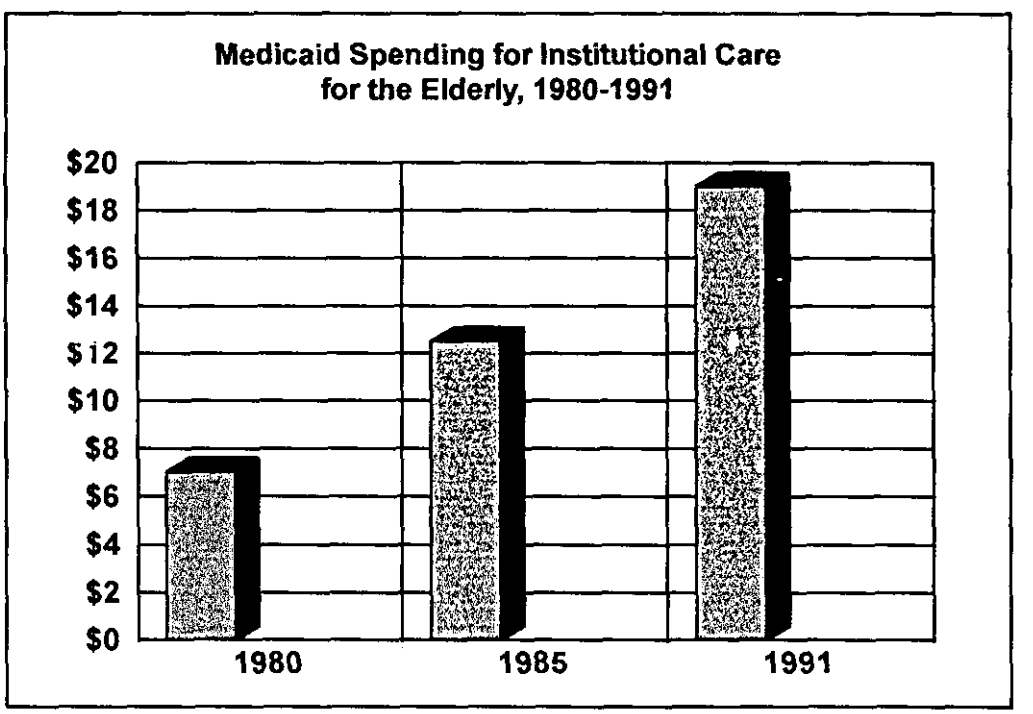
Source: Familiar Faces: The Status of America's Vulnerable Populations. Portland OR, 1992K. Levit et al., 1991

Chart 6

Number of Elderly Persons in Nursing Homes



Total Dollars for Institutional Care for the Elderly



Source: HCFA, Bureau of Data Management and Strategy. Familiar Faces: The Status of America's Vulnerable Populations. Portland OR, 1992K.

Chart 7

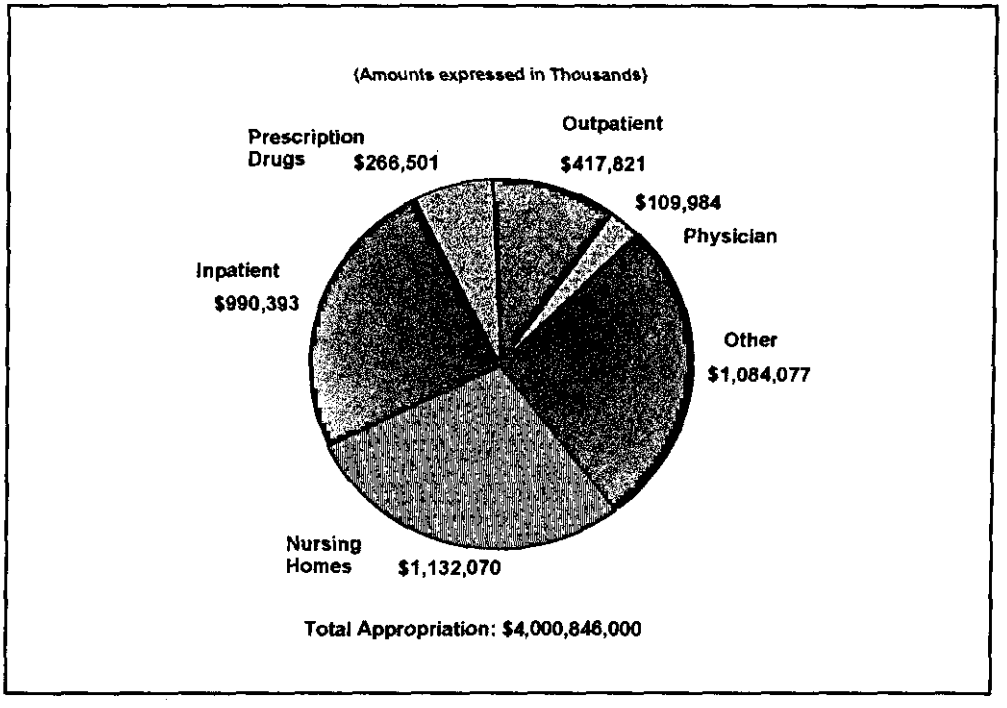
Public Expenditures for Vulnerable Populations - 1991

	Massachusetts	New Jersey	New York	Pennsylvania	U.S. Total
Federal SSDI Payments	$480.0	$584.4	$1,525.2	$1,012.8	$20,692.8
Federal SSI Payments	358.8	362.4	1,468.8	688.8	16.230.0
State Supplemental Payments	139.2	63.6	444.0	92.4	3,980.4
Medicaid Nursing Home Expenditures	1,150.3	836.2	3,345.5	1,073.8	20,798.8
Medicaid ICF-MR Expenditures	331.1	286.1	1,644.0	466.3	8,115.3
Medicaid Home Care Expenditures	236.2	230.4	1,914.0	143.8	4,746.6
Other State Spending for MR/DD Services	313.2	198.5	447.7	253.9	4,657.6
State Mental Health Expenditures	520.0	455.1	2,192.9	695.8	12,490.4
Total Federal/ State Spending	3,528.8	3,016.6	12,982.1	4,427.6	91,711.9
Total Federal	1,801.6	1,714.2	6,884.3	2,794.5	58,448.9
Total State	1,727.2	1,302.5	6,097.8	1,633.1	33,262.9
Spending Per Capita	596	386	727	368	367

Source: Familiar Faces: The Status of America's Vulnerable Populations. Portland OR, 1992.

Chart 8

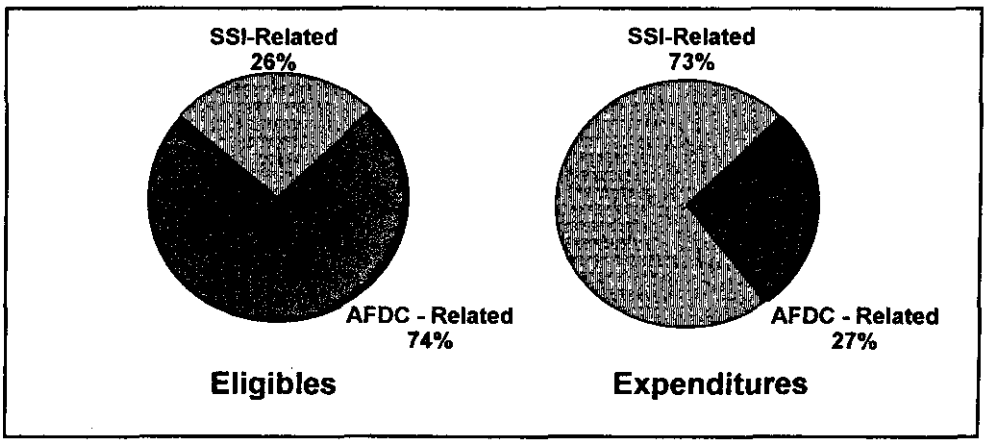
SFY 1994 Medicaid Benefits



Source: NJ SFY 1994 Appropriation Bill

Chart 9

MEDICAID ELIGIBLES VS. EXPENDITURES
by eligibility category - Federal Fiscal Year 1993



Source: New Jersey Medicaid

Chart 10

Overview of Division of Medical Assistance and Health Services Operations

Division of Medical Assistance and Health Services (DMAHS) is responsible for the administration of a number of programs which provide services to eligible New Jersey Residents. They include:

Federal/ State/ Casino Funded Medicaid Program

- **Regular Medicaid Program**
- **New Jersey Care . . . Special Medicaid Programs for Maternal and Child Health and for the Aged, Blind and Disabled, including the Medically Needy segment**
- **Statewide Respite Care Program**
- **HealthStart (with the Department of Health)**
- **Waiver Programs**
  - **Community Care Programs for the Elderly and Disabled (CCPED)**
  - **AIDS Community Care Alternatives Program (ACCAP)**
  - **Model Waivers I, II and III**

General State Funded/ Casino Revenue Funded

- **Pharmaceutical Assistance to the Aged and Disabled (PAAD)**

Casino Revenue Funded

- **Home Care Expansion Program (HCEP)**
- **Hearing Aid Assistance for the Aged and Disabled (HAAAD)**
- **Lifeline Programs (Utilities Assistance)**

The Division budget for FY'94 totals $4.32 Billion. Approximately 98.2% of these costs will go to benefits, .8% will go to salaries and 1% to administration.

Source: Department of Human Services., Division of Medical Assistance and Health Services

Chart 11

EXPENDITURES BY SERVICE AND COUNTY SFY 1993

COUNTY	ATLANTIC	BERGEN	BURLINGTON	CAMDEN	CAPE MAY	CUMBERLAND	ESSEX	GLOUCESTER	HUDSON	HUNTERDON	MERCER	MIDDLESEX	MONMOUTH	MORRIS
ACUTE CARE HOSPITAL	31,100,845	43,483,260	22,153,383	87,151,858	8,537,792	23,075,527	222,400,119	16,548,191	170,181,899	3,175,319	37,215,790	47,428,978	41,478,801	13,075,638
OTHER HOSPITAL	1,438,252	839,783	1,690,485	4,123,093	201,435	1,541,850	4,427,136	382,617	2,229,510	217,202	1,890,040	1,881,000	1,700,114	868,897
RES TREATMENT CENTER	822,734	968,308	1,037,136	3,019,517	472,203	530,170	5,158,833	846,182	3,882,799	348,145	1,267,208	1,294,000	3,023,783	477,501
INPATIENT MENTAL-GOVT	81,812	54,190	(4,363)	139,380	(868)	(4,312)	127,102	(8,684)	(223,719)	129,900	(123,593)	21,715	167,587	86,338
INPATIENT MENTAL-PVT	7,489	1,848,365	2,238	47,947	0	0	109,700	0	85,448	83,010	31,818	44,330	176,104	23,478
OUTPATIENT	8,082,501	11,088,840	7,824,871	18,803,980	2,215,275	8,855,493	80,572,313	4,149,338	38,882,752	1,352,852	18,087,344	22,571,789	17,724,684	7,784,718
ICF-MR	254,524	5,188,738	3,379,609	377,345	2,703,357	3,888,213	970,908	188,498	378,488	7,904,387	2,830,412	8,765,125	277,830	501,306
NURSING FACILITY	44,823,152	87,889,135	38,721,007	85,784,013	17,974,098	18,735,789	97,489,894	23,801,848	88,804,988	7,580,085	34,401,104	54,598,477	87,922,781	47,074,158
MENTAL CLINIC	1,519,082	4,325,047	3,123,573	4,079,678	336,871	585,052	3,992,488	857,535	2,280,477	72,484	2,189,782	820,382	1,481,789	470,618
OTHER CLINIC	1,708,038	372,878	870,051	2,325,591	224,645	1,218,304	3,305,276	320,887	2,059,782	14,887	1,545,516	1,408,954	807,834	147,991
OPTICAL APPLIANCES	128,815	113,814	115,409	395,787	45,027	149,948	782,902	90,850	739,818	7,101	181,810	185,391	187,284	49,705
PHYSICIAN	3,999,420	2,458,017	2,893,750	10,882,918	1,497,586	3,083,879	18,087,870	2,813,449	14,287,105	272,278	3,779,878	4,111,875	3,850,887	1,118,710
DENTAL	832,047	1,372,025	811,939	2,884,377	183,811	833,701	7,844,720	572,127	8,090,850	103,374	1,311,783	1,500,149	1,098,118	378,522
FREESTANDING ABC	84,303	105,879	52,803	276,457	17,039	25,182	799,655	38,574	385,904	5,851	153,281	155,314	87,227	24,659
OPTOMETRY	79,849	88,804	89,855	237,085	20,018	81,443	452,323	58,095	380,048	3,057	83,851	113,879	103,872	20,954
CHIROPRACTOR	8,448	28,700	12,480	37,178	5,043	12,849	51,755	18,071	89,365	3,814	14,678	18,850	20,379	5,872
PSYCHOLOGIST	12,550	40,933	38,097	74,882	8,124	17,173	312,479	20,980	71,941	9,332	80,110	88,258	58,134	25,085
PODIATRIST	81,825	58,538	48,888	348,124	15,851	48,415	411,491	42,879	318,784	7,488	88,384	54,218	88,827	42,081
PROSTHETICS & ORTHOTICS	220,000	205,738	108,740	298,444	75,810	94,811	164,480	58,889	713,904	38,441	188,034	183,993	210,895	144,776
MIDWIFERY	114,458	371	8	832	57,811	198,870	185,381	25,135	3,783	18,198	525	3,148	792	0
DRUGS-LTC	1,828,524	2,487,838	2,048,828	3,348,547	788,885	1,150,449	4,130,587	1,208,145	2,825,184	450,883	1,300,347	2,720,157	2,552,157	2,331,073
DRUGS-RETAIL	7,575,772	8,508,542	8,384,287	22,852,003	2,847,888	8,258,052	47,457,012	5,240,164	37,288,383	858,844	7,588,218	8,878,184	8,577,212	3,587,801
MEDICAL SUPPLIES	328,827	387,088	470,081	870,004	212,723	371,171	2,472,703	207,070	1,765,854	81,648	402,774	481,287	468,744	250,885
DURABLE MED EQUIPMENT	853,500	805,288	484,338	1,824,343	223,288	505,318	2,838,460	970,118	2,134,435	107,767	888,784	1,031,234	1,284,089	879,413
HEARING AID SERVICES	73,087	118,444	39,033	138,087	18,875	28,524	713,471	48,078	238,510	8,290	84,878	113,020	82,738	50,724
HOME HEALTH	2,951,487	8,634,817	3,082,744	8,139,498	504,532	830,102	10,732,393	4,217,815	15,048,238	388,002	3,299,779	2,873,484	4,258,887	1,078,990
HOSPICE CARE	0	850	88,304	53,288	0	18,488	70,142	1,140	5,851	4,548	5,810	8,802	172	1,808
LABORATORY	373,208	315,828	204,724	852,492	83,307	221,920	3,277,883	150,117	1,082,118	28,798	378,038	534,841	307,795	117,270
RADIOLOGY	442,924	289,838	312,731	945,865	166,868	333,855	2,384,508	274,181	1,788,724	50,054	482,089	847,411	337,788	128,812
TRANSPORT	813,052	883,042	322,300	1,150,898	118,818	509,002	15,884,788	270,208	4,728,408	82,218	1,084,885	1,013,075	838,818	864,765
MED DAY CARE	1,373,877	317,021	485,109	2,889,492	799,235	3,588,220	2,338,353	484,144	504,508	88	858,215	120,750	47,806	89,170
PERSONAL CARE	182,213	4,735,821	828,855	842,841	103,553	1,282,343	12,495,789	80,533	10,814,412	181,498	1,732,818	3,002,248	2,287,203	878,215
ABC WVR	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DDD WVR	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CCPED WVR	0	0	0	0	0	0	0	0	0	0	0	0	0	0
ACCAP WVR	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MODEL I	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MODEL II	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MODEL III	0	0	0	0	0	0	0	0	0	0	0	0	0	0
OSHP	271,550	128,702	472,481	8,184,074	32,793	42,847	15,735,845	92,888	871,477	13,035	83,290	4,784,849	141,190	101,298
PREPAID HEALTH	8	389	183,354	8,640	0	1,188	1,189	188,115	2,057,358	0	0	513	1,815	0
OTHER	278	887	132	183	55	28	1,459	12	71	181	35	187	282	15
HOME CARE EXPANSION	0	0	0	0	0	0	0	0	0	0	7,897,250	0	0	0
SFY 1993 SUB TOTAL	112,193,810	188,510,749	97,073,868	231,049,875	40,507,935	77,464,411	509,085,837	83,441,047	350,032,809	23,303,540	130,838,016	172,310,727	162,418,437	81,744,579
BUY IN - A	27,280	158,241	28,679	178,497	8,048	21,046	304,114	(2,858)	398,601	5,838	48,115	430,898	118,758	60,953
BUY IN - B	1,738,537	3,118,429	1,381,985	2,853,898	582,638	1,298,084	8,907,345	848,724	5,482,868	269,968	1,828,888	2,538,535	2,563,478	1,265,598
SFY 1993 TOTAL	113,958,627	189,788,419	98,482,532	234,181,875	41,078,621	78,781,521	575,997,298	84,388,809	355,912,078	23,578,344	132,717,017	175,277,980	165,099,673	83,071,070

COUNTY	OCEAN	PASSAIC	SALEM	SOMERSET	SUSSEX	UNION	WARREN	OA FIXED 66	INST	SPECIAL	WAIVERS	BEN HAGEDORN	RETRO ELIG	UNKNOWN	TOTAL
ACUTE CARE HOSPITAL	32,498,888	78,348,149	8,724,238	9,793,353	8,182,829	57,574,133	4,135,958	290,867	8,220,984	822,078	20,497,842	279,818	83,217,323	8,304	983,887,890
OTHER HOSPITAL	1,380,108	1,799,858	805,080	3,310,283	138,721	3,147,848	383,348	0	988,002	782,311	821,788	12,728	128,859	0	34,952,882
RES TREATMENT CENTER	2,822,788	1,118,147	328,348	877,808	435,098	7,081,880	430,817	(8,432)	0	8,824	8,378	0	0	0	31,187,284
INPATIENT MENTAL-GOVT	8,834	70,855	(851)	0	53,397	(7,971)	8,947	0	25,884,499	(84,831)	0	19,888	0	8,482	28,818,974
INPATIENT MENTAL-PVT	130,798	117,257	0	12,022	17,776	99,573	23,770	5,417	78	88	897	0	7,032	0	2,739,243
OUTPATIENT	13,258,180	29,181,738	2,708,439	5,381,874	3,818,089	20,749,954	1,882,343	179,903	2,314,712	337,148	3,851,123	115,518	711,141	3,284	338,384,244
ICF-MR	183,217	3,137,209	195,888	3,132,735	158,783	789,398	79,532	(34,714)	242,929,480	80,430	8,300	0	0	8,190	298,927,378
NURSING FACILITY	84,879,788	84,318,887	11,981,987	24,059,923	18,811,782	59,584,317	17,898,088	138,510	335,588	39,559	12,779	40,708	131,527	30,793	879,931,331
MENTAL CLINIC	1,240,722	7,421,442	315,870	331,498	48,508	2,465,748	885,423	10,924	880,388	118,110	318,083	1,771	11,128	8	33,811,384
OTHER CLINIC	808,814	1,830,288	158,120	443,841	105,874	1,519,510	80,558	13,454	8,094	14,111	298,399	818	4,873	341	20,731,332
OPTICAL APPLIANCES	147,387	348,317	47,857	29,785	18,499	209,237	27,338	2,243	7,453	8,410	25,778	299	171	19	3,998,331
PHYSICIAN	3,823,171	11,832,292	1,331,737	808,158	511,072	4,905,828	770,538	42,884	399,557	79,761	788,422	12,088	410,430	1,088	94,351,241
DENTAL	1,088,241	4,478,899	184,889	372,491	287,407	2,587,505	288,999	27,945	33,288	72,584	348,514	2,884	2,589	381	34,857,491
FREESTANDING ABC	87,133	278,172	8,721	35,420	10,419	154,856	10,084	1,044	282	0	2,285	0	81	0	2,768,341
OPTOMETRY	88,748	184,733	24,124	13,887	8,255	88,849	17,880	1,183	7,824	6,708	13,819	83	114	0	2,370,440
CHIROPRACTOR	43,914	48,298	1,683	7,543	4,331	12,958	150	0	7	812	1,054	18	8	0	458,445
PSYCHOLOGIST	72,273	95,803	4,851	48,125	39,577	88,411	8,512	872	5,391	12,823	84,954	0	111	0	1,260,351
PODIATRIST	88,884	148,408	21,379	18,481	14,559	73,044	7,889	584	19,168	22,104	83,151	132	487	87	2,087,204
															0
PROSTHETICS & ORTHOTICS	183,884	328,137	23,537	85,880	88,930	770,888	87,881	7,324	137,047	80,798	184,803	2,724	77	0	4,833,435
MIDWIFERY	28,288	2,228	4,842	211	0	85,121	11	1,734	0	88	0	0	339	0	710,817
DRUGS-LTC	3,882,774	2,814,889	884,448	1,040,857	1,120,154	2,350,188	889,883	8,030	13,840,488	380,040	180,398	3,887	4,143	90	88,309,128
DRUGS-RETAIL	7,038,315	23,170,083	2,185,719	2,419,798	1,489,638	12,080,593	1,480,755	49,009	298,718	834,818	8,757,748	82,437	23,172	4,078	238,839,219
MEDICAL SUPPLIES	430,488	838,843	83,188	148,454	89,184	548,378	81,808	7,128	19,271	724,019	3,042,098	837	4,459	1,871	14,349,714
DURABLE MED EQUIPMENT	1,428,853	1,218,891	178,732	428,544	182,178	1,215,307	155,408	3,207	1,188,874	134,288	1,824,851	7,474	25,708	1,834	72,227,728
HEARING AID SERVICES	63,481	149,584	8,448	38,978	20,435	117,114	5,499	835	18,643	7,348	48,887	100	934	0	1,700,541
HOME HEALTH	1,823,720	8,788,418	418,188	848,401	251,933	4,003,604	120,348	28,183	5,790	80,833	12,875,828	15,929	37,742	11,188	91,910,540
HOSPICE CARE	0	288	0	1,148	0	37,402	7,182	0	0	8	80,378	2,284	0	0	387,118
LABORATORY	251,857	1,830,239	180,502	87,090	43,597	522,598	82,789	5,807	408,788	48,484	139,527	1,283	12,089	47	12,473,092
RADIOLOGY	417,211	1,189,473	140,519	104,922	87,863	549,804	87,281	8,183	104,383	10,410	132,994	3,215	80,581	458	11,378,735
TRANSPORT	884,303	2,811,165	183,878	218,870	281,598	2,557,895	140,234	17,442	310,470	83,748	1,320,822	1,309	7,771	1,178	38,194,555
MED DAY CARE	298,203	488,538	144,891	21,583	1,828	445,408	0	3,941	18,590	100,331	2,748,185	0	44	0	18,451,334
PERSONAL CARE	1,848,874	8,402,081	114,847	271,113	238,385	1,274,753	281,704	7,857	227,940	8,214	1,880,874	48,804	8,222	10,247	80,348,591
ABC WVR	0	0	0	0	0	0	0	0	0	0	129,501	0	0	0	129,501
DDD WVR	0	0	0	0	0	0	0	0	0	0	98,840,019	0	0	41,345	98,881,364
CCPED WVR	0	0	0	0	0	0	0	0	0	0	22,211,398	0	0	0	22,211,398
ACCAP WVR	0	0	0	0	0	0	0	0	0	0	5,985,785	0	0	0	5,985,785
															0
MODEL I	0	0	0	0	0	0	0	0	0	0	50,490	0	0	0	50,490
MODEL II	0	0	0	0	0	0	0	0	0	0	191,504	0	0	0	191,504
MODEL III	0	0	0	0	0	0	0	0	0	0	14,223,239	0	0	0	14,223,239
OSHP	182,898	148,224	27,984	83,425	39,538	1,919,790	20,775	3,884	38,887	0	75,883	54	1,332	298,733	31,729,903
PREPAID HEALTH	0	0	0	0	0	513	0	1,784	15,298	0	0	0	0	73,128	2,534,247
OTHER	358	91	0	24	24	33	20	0	18	0	0	0	10	0	6,139
HOME CARE EXPANSION	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7,897,250
SFY 1993 SUB TOTAL	180,418,090	243,728,583	31,789,479	53,320,547	31,083,494	183,881,960	24,567,937	880,140	298,198,240	6,175,003	201,802,374	589,522	54,803,197	470,778	3,565,477,527
BUY IN - A	18,582	88,002	10,129	94,450	8,239	305,384	14,583	0	19,909	4,072	0	0	0	10,689	2,347,880
BUY IN - B	1,848,008	3,238,485	412,120	844,521	451,948	2,824,357	403,515	0	1,231,778	509,322	0	0	0	118,054	44,558,789
SFY 1993 TOTAL	182,383,877	247,055,070	32,187,721	54,259,518	31,523,681	186,811,701	24,985,615	880,140	297,449,928	6,688,397	201,802,374	589,523	54,803,197	599,521	3,612,376,956

Chart 12

New Jersey Medicaid Eligibles and Expenditures By Eligibility Category, SFY 1992, 1993

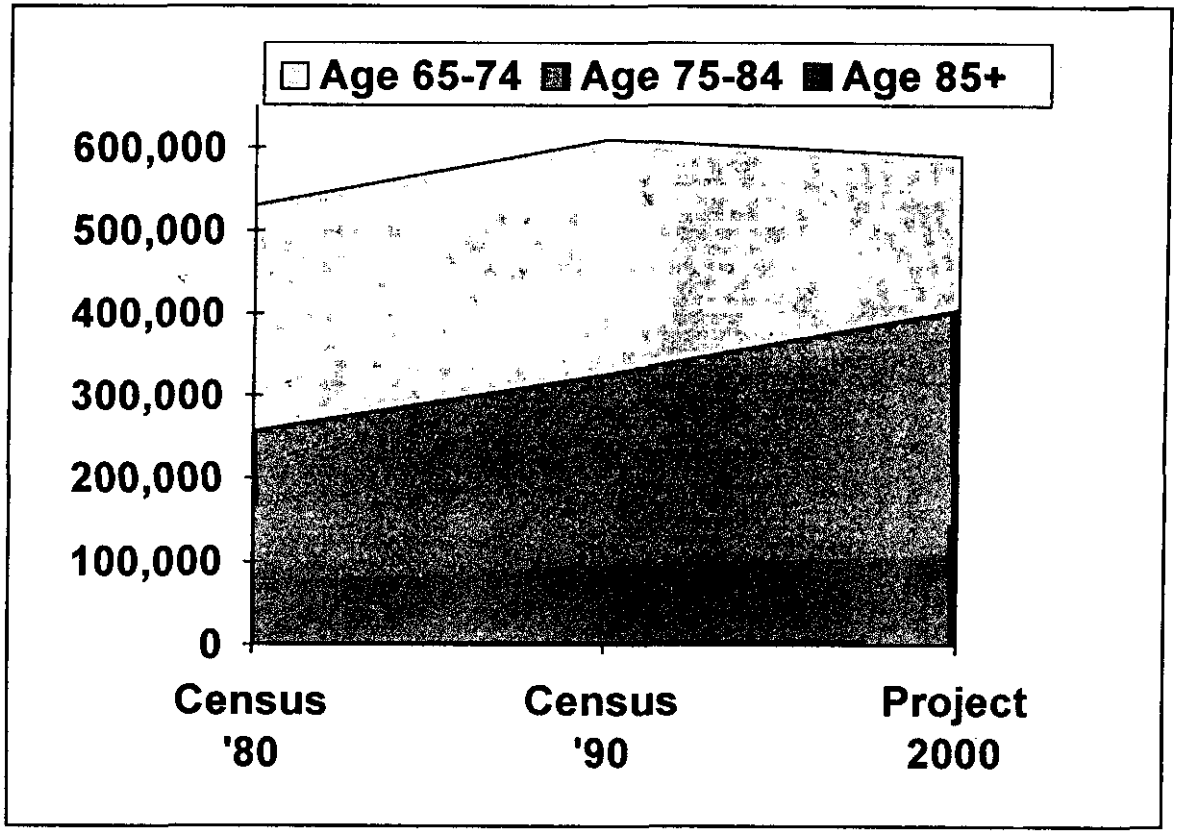
Category	Eligibles * 1992	Eligibles * 1993	Expenditures 1992	Expenditures 1993
AFDC	404,818	442,138	$641,660,672	$916,908,338
SSI-Related	149,383	164,760	1,619,082,071	2,122,873,818
Government Institutions (Total)	9,509	9,365	327,893,137	306,500,313
Aged	1,632	1,635	58,265,543	48,915,726
Disabled	7,524	7,442	248,736,416	242,574,062
Children	353	288	20,856,501	15,010,525
Developmental Disabilities (Community Living)	5,384	5,703	109,527,362	115,392,319
Medically Needy	2,495	2,985	3,139,593	4,660,746
Aged	43	60	117,807	195,974
Disabled	189	306	1,241,156	2,255,991
AFDC	2,262	2,615	1,777,209	2,205,294
Blind	1	4	3,421	3,487
Total for Categories Represented	571,589	624,951	2,701,302,835	3,466,335,534
Total for All Categories	604,094	659,997	2,756,852,609	3,557,777,964

* Eligibles - Annual average monthly number of Medicaid Eligibles. Currently, enrollment rate compared to eligibility rate was 60%

Source: *New Jersey Medicaid*

Chart 13

New Jersey Population Growth: 1980 - 2000
Age Groups 65 and Over

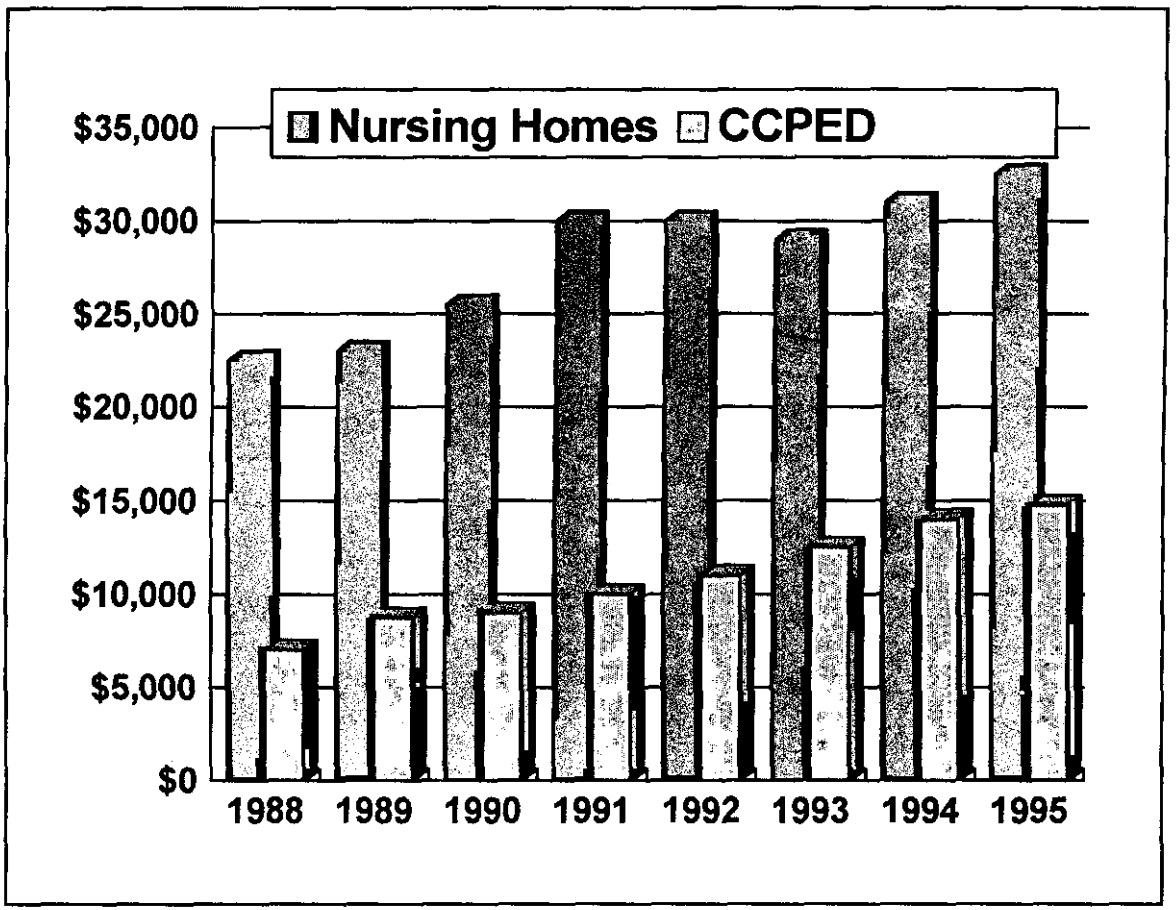


	Census '80	Census '90	Project 2000
Age 65-74	530,707	610,192	590,000
Age 75-84	256,833	326,286	405,100
Age 85+	72,231	95,547	106,900

Source: New Jersey Medicaid

Chart 14

Nursing Homes vs. Community Care Program for the Elderly and Disabled (CCPED)



Source: New Jersey Medicaid

Chart 15

Medicaid Payments for Long Term Care Services

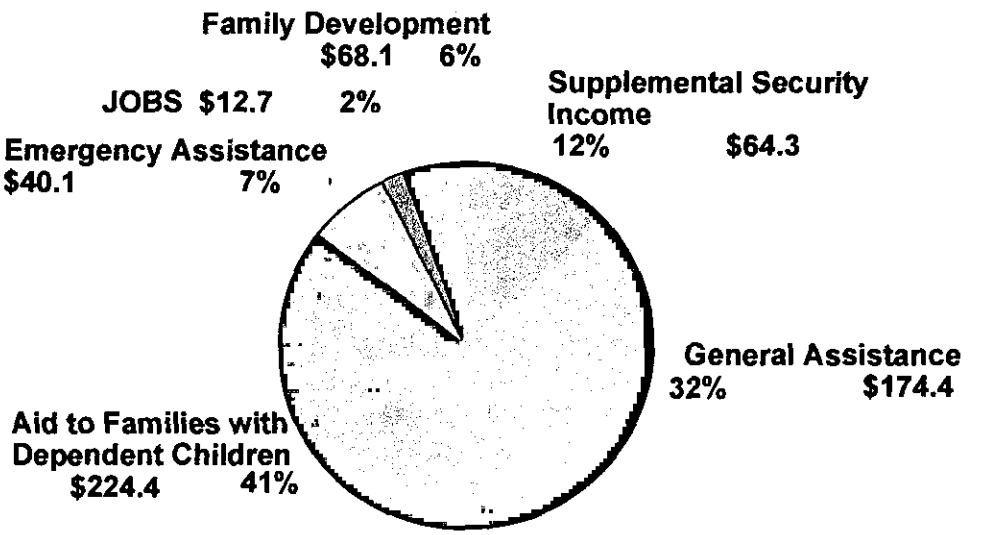
Year	Amount	Percent Increase
	Nursing Homes	
1991	$815,522,542	22.9%+ (fr 1990)
1993	929,931,331	14%+ (fr 1993)
	Community Care PED	
1991	$22,326,241	11.5% (1990)
1993	31,924,064	37%+ (1993)
	Medical Day Care	
1991	$10,141,945	23%+ (1990)
1993	16,451,334	62%+ (1991)
	Home Health	
1991	$58,221,208	12.5% (1990)
1993	91,510,540	57% (+1991)
	Model Waiver 3	
1991	$9,063,123	71%+ (1990)
1993	14,223,239	57%+ (1991)

Source: New Jersey Medicaid

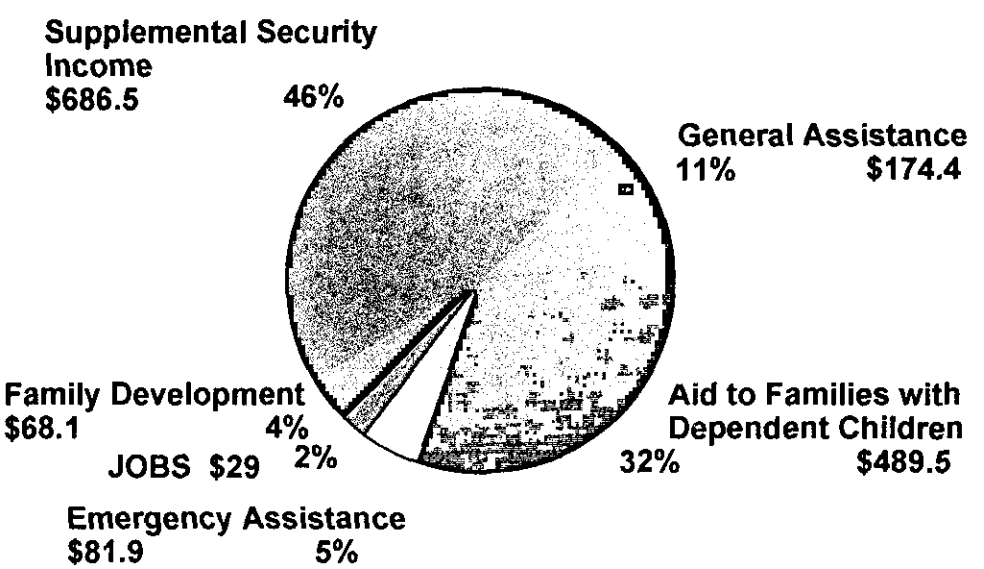
Chart 16

New Jersey Income Assistance Programs
FY 1994 Funding By Program (In Millions)

State Funds Only- $550.5



All Funds - $1,529.3



Source: New Jersey SFY Budget Book

Chart 17

New Jersey Medicaid Reimbursement and Rates System

Provider	Payment System	Rate Setting Entity	Cost - 1993
Nursing Home Services	Prospective per diem	Dept of Health - Office Facilities Rate Setting- Approved by DMAHS	$81.11 per diem
County Psychiatric Hospital	Interim per diem with	BC/BS/NJ Using Medicare Principles	$281.77 per diem
Hospital Inpatient Services	DRG	DMAHS	$515.71 avg. cost per day
Hospital Outpatient Services	Cost to charge or fee-for-service	DMAHS	$139.42 cost per visit
Physician Services	fee-for-service	DMAHS	$20.39 cost per visit
Prescription Drugs	Average wholesale price + fee - regression	DMAHS	$21.04 cost per prescription
Home Health Care	Reasonable costs	BC/BS United Wisconsin freestanding BC/BS/NJ - Hospital based	$63.17 per visit
Dental Services	Fee-For-Service	DMAHS	$88.39 per recipient

Chart 18

New Jersey Department of Human Services

Division of Medical Assistance and Health Services

1994 MONTHLY INCOME STANDARDS AND RESOURCE LEVELS
as of January 1, 1994

Family Size	AFDC (payment standard)		SSI		Medically Needy	
	Income	Resources	Income	Resources	Income	Resources
1	185	1,000	477.25	2,000	433	4,000
2	369	1,000	694.36	3,000	500	6,000
3	443	1,000			591	6,100
4	507	1,000			683	6,200
5	567	1,000			758	6,300
6	624	1,000			833	6,400

New Jersey Care - 1994								
Family Size	Aged, Blind, & Disabled 100% of Poverty Level		Pregnant Women and Children under the Age of 1 185% of Poverty Level		Children under the Age of 6 133% of Poverty Level		Children Born after 9/30/83 100% of Poverty Level	
	Income	Resources	Income	Resources	Income	Resources	Income	Resources
1	614	4,000	1,135		816		614	
2	820	6,000	1,517		1,091		820	
3			1,900		1,366		1,027	
4			2,282		1,641		1,234	
5			2,664		1,916		1,440	
6			3,047		2,191		1,647	

New Jersey Care resource limits apply only to aged, blind, and disabled individuals.
The income standard (Medicaid "cap") for long term care is $1,338.

FEDERAL POVERTY LEVELS (1994)

Family Size	100% Poverty Level		110% Poverty Level		133% Poverty Level		185% Poverty Level	
	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly
1	7,360	614	8,096	675	9,789	816	13,616	1,135
2	9,840	820	10,824	902	13,087	1,091	18,204	1,517
3	12,320	1,027			16,386	1,366	22,792	1,900
4	14,800	1,234			19,684	1,641	27,380	2,282
5	17,280	1,440			22,982	1,916	31,968	2,664
6	19,760	1,647			26,281	2,191	36,556	3,047

DMAHS/DEPD 2/25/94

Chart 19

New Jersey Department of Human Services
Division of Medical Assistance and Health Services

MEDICAID
1994 MONTHLY INCOME AND RESOURCE STANDARDS
Long Term Care and Home Care

Eligibility Category		Monthly Income	Resources
Supplemental Security Income (SSI)	Single	$477.25	$2,000
	Couple	$694.36	$3,000
New Jersey Care	Single	$614.00	$4,000
	Couple	$820.00	$6,000
Residential Health Care Facility (RHCF)	Single	$596.05	$2,000
	Couple	$1,173.36	$3,000
Nursing Facility (NF)	Single	$1,338.00	$2,000
	Couple	$2,676.00	$3,000
Community Care Program for the Elderly and Disabled (CCPED)	Single	Between $477.25 and $1,338.00	$2,000
	Couple	Between $694.36 and $2,676.00	$3,000
AIDS Community Care Alternatives Program (ACCAP)	Single	$1,338.00	$2,000
	Couple	$2,676.00	$3,000

HOME CARE EXPANSION PROGRAM
(not Medicaid)

	Annual Income	Resources
Single	$18,000	$15,000
Couple	$21,000	$15,000

DMAHS/OEPO 3/22/94

NEW JERSEY DEPARTMENT OF HUMAN SERVICES
Division of Medical Assistance and Health Services

Estimate: The Division provides some type of service to approximately one in eight New Jersey Residents.

REGULAR MEDICAID PROGRAM OVERVIEW

Who is eligible?

Medicaid reimburses providers for health care services provided to individuals whose income and resources are equal to or below the limits established for the program. They include:

- Those who receive cash assistance through programs such as Supplemental Security Income (SSI) or Aid to Families with Dependent Children (AFDC)
- Those with incomes at or near the Federal Poverty Level guidelines and who are not eligible for Medicaid benefits under a cash assistance program.
    - New Jersey Care...Special Medicaid Program
      1993 Income Standards: (see attached 1993 Monthly Income Standards and Resource Levels)
    - Medically Needy Program
- Children in foster homes
- Subsidized adoption and private child care institutions under auspices of Division of Youth and Family Services (DYFS)
- Persons in State and County psychiatric hospitals
- Persons in Intermediate Care Facilities for the Mentally Retarded
- Various refugee groups
- Persons who quality for Medical Assistance Only (MAO) (primarily in long-term care facilities)
- Persons eligible for home and community-based services under waivers
- Those with family members who require respite care in order to maintain the individual in the community

Worth Noting: Eligibility for Aged, Blind and Disabled growing significantly: A trend that is noteworthy in light of NJ's aging population. The Aged, Blind and Disabled, while comprising only 1/3rd of all program eligibles, account for nearly 3/4ths of all program costs.

NEW JERSEY MEDICAID (TITLE XIX) ELIGIBILITY GROUPS

MANDATORY & OPTIONAL ELIGIBILITY GROUPS

ELIGIBILITY GROUPS REQUIRED BY FEDERAL REGULATION:

- AFDC Recipients
- Non-recipients of AFDC benefits who are deemed to be AFDC recipients for Medicaid purposes
- Families that lose AFDC because of employment or loss of time-limited income disregards (benefits for 12 months)
- Individuals ineligible under AFDC because of requirements not applicable to Medicaid
- Individuals eligible for AFDC except for the 1972 Social Security increase
- Pregnant women who would be eligible for AFDC if the child was born
- Children born after 9/1/83 up to age 19 whose family income does not exceed 100% of the federal poverty level
- Pregnant women and children under six whose family income does not exceed 133% of the federal poverty level.
- Pregnant women during the presumptive eligibility period
- Women currently receiving Medicaid benefits for 60 days postpartum
- Newborn children of Medicaid-eligible women
- Infants and children who are receiving inpatient hospital services, but whose eligibility would end because of their age. (Eligibility continues only through the end of their hospital stay.)
- Recipients of SSI benefits
- Severely impaired blind or disabled individuals under age 65 who meet special eligibility requirements
- Disabled adult children who are at least 18 years old who meet special eligibility requirements
- Individuals ineligible for SSI or optional state supplements because of requirements inapplicable under Medicaid

- Spouses and couples who were eligible for Medicaid as of 12/31/73
- Institutionalized individuals who were eligible for Medicaid as of 12/31/73
- Blind or disabled individuals who were eligible for Medicaid as of 12/31/73
- Individuals eligible for SSI except for the Social Security increase in 1972
- Individuals eligible for SSI except for the Social Security increases after April 1977
- Individuals who lost SSI because of 1984 increases in their widow's or widower's disability benefits
- Individuals aged 60 or older who lose SSI upon obtaining early widow's or widower's benefits until they receive Medicare benefits
- Certain qualified Medicare beneficiaries (QMBs) whose income does not exceed 100% of the federal poverty level and whose assets do not exceed $4,000 (eligibility is limited to Medicare cost-sharing provisions).
- Specified Low Income Medicare Beneficiaries (SLIMBs) whose income is greater than 100% of the federal poverty level (FPL) but less than 110% FPL, and whose assets do not exceed $4,000 (eligibility is limited to Medicare Part B premiums).
- Certain qualified working disabled individuals (QWDIs) whose income does not exceed 200% of the federal poverty level and whose assets do not exceed $4,000 (eligibility is limited to payment of Medicare Part A premiums).
- Certain individuals who are eligible as a result of enrollment into health insurance coverage offered by an employer of an eligible individual in the household. (Benefits are for the individual's cost share of any such policy.)

MANDATORY ELIGIBLE GROUPS WHICH MUST BE IMPLEMENTED BY JANUARY 1, 1995

- Certain aged, blind or disabled individuals (SLIMBs) whose income does not exceed 120% of the federal poverty level and whose assets do not exceed $4,000 (eligibility is limited to payment of Part B premiums only).

OPTIONAL ELIGIBLE GROUPS COVERED IN NEW JERSEY

- Individuals eligible for AFDC or SSI assistance who have elected not to receive cash assistance.
- Individuals eligible for AFDC or SSI assistance except that they reside in an institution

- Individuals enrolled in federally qualified HMOs who lose their eligibility (for up to six months from their date of enrollment or reenrollment in the HMO)
- Individuals receiving home and community-based services under federal waivers, including ACCAP, CCPED, the Model Waivers, the ABC Waiver, and the waiver for the developmentally disabled
- Individuals who do not qualify for AFDC because they do not meet the definition of dependent children
- Children under adoption assistance agreements other than Title IV-E
- Individuals who could qualify for AFDC if AFDC were as broad as federally allowable
- Individuals who only receive optional state supplements under the SSI program
- Institutionalized individuals under a special income-eligibility level (much of the nursing home population is eligible as a result of this option)
- Poor, aged or disabled individuals whose income does not exceed 100% of the federal poverty level and whose assets do not exceed $4,000 (eligibility is for all Medicaid State Plan services)
- Medically Needy, including pregnant women, children and the aged, blind and disabled
- Pregnant women and infants up to age one whose family income does not exceed 185% of the federal poverty level
- Individuals not eligible in the community for Medicaid who would be eligible if they were institutionalized
- Terminally ill individuals who do not otherwise qualify but for the election of hospice services

OPTIONAL ELIGIBILITY GROUPS NOT COVERED UNDER THE NEW JERSEY MEDICAID PROGRAM

- Individuals who would be eligible for AFDC if their child care costs were not paid by a State agency
- Disabled children up to age 18 who would qualify for SSI if they were in a medical institution. (These children must require institutional care and it must be determined that home care is medically inappropriate for them.)
- Caretaker relatives under the Medically Needy Program

NJ RESIDENTS WHO ARE PRECLUDED BY FEDERAL STATUTE FROM MEDICAID ELIGIBILITY

- single adults (non-pregnant females)
- married adults with no children
- non-disabled adults
- families, aged and disabled individuals whose income and assets exceed the Medicaid income and assets standards

SERVICES PROVIDED

What benefits are received?

Full Medicaid benefits include these services:

- Physician
- Outpatient hospital
- Intermediate care facility for the mentally retarded
- Medical day care
- X-ray
- Podiatry
- Psychology
- Optometrist
- Prosthetics and orthotic
- Optical appliance
- Medical supply and equipment
- Hearing aid
- Pharmaceutical, including some over-the-counter medications
- Early and Periodic Screening, Diagnosis and Treatment
- Health Maintenance Organization (HMO)
- Inpatient hospital
- Nursing facility
- Inpatient psychiatric hospital
- Hospice
- Laboratory
- Medical transportation
- Chiropractor
- Clinic (including Federally Qualified Health Centers)
- Payment of premiums, co-insurance and deductibles for Medicare Parts A & B
- Dental
- Personal care
- Nurse-midwife
- Home health care
- Therapy

Not all of these services are received by persons in the Medically Needy segment, the waiver programs, and the respite care segment of Medicaid.

Medically Needy option:

- Benefits for pregnant women and children, the aged, blind and disabled
  - Income too high to qualify for regular Medicaid program
  - Excessive unpaid medical bills
- Spend-down feature to reduce income to prescribed eligibility limit

HealthStart program:

- Provides an enhanced package of Medicaid benefits to
  - Eligible pregnant women including coverage for 60 days following delivery or date pregnancy ends
  - children up to two years of age
- Package includes
  - Case management of health care of mother and unborn child
  - Nutritional counseling
  - Help with keeping appointments for preventive health care of child

Income and Resource Limits

See Chart of 1994 Monthly Income Standards and Resource Levels (attached).

Eligibility Determinations:

- Generally processed by County Welfare Agencies/Boards of Social Services
- Exceptions
  - Presumptive eligibility determination for some services for pregnant women by selected Medicaid providers

MEDICAID WAIVERS

New Jersey's Medicaid Waiver Program

Community Care Program for the Elderly and Disabled (CCPED)

In operation since 1983, CCPED offers a package of services that includes home health care, medical day care and medical transportation, plus case management and other assistance services. There are specific income and asset standards for eligibles. The program is in operation in all counties, with 2,900 slots as of March 1993. As of June 30, 1993, 11,664 people were served through the program and 2,635 are currently active. State Fiscal Year 1993 expenditures for CCPED were $31,934,064. While the average cost for Medicaid nursing home recipients was close to $30,000 per year in 1993, the average cost for CCPED recipients was approximately $12,523 (See Section I, Data Book, "Nursing Homes vs. CCPED, Cost per Recipient").

Home and Community-Based Services Waivers for Blind or Disabled Children and Adults (Model Waivers I, II and III)

Each of the Model Waivers became effective in the mid-1980s. The Model Waiver programs offer, with the exception of nursing facility services, all New Jersey Medicaid services, plus case management. They encourage the use of community-based services for people who need long term institutional care. Model Waiver III also offers private-duty nursing, meaning individual and continuous care limited to a maximum of 16 hours per day per person. There are varying eligibility requirements for the Model Waivers; eligibles must be blind or disabled children and adults. Model Waivers I and II each serve a maximum of 50 people; Model Waiver III services a maximum of 150 people. 1993 Medicaid spending for Model Waivers I, II and III totaled $14,465,233, with 98 percent of the total expended on Model Waiver III program services.

AIDS Community Care Alternatives Program (AACAP)

This statewide home and community-based services waiver, in operation since 1987, was the first of its kind in the country. A 1992 Health Care Financing Review report, "New Jersey's Medicaid Waiver for Acquired Immunodeficiency Syndrome," reports that as a result of improved therapeutics and extended survival of people with AIDS, treatment of individuals with HIV disease is shifting from the acute care inpatient hospital setting to outpatient and community-based modalities (Merzel et al. 1992). The report's major findings indicate lower hospital costs and hospital utilization by waiver participants. Average program expenditures were $2,400 per person per month. As of June 30, 1993, approximately 841 individuals are being served. Since 1987, approximately 3,494 total people have been served in the program. New Jersey's experience with AACAP has show that case management is a critical service available through the waiver program, resulting from the complex medical and health services needs for people with AIDS and the necessity of having a case manager coordinate and facilitate access to services.

Other Medicaid Home and Community-Based Waivers

There are several other waiver programs initiated recently in New Jersey, which include: the Home and Community-Based Wavier for Medically Fragile Children (The ABC Program), prepared by the Division of Youth and Family Services with assistance by Medicaid; and the Home and Community-Based Services Waiver for Persons with Traumatic Brain Injuries (TBI Waiver) which provides a community alternative for brain-injured individuals

Other Medicaid Community-Based Programs

As discussed earlier, Medicaid also oversees (through New Jersey Casino Revenue funds), the Home Care Expansion Program (P.L. 1988, c. 92), to offer home care services to elderly and disabled individuals who are at risk of institutionalization and whose income and resources exceed the financial limits or Medicaid or the CCPED. There are 550 slots available statewide. Medicaid also administers the Statewide Respite Care Program (P.L. 1987, c. 119) in operation since April 1988, which has been state-only funded since October 1, 1992. Its purpose is to provide respite services for elderly and functionally impaired individuals to relieve their unpaid caregivers. There is a maximum service cap of $3,000 per year, with a maximum allotment of 21 days per year in a licensed medical facility.

GLOSSARY

GLOSSARY of CHRONIC and LONG-TERM CARE WORDS and PHRASES

The Glossary is adapted and reproduced from *"Familiar Faces. The Status of America's Vulnerable Populations. A Chartbook."* Center for Vulnerable Populations. Portland, Maine 1992.

GLOSSARY: (Please note—issues of regulation, payment and accreditation are primarily institutional, hence the focus of this glossary is primarily institutional.)

ELIGIBILITY

Asset spend-down: The depletion of a privately paying nursing home resident's assets to the level at which the resident reaches the Medicaid threshold for eligibility (generally and in New Jersey $2,000 for a single individual). Not to be confused with "income spend-down." Medicaid applicants must meet both income and asset criteria in order to be eligible for Medicaid coverage.

Spend-down: Process of depleting income and assets in paying for medical care until a person is impoverished and eligible for Medicaid.

Spousal impoverishment rules: Rule protecting the income and resources of the community residing spouse of an institutionalized husband/wife from being included in the resources available for paying for the institutionalized spouse's nursing home stay and determining the institutionalized spouse's eligibility for Medicaid. As of July 1, 1992, monthly income totaling 150% of the federal poverty level is reserved for the community dwelling spouse, and must be subtracted from the income deemed available for paying nursing home expenses. Also, the community spouse is entitled to protect between $12,000 and $60,000 in non-exempt assets (actual amount of State's discretion) for him/herself which sum cannot be used in determining Medicaid eligibility for the institutionalized spouse.

Transfer of assets: Process whereby individuals divest of their assets typically by giving them to family members either directly or by establishing trusts in order to protect their assets from having to be spent down in order to qualify for Medicaid in the event they require institutionalization in a long-term care facility.

MEDICAL CARE AND SOCIAL SERVICES

Ambulatory care: Medical services that are provided on an outpatient (non-hospitalized) basis. Services may include diagnosis, treatment, and rehabilitation.

Acute care: Medical services provided usually at a hospital in response to a disease which is characterized by a single episode of a fairly short duration from which a patient returns to his or her normal or previous state and level of activity.

Activities of Daily Living (ADLs): Activities such as bathing, dressing, eating, mobility, toileting, and including meal preparation, light housework, grocery shopping, medication management, using transportation or using a telephone.

Case manager: Typically a social worker or nurse who is responsible for assessing and reassessing a client's needs, overseeing the coordination of services provided, and assuring that services provided meet program standards.

Community based services: Refers to medical and other essential and supportive services that are usually located in a community setting and promote health and independence while addressing the health needs of the individual.

Developmental disability: A severe chronic condition that is first manifested in childhood (prior to age 22), is likely to continue indefinitely, results in substantial functional limitations in areas of major life activity, and reflects a need for care, treatments, or services of an extended duration. Persons with mental retardation are developmentally disabled, but there are other persons with developmental disabilities who do not have mental retardation, such as persons with autism, cerebral palsy, and epilepsy.

Long-term care: The continuum of broad ranged maintenance and health services to people with chronic illness, disabilities, or mental illness. Services may be provided on an inpatient (rehabilitation facility, nursing home, mental hospital), outpatient, or at home basis.

Personal care: Two definitions of this term are commonly used. Generically, personal care refers to "hands on" care (e.g. bathing, dressing, toileting assistance) provided to individuals who cannot perform activities of daily living independently. Under the Medicaid program, "personal care" is also a specific service which States can choose to include as part of their State Medicaid plan. Under Medicaid, "personal care services" are defined as services provided in an individual's own home where treatment is authorized by a physician in accordance with a plan of treatment by someone who is qualified to perform the service, under the supervision of a registered nurse, and not a member of the recipient's family.

Personal needs allowance: The amount of income which nursing home (or ICF-MR) residents are allowed to retain under the Medicaid program for meeting personal maintenance needs (e.g. clothing, toiletries). By Federal law, the personal needs allowance must be at least $30 per month, although States may set higher allowances if they choose to. Medicaid recipients in nursing homes must contribute all of their income above the personal needs allowance toward the cost of their nursing home care.

Respite care: Overnight care furnished in a Medicaid certified institution or in a residential facility in which payment is made for room and board. Purpose is to provide care to elderly person or persons with mental retardation so that the primary caretaker(s) (usually the family) can rest.

Skilled care: Service under a physician's order that:

(1) requires skills of qualified technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, or speech pathologists.

(2) must be provided directly or under the supervision of these skilled personnel to assume the safety of the individual and achieve the desired result.

SNF — Skilled nursing facility: Facility which provides skilled nursing care and related services or rehabilitation services. Services provided are similar to those provided to hospital inpatients but at a lower level of care.

Supported living: A model of services for persons with mental retardation/developmental disabilities in which the recipient lives in his or her own home and receives supportive services on an intermittent basis as needed. Also places strong emphasis on allowing recipients to make more of their own decisions about where to live, what services they receive and how they spend their time.

FACILITIES/SETTINGS

Alternate delivery systems: Health services provided in other than institutions (e.g., inpatient acute care hospital, nursing homes, emergency rooms). Examples included skilled and intermediate nursing facilities in place of the hospital, hospice programs, home health care, community based and a variety of supportive services.

Assisted living: A program design that combines housing, supportive services, including personal care, supervision, activities and some health services in an environment that is home-like and supports individual choice and decision making.

CCRC: Continuing Care Retirement Community: Organizations formed to provide older persons with services that may be needed as they age and become more dependent. These communities typically provide housing, meals, recreational activities, and health services. They usually include a licensed and certified nursing facility which residents may enter if the need arises. A subset of CCRCs also have a long-term insurance component in which entrance fees are partially used as lump sum premium payments for long-term nursing home coverage. Other CCRCs offer nursing home care on a "pay as you go" basis. There are approximately 700 CCRCs in operation nationwide, housing about 35 to 40,000 nursing home beds.

Certification: Process of determining whether nursing facilities meet conditions of participation in the Medicaid and/or Medicare programs. Certification is generally conducted by State public health agencies, under Federal guidelines.

Group home: A residential facility (usually for persons with mental retardation) in which a number of persons (usually 3-15) live together, generally with 24 hour supervision.

ICF-Intermediate Care Facility: Prior to 1990, a Medicaid certified nursing home which supplies health-related services to individuals who do not require the intensity of treatment which a hospital or Skilled Nursing Facility (SNF) is designed to provide, but who require care and services above the level of room and board because of their mental or physical condition. The ICF categorization of nursing homes was terminated in 1990, when Medicaid ICFs and SNFs were combined into a single category (Nursing Facilities) with uniform conditions of participation for all facilities.

Level of care: The functioning level required to be eligible for coverage by a third party payer such as Medicare or Medicaid. For example, the "level of care" requirement for Medicare SNF coverage includes a need for daily skilled nursing care or therapy. Medicaid "level of care" requirements vary across States.

Nursing homes: Institutions which are primarily engaged in providing nursing and related services to residents who require medical or nursing care or rehabilitation services. Nursing homes are licensed under State law, and most facilities which are licensed as nursing homes are also certified to participate in the Medicare and/or Medicaid programs. Licensed nursing homes

which do not participate in Medicare or Medicaid generally cater to relatively wealthy individuals who pay for their care entirely through private resources.

Public Hospital/Public Institution: An acute, chronic, or rehabilitation hospital, nursing home or inpatient health facility that is owned by the federal, state, county, or local government. Public institutions were established to serve American Indians, merchant seamen, veterans, military personnel, patients with tuberculosis, the poor, and persons who are mentally ill, retarded, aged and disabled.

Room and board charge: The component of the total nursing home charge that covers the non-service costs of operating the facility. In some nursing homes, the "room and board" charge is a separately distinguishable charge from nursing and other ancillary charges. In other nursing homes, the room and board charge is not disaggregated and is simply reflected in the total facility charge.

State veterans homes: State veterans homes are owned and operated by state governments for the use of veterans. The Federal VA provides initial construction/capital subsidies and a flat per diem payment for each day of care. In at least some states, veterans in these homes must supplement the per diem paid by the VA from private resources or from Medicare or Medicaid coverage. In other states, a portion of the difference may be paid from a state appropriation.

VA owned homes: The VA owned homes are operated by the VA medical centers and are not Medicare or Medicaid certified. There are no charges, payments, or costs recorded for an individual patient's car.

INSURANCE—FINANCING

Capitation: A method of payment for health services in which a physician, hospital or other provider is paid on a fixed amount for each person served or enrolled regardless of the actual number of services provided to each person.

Federal Financial Participation (FFP): The rate at which the Federal Government reimburses a State for the cost of services eligible for coverage under Medicaid. This rate varies by State, according to State per capita income, from a minimum of 50% to a maximum of 83%.

HCFA: Health Care Financing Administration. Part of department of Health and Human Services. Responsible for administration of the Medicare and Medicaid programs.

Indemnity payment: Insurance benefits paid in a predetermined amount for a covered event. Many private long-term care insurance policies do not pay a "daily rate" for nursing home care, but an indemnity payment directly to the policyholder (e.g. $100 per day) regardless of the cost of the basic daily charge in nursing home where the policy holder is receiving care.

Long-term care insurance: An insurance policy which pays for long-term nursing home care according to benefit criteria established under each individual policy. Most policies require receipt of service before payment is made (e.g. most long-term care insurance policies do not pay benefits unless the policy holder is admitted to a nursing home). A few policies have benefit criteria based on disability criteria, regardless of whether the policy holder has been admitted to a nursing home or not. Some policies also provide coverage of home care services.

Managed care: Health care systems that integrate the financing and delivery of appropriate health care services to covered individuals by arrangements with selected providers to furnish a comprehensive set of health care services, explicit standards for selection of health care providers, formal programs for ongoing quality assurance utilization review, and significant financial and/or other incentives for members to use providers associated with the plan.

Medi-gap insurance: Supplemental private insurance which pays an individual's copayments and deductibles under Medicare. More expensive policies may also pay for the costs of some services not covered by Medicare, most notable outpatient prescription drugs. The cost of this coverage varies, depending on the age of the beneficiary and the scope of coverage (costs from $500 to $1,300 per year). Most elderly Medicare enrollees not eligible for Medicaid have Medi-gap insurance.

Per diem rate: Rate charged by facilities to cover room, board, and basic nursing care. "Basic charge," "daily rate" and "per diem" rate are closely related terms which are often used interchangeably.

Pre-existing condition: An insurance term for the physical and/or mental condition of a person which first manifested itself prior to the issuance of a health insurance policy or which existed prior to issuance and for which treatment was received.

Social Security: Typically refers to retirement insurance paid to workers attaining retirement age (62 or older) or to income security payments to a disabled worker under age 65. Spouses of insured retired or disabled workers, under certain conditions, are also eligible for benefits, as are dependents. Surviving spouses and dependent parents of deceased insured workers, under certain age and dependency categories, are also eligible for benefits. Benefit amounts are based on workers' accumulated "quarters of coverage" and the amount of payments made into the system.

SSDI—Social Security Disability Insurance: A social insurance program authorized under the Social Security Act which provides income to insured workers under age 65 who become disabled, and their dependents. Disability benefits are only payable to individuals who have sufficient quarters of coverage in jobs covered by Social Security. Individuals who receive SSDI benefits are also eligible for Medicare coverage, after a two-year waiting period.

SSI—Supplemental Security Income: A program of cash assistance for low income aged, blind, and disabled persons, established by Title XVI of the Society Security Act. Unlike the Social Security Disability Insurance, SSI is available to persons age 18 and over whether or not they have ever been employed (if they meet SSI income and asset criteria) automatically eligible for Medicaid coverage.

Uncompensated care: This term refers to health care services that are provided by hospitals for individuals who are unable to pay for all or a part of those services because of their income level. Usually these individuals have no insurance, or have deductibles or copayments in their insurance plans. Some states have organized systems to pay for uncompensated care.

VA: Department of Veterans Affairs. Administers pension and medical benefits to military veterans.

Income cap state: A state which has an income ceiling above which individuals cannot qualify for Medicaid nursing home coverage even if the cost of their medical expenses would qualify them for Medicaid under the medically needy option. This income ceiling can be set anywhere up to 300% of the Federal SSI benefit level ($1,422 in 1992). In 1992, 19 States were "income cap" States and 31 were "medically needy" States in regard to eligibility rules for nursing home coverage. New Jersey's income cap in 1994 is $1,338 for a single individual and $2,676 for a couple.

Income spend down: A method by which an individual establishes Medicaid eligibility by reducing his or her gross income through medical expenses until net income (after medical expenses) meets Medicaid financial requirements. For Medicaid recipients in nursing homes, "income spend down" refers to the amount of income which the recipient contributes to the cost of his or her care, after which Medicaid will pay the balance of the Medicaid allowed charge. In general, nursing home recipients must contribute all countable income (after allowable deductions such as contributions to a community spouse) above the personal needs allowance as their "income spend down." Also referred to as the "recipient contribution amount." Not the same as "asset spend down" which refers to the spending of assets prior to the point at which nursing home residents become eligible for Medicaid.

Medicaid Title XIX: A program under the Social Security Act, funded jointly by the Federal government and the States, which provides medical assistance to the poor. To be eligible for Medicaid coverage, applicants must meet both categorical (group) and financial (income assets) criteria. Persons receiving AFDC or SSI benefits are automatically eligible for Medicaid in most States, although other persons not receiving cash assistance from AFDC or SSI can also be eligible for Medicaid. Although coverage of some groups is mandatory under Federal law, States have considerable discretion in covering other groups, and setting financial criteria, at their option. Thus, specific Medicaid eligibility criteria may vary from State to State.

Medically needy state: A State which offers Medicaid coverage to those persons whose medical expenses reduce their income to below their state's medically needy threshold. In regard to nursing home coverage, medically needy State's provide coverage to persons with incomes below the Medicaid nursing home reimbursement rate (provided the recipient also meets Medicaid asset criteria). Medically needy States are distinct from "income cap" States, which limit Medicaid eligibility in nursing homes to persons below a specific institutional income standard.

Medicaid payment rate: Amount paid by Medicaid to a specific nursing home for eligible patients. Covers room, board, and nursing care and may cover some or all ancillary services not billed to Medicare (e.g. therapy). By Federal law, the Medicaid reimbursement rate must be "reasonable and adequate to meet the costs of efficiently and economically operated facilities." Specific rate setting methods under Medicaid vary considerable from state to state. Also may be referred to as the Medicaid reimbursement rate.

Waiver-Medicaid: Allows states to receive Federal Medicaid funds for services not otherwise covered by Medicaid. The Medicaid waiver program has provided a mechanism to finance alternative services which in some instances are more flexibly tailored to the individual needs of persons who need residential and other supportive services. A state must receive Federal approval for a waiver.