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

before

SUBCOMMITTEE ON HEALTH CARE COSTS
of the
SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE

Held:
December 15, 1980
Room 223
State House
Trenton, New Jersey

MEMBER OF SUBCOMMITTEE PRESENT:

Senator William J. Hamilton, Jr. (Chairman)

ALSO:
Eleanor Seel, Research Associate
Office of Legislative Services
Aide, Senate Institutions, Health and Welfare Committee

* * * *

I N D E X

- - - -

SENATOR WILLIAM J. HAMILTON, JR. (Chairman): Good morning. I would like to thank all of you for being here and also for your patience in bearing with me as I took care of some other matters.

Many of you who were with us at the earlier meeting of our subcommittee are aware of the general areas of interest of this subcommittee. I don't think a long opening statement is necessary. But at our September 4th hearing, the subcommittee heard testimony concerning the scope and extent of health care insurance coverage in the areas in which further government and insurance industry involvement may be needed. We have received from many of you who testified at that hearing the additional materials that you indicated would be sent to us.

Today the subcommittee will look at existing health care resources; that is, State and local government health programs and the funds that support those programs. We are interested in determining what programs exist, who pays for them, do any of the programs overlap, what more can be done at the current level of funding - that is, can any funds be reallocated or services be organized or provided differently? We want to know what resources we have in the health care area. We want to know how they are being extended. We want to know whether they can be leveraged for any greater effect. We want to know what the effects are of increases or changes in those various programs and those various resources.

Without any further preliminary, we have a number of you who have been asked to appear here today. Of course, if others have a contribution to make, we will be happy to hear them.

Let me say what I said at the outset of the earlier hearing. We are not starting with answers; we are starting with questions. We hope that with this session and one or two more we may be in a position to start formulating some conclusions, hopefully, for legislative action; and, if not legislative action, other action.

With that, I would like to call on Dr. Koplin who is Deputy Commissioner in the Department of Health. I understand, Dr. Koplin, you are prepared to take us through the flow with respect to the Department of Health.

D R. A L L E N N. K O P L I N: Thank you very much, Senator.

I have here a couple of documents I would like to give you. This is a general breakdown of all the problematic descriptions in our budget by state and federal funds.

This document is a shorter document which refers more specifically to those programs that might be considered in the scope of health care. Many of the things, as you know, involve inspections of hospitals and licensure and also sanitrary inspections of many institutions. We have many educational and preventive activities that are not, strictly speaking, in the care area. But these programs listed here - there are nine of them - are more directly related to care.

SENATOR HAMILTON: We will have both of these marked as exhibits, if you will; and, certainly as attachments to today's hearing.

(Exhibits submitted by Dr. Koplin can be found in the appendix to this hearing.)

DR. KOPLIN: As you probably realize, in the national scene and in most states, the amount of money and the programmatic services that are attributable to a health department represent a very small share of the total health enterprises in the United States. The total health expenditures in this country are up in the

200 - 250 billion dollar bracket. I think, in 1979, the figure was $212 billion. Of that total, the total public health expenditure for departments like ours nationally is less than 3 percent. So we are not really in a very large business of providing health care compared to the national picture.

Secondly, those programs were we do mount some health care services must be looked at, and these figures must be looked at, in terms of something more than simply paying the bill for the services because it is our responsibility under federal and state laws usually to develop a delivery system in terms of quality. For example, in the Crippled Children's Program, which is a very old program in the United States, this State contributes, as you see in that short list, Senator, about $2 million a year for the care of children with various kinds of congenital and other defects, primarily orthopedic defects, and the federal government contributes about a million and a half dollars. That $3.6 million program is a care program that dates back 60 or 70 years, almost since the days when the original Social Security Act was passed. But, in providing those funds and in that budget, there are staff who deal with institutions in terms of contract where certain standards of performance are required. This Crippled Children's Program pioneered in the early days in terms of the training and qualifications of physicians that would provide services for these children. They talked about American Board certification for orthopedic surgeons long before we ever heard of medical audit or PSRO or utilization review and the current crop of quality control systems.

What I am saying is that we do not just provide care in any of these programs. We have staff who develop networking, who develop standards for the care. We do something, frankly, that is not done quite as well in the general health enterprise in this country. All of these programs which you see have similar flavor; the renal program, the hemophilia program have a review of quality and an establishment of standards as part of what we do.

Another thing we do is keep data on all of these programs and we have quality reviews and as well are concerned with outreach. In other words, we have social workers and nurses who can assist in bridging the gap between the patient's needs at home and the patient's needs in the hospital and the patient's needs in the clinic.

The main thrust of my statement is that the moneys noted here for care carry with them a great deal of delivery system, coordination, management, quality development, etc.

I think, if you will notice, the communicable diseases are still with us to a degree. Tuberculosis has not been resolved in this country or this state. We, therefore, have a fairly substantial appropriation from the State for tuberculosis control. This too, as I mentioned previously, involves the establishment of clinics and standards for therapy and for followup. This has to be done very carefully because contacts of tuberculosis patients have to be followed and have to be put under therapy to halt the chain and the spread of the disease.

SENATOR HAMILTON: How is that service delivered, Doctor?

DR. KOPLIN: We have about five regional locations in the State of New Jersey and we normally work in a hospital or in a local health department. We place our staff and merge our staff with local staff. The law requires reporting of tuberculosis when it is diagnosed. Our incentive - and we have about 1,000 cases

a year that are diagnozed --- and our immediate action there is to place the patient under modern clinical therapy to prevent spread of the disease, to make the patient noncommunicable. Then we work back through the patient's contacts, to the family, people who work with the individual, and attempt to place everyone under care so that the chain of spread is limited. We have fairly good success now with tuberculosis. Most of the patients are managed on an out-patient basis. Fortunately, we don't have to have the big hospital program we once used to have because we are nipping the disease in the bud most of the time.

SENATOR HAMILTON: Do many of these $2.2 million represent actual payment of medical expenses incurred by persons who are detected as having tuberculosis or is that, for the lack of a better word, what I would call support money; that is, the detection system and the referral system?

DR. KOPLIN: No, some of it actually pays for medication, which is part of health care. Up to this year, we were paying for hospitalization. About $200 thousand a year was spent during 1980 for those serious patients who needed to be treated in a hospital. You know that is really a tremendous reduction compared to what we used to spend for a tuberculosis hospital years ago. I think you are familiar with the Glen Gardner Hospital. Most of the states have gone through the process of closing TB hospitals because of our successes. This year, we are not paying for hospitalization because of other budgetary constrains and also because this was really a kind of last resort payment. We required that the patient exhaust every possible other opportunity through Medicaid insurance or whatever. Now, we are ceasing that payment and we are hopeful that this can become part of the normal coverage that is provided through third parties or the hospital can be reimbursed through its reimbursement system.

SENATOR HAMILTON: What you are really saying is that of these end-of-year figures that are just over $2.2 million, the .2 was the actual reimbursement for hospital expenses of tubercular patients?

DR. KOPLIN: That is correct.

SENATOR HAMILTON: Can you quantify at all the amount for medication?

DR. KOPLIN: It is somewhere in the neighborhood of $200 thousand a year.

SENATOR HAMILTON: Another $200 thousand?

DR. KOPLIN: Yes.

SENATOR HAMILTON: And that will continue in this fiscal year?

DR. KOPLIN: That will continue.

SENATOR HAMILTON: I gather you are going to run down some of these categories and I am going to let you do that. But if you skip over one that I want to ask you some questions about, I am going to stop you and we will back around, all right?

DR. KOPLIN: Okay. The Chronic Diseases Program is a small program that basically is involved with the training of home health aides - there is about $30 or $40 thousand in that - to give them greater familiarity with chronic diseases and with patients who are homebound. We have a very strong program in this State of home health services.

SENATOR HAMILTON: How do you define chronic diseases?

DR. KOPLIN: Well, something that persists for many, many years, usually.

SENATOR HAMILTON: Who are those health aides being furnished to at this point in time?

DR. KOPLIN: These are independent agencies. There are 25 or so home health agencies in the State of New Jersey and about a similar number of homemaker organizations, both of which work in the home. Let's say you have a patient who is elderly and has heart disease and requires medication many times a day and other sorts of attention in the home. We make an effort to assist these independent agencies to help these people so that they can manage at home. We train their families so they can give them medication. Of course, this is all done under medical supervision. But it is sort of a long-range supervision; that is, the physicians don't very often go to the home and do this kind of thing any longer.

SENATOR HAMILTON: Last fiscal year, you spent about $197 thousand in that way.

DR. KOPLIN: Yes, sir.

SENATOR HAMILTON: You have tools of measurement that you use in terms of showing in a rough sort of a way cost effectiveness. How many people were served or what other measuring tools do you use with respect to that particular program?

DR. KOPLIN: Through those agencies, I think the number is in the tens of thousands that they are serving. I must say that we don't have cost effectiveness tools like we wish we had. That is a gap. We know, however, that the service - and this is more or less anedoctal - is very useful and is called upon a great deal, especially the homemakers that can come into a home and keep the home running where the mother or the father is left to their own devices and cannot manage to arrange for the marketing, the cleaning up, etc. And we know that the nursing attention that is provided through the home health agencies - there are trained nurses who go in and bathe the patient and see that they are taking the medicine properly and notify the physician if there any change that he needs to be aware of - is an extremely valuable service to the State of New Jersey.

SENATOR HAMILTON: Doctor, I know you have been before the full I.H.&W. Committee. I don't know if you have ever been before it when we have talked about this area. If you haven't been, then you would not be aware that on the Committee there are at least two members and probably more who have a very real interest in seeing this expanded, but who would like to have at the same time the best kind of measurement tools that can be had. In other words, you have $134 thousand in State funds. Were that to be doubled - an unlikely occurrence at this point in time - how many people are you going to serve by doubling it and how would it be expended? I don't expect you to have the answer to that. But merely to say in tens of thousands, that means one thing. If it is $10 thousand, it means another thing. If it is $90 thousand, how many daily contacts might that be? I don't know what the measurement tools ought to be. But they are the kind of things that, at least, some members of the Legislature do look for in terms of trying to see where health dollars ought to be expended. So if we could get any further data on that out of your particular section, we would certainly appreciate it.

DR. KOPLIN: The reason I was sort of vague is that my staff mentioned just before I left - and we were really not certain which of these specific items we would have to know in that detail - something about 62 thousand. And I am not certain what that means. I was reluctant to be specific.

SENATOR HAMILTON: --- whether that means one visit or what?

DR. KOPLIN: I don't know whether it is 62 thousand visitsor 62 thousand people. I am a little doubtful of the figure. Therefore, I didn't quote it to you. But I will find out for you.

SENATOR HAMILTON: What is the next area you are going to go into, Doctor?

DR. KOPLIN: The Cardiovascular and Diabetes Program. That involves our major effort to control hypertension. As you see, it is primarily through federal funds. This is a national program which has been found very useful, promoting subcontracts with health departments, primarily local health departments, whereby there is an intensified screening of patients and taking of blood pressure. It is being done now in all kinds of clinical settings, not only physicians' offices but in family planning clinics, dental offices, etc. Everyone is very sensitive to this problem because one of the major causes of heart disease and mortality from heart disease, which is our number one cause of death, is related to hypertension. Fortunately, we are controlling hypertension because of this program. This is one of the best things that this country and this State have ever done.

SENATOR HAMILTON: The State is making what could very truly be said to be a modest effort in that regard if your figures are correct.

DR. KOPLIN: Well, that is true.

SENATOR HAMILTON: $1,000 - but I am not here to be critical of that. I am here to get an understanding. I was not going to stop at Cardiovascular and Diabetes.

DR. KOPLIN: It is not as though the program could not be expanded. Frankly, the federal government has gone so fast and furiously in this direction because it is one of the best tools we have that we really haven't needed to rely on the State at this point.

SENATOR HAMILTON: I am going to go next to Crippled Children, but anything you have in between, you will have an opportunity to comment on.

DR. KOPLIN: I mentioned the Crippled Children's Program earlier. As I said, we supplied your overall Senate Committee last year, Senator, a listing of all the kinds of conditions that are treated through the Crippled Children's Program and the agencies - something like 25 or 30 hospitals who participate in the outpatient clinics, etc. I would be glad to provide any further details you want. What this really involves is finding the children early that are handicapped so they can be placed under treatment. And a great deal has been accomplished in that program, especially with the locomotor-orthopedic difficulties, cardiac difficulties, etc.

SENATOR HAMILTON: What do these state and federal funds of $3.6 million support? Do they support clinics?

DR. KOPLIN: Clinics, hospital care, treatment.

SENATOR HAMILTON: Is that again after the exhaustion of other sources?

DR. KOPLIN: Yes, it is. It does not duplicate, as far as I can tell - and we have looked at this very carefully because you asked us that question once before --- it does not duplicate what is being done by other State agencies or that can be done in the private agencies.

SENATOR HAMILTON: What part of that 3.6 is for reimbursement of medical expenses?

DR. KOPLIN: I would say it is 90 percent medical expenses. Part of it is staff for us. In other words, we have some staff.

SENATOR HAMILTON: Ninety percent out of the $3.6 million or something in the order of over $3 million is actual payment of ---

DR. KOPLIN: No. If you want to pin me down to that figure , I will have

to give it to you.

SENATOR HAMILTON: I don't want you to be exact.

DR. KOPLIN: Our staff component is very small compared to our payment for services. It is historically a very old and very successful program. When these children come through us they move into the hands of the best qualified physicians available: neurosurgeons, psychiatrists and other kinds of people who look at the various aspects of their problems. Orthopedic surgeons figure very prominently, specialists in internal medicine, cardiology and some family physicians.

SENATOR HAMILTON: Are the payments you make to institutions or to individual providers like physicians?

DR. KOPLIN: We have both. We are moving now toward a contractual relationship so that we can have an advance economic commitment to and from those providers and have some idea as to what we are getting into as far as our total expenditure is concerned. We are moving away from individual payments where we can accomplish this and we are getting a great deal of cooperation. This is a kind of a cost containment system of its own.

SENATOR HAMILTON: I wasn't paying enough attention. Tell me again what you are moving toward?

DR. KOPLIN: Instead of just opening the doors to well qualified people and having bills come to us, we kind of make an advanced contract, say, with a specialist or with a group of specialists and say, "We will establish a fiscal amount of money that we will make available to you as a kind of a stipend or a contract." If the physicians feel this is satisfactory, they accept this. It has an element of prepayment to it and cost containment as a result. It is less open-ended than it used to be.

SENATOR HAMILTON: The non-state funds do not necessarily imply federal funds.

DR. KOPLIN: Yes.

SENATOR HAMILTON: In this particular program is that federal funds?

DR. KOPLIN: Yes.

SENATOR HAMILTON: Is that geared at all to the State contribution or is the figure arrived at in some other fashion?

DR. KOPLIN: There is a matching requirement. I don't remember exactly what it is. But we are more than able to justify matching from the federal government. We are spending more than the federal.

SENATOR HAMILTON: The direction you are going now is advanced purchase of services?

DR. KOPLIN: Yes.

SENATOR HAMILTON: On a regional basis?

DR. KOPLIN: No. It does spread out all over the State because of the need for accessibility. But it is primarily related to the quality of the resources available. And, fortunately, there are good resources available all over the State.

SENATOR HAMILTON: So we do have fairly good coverage?

DR. KOPLIN: Yes. And if you like, I could give a list of all of the hospitals and the providers. We aren't shortchanging any sections. It is primarily because of accessibility. It is very difficult to expect children to be transported great distances for follow-up care.

SENATOR HAMILTON: I don't want to cut you out of anything you want to say, but I would go next to Hemophilia and Renal.

DR. KOPLIN: These are State mandated programs. The Hemophilia Program is one in which we provide some 500 hemophiliacs with blood products, the things that they need to allow the blood to clot. We focus our attention there on two evaluation centers. One is at Rutgers Medical School and the other is at St. Michaels Hospital in Newark where they have specialized staff, as I mentioned earlier, who are interested and qualified to evaluate these patients. These blood products are established in depots around the State so that it doesn't require, after the patient has been evaluated in these two centers --- it doesn't require that they travel back and forth to Newark or to Rutgers in order to obtain these medications.

It is a very important service. I don't know how blood products are covered by Blue Cross and other insurance in the State. I know that what we purchase in this program amounts to about - let's see - I think it is about five or six hundred thousand of that total. It is roughly about half of that total. We screen these patients for other coverage. In other words, we are the last resort; and if they have eligibility anywhere else, we, of course, encourage them to use it and we will not pay. But most of these patients are those who fall through the cracks and don't have any coverage.

SENATOR HAMILTON: But there is no income qualifier ---

DR. KOPLIN: Yes, there is.

SENATOR HAMILTON: --- it is only if there is other coverage?

DR. KOPLIN: Well, no, there is income coverage as well.

SENATOR HAMILTON: Now, this is almost totally a State program. It is about five years old. I think I was in the Legislature when we started it. There is no other way to pick this up; it has to be categorical?

DR. KOPLIN: In some states, it might be paid through third parties. As I say, unfortunately, I don't know how extensive the insurance policies are. Perhaps someone from the insurance industry can indicate that.

SENATOR HAMILTON: We can ask them.

DR. KOPLIN: If they do cover it, of course, that would be an added resource. That would come from a different source.

Now, the Renal Program is a really tough problem in this country. I don't know whether you realize it, Senator, but this country is spending a billion dollars a year on the dialysis program. It is a very highly charged situation because, without dialysis, people die. There is no question about it. We have tried and the federal government has tried to move the dialysis program from the hospital-based, out-patient dialysis program, which costs something like $40,000 a year per patient, to the home-based. It is a difficult thing to do, but we are having some success. In other words, dialysis patients instead of going to an institution where costs have to be very high, after they have been stabilized, can have the dialysis apparatus in their homes; and with the training of their families and with visits from Visiting Nurses or other people, they can maintain themselves on dialysis at home.

SENATOR HAMILTON: The cost differential is what, if you can establish that?

DR. KOPLIN: I think it is less than half if you can do it at home.

SENATOR HAMILTON: How much of this $1.5 million is renal as opposed to hemophilia?

DR. KOPLIN: In 1980, there was about $700,000 of that in the renal.

This year we are asking for a little bit less because we think we have been successful in developing more of the out-patient dialysis. We are shooting for 20 percent out-patient dialysis , a very, very difficult job. You realize, of course, that this is only a small part of the cost of care because the majority of this comes through Medicare. These patients only come in for State assistance in the first three months when they are not eligible for Medicare. Then we pay some of the co-insurance. So Medicare really has the bulk of the program.

Here again we are involved in the establishment of resources. We determine where the patients can best be sent and attempt to develop some surveillance of that whole renal network. It is a pretty good one in the State.

SENATOR HAMILTON: I would move next to Treatment and Rehabilitation. But, again, I would give you the opportunity to comment on anything that is at an earlier part of your listing.

DR. KOPLIN: Well, VD is still with us and we are beginning to have some effect on that program. It is going to continue I am afraid for quite a long time. Fortunately, we are able to detect VD a lot easier. And, once we get the people under care, the therapy is effective - mostly effective. We are beginning to see a little drop in the State of New Jersey which we are very proud of. We hope to do more of that.

You mentioned Treatment and Rehabilitation, Senator.

SENATOR HAMILTON: What does that include?

DR. KOPLIN: That is the drug treatment. The word "drug" has been left off of that. That is our major approach to drug abuse in the State.

SENATOR HAMILTON: State Support for Public General Hospitals.

DR. KOPLIN: There you have me over into Mr. Wagner's area. I think you know this is part of --- Mr. Hubb is here with me.

SENATOR HAMILTON: Jersey City Medical Center and Bergen Pines, I assume.

MR. JAMES HUB: That's right.

SENATOR HAMILTON: And this was a new program in, I think, 1977?

MR. HUB: Right.

SENATOR HAMILTON: What was the initial appropriation?

DR. KOPKIN: Do you know?

MR. HUB: No, I don't offhand.

SENATOR HAMILTON: Is that geared into any quota or is that just a statutory amount?

MR. HUB: That is a formula.

SENATOR HAMILTON: Will you furnish us with a copy of the calculations for this year?

MR. HUB: Certainly.

SENATOR HAMILTON: Are those the only two hospitals that are now eligible?

MR. HUB: To my knowledge, yes, Senator.

SENATOR HAMILTON: And that is not because of any fiscal data; it is because of the descriptive data, I believe, that is in the bill; is that correct?

MR. HUB: Yes.

SENATOR HAMILTON: Public, general hospital and maybe one other qualifier in there that narrows it down to Bergen Pines and to Jersey City?

MR. HUB: Public and general hospital. I am not familiar with the other, but I will find that out for you.

SENATOR HAMILTON: Public Health Priority Funds.

DR. KOPLIN: That is the program that we administer in order to improve local health department activities. The law provides that health departments with responsibility for 25,000 population and over may be assisted in the provision of services in the chronically ill, in the maternal and child health area and in the communicable disease area. This program has been working rather well. We distribute this money according to applications we receive from each of the health departments. Although there are 567 municipalities with health responsibilities in this State, under the public health priority funding, we have been able to give some assistance to them in terms of amalgamation of resources, merging of resources.

SENATOR HAMILTON: Is this a grant type thing that you are doing?

DR. KOPLIN: Yes. And we have about 110 individual grants on the public health priority funding. So there has been that degree of amalgamation and the 567 becomes 110 and probably ought to be no more than 20 or 30 the way our State is arrayed in terms of population. It is a small amount of money. It is not really enough to do the job because of the fact that these local health departments in this State probably spend more like $70 million on their on. So, in some parts of the State, our funding helps as an incentive, but it is a very small percentage of their activity. We have asked the Governor's Office and the Legislature from time to time for more money. We have not been too successful in obtaining it. It would improve local health a great deal if we could accomplish that.

SENATOR HAMILTON: Both the State support for public general hospitals and public health priority funds have no non-state dollars.

DR. KOPLIN: That's right.

SENATOR HAMILTON: And virtually every other program you have here has some non-state funds, frequently far in excess of the State contributions, sometimes less.

DR. KOPLIN: I must qualify that, Senator. These local health departments who receive these public health priority funding ---

SENATOR HAMILTON: --- have their own funding.

DR. KOPLIN: And they also get grants. In other words, I mentioned the Hypertension Program. Some of that hypertension money may be going to these local health departments. Cancer control funds and other federal funds that go out on a project contract basis, there are a good many of those that go to local health departments.

SENATOR HAMILTON: But they are funneled through another program.

Let's go back up to Maternal and Child Health. There is a small amount of State funds and a large amount - almost $19 million - of, I assume, federal funds.

DR. KOPLIN: Yes.

SENATOR HAMILTON: What activities does that cover?

DR. KOPLIN: That is kind of the original legislation passed in this country to approach the problem of women and children and their health. The program is broken down into several pieces. One part of that is family planning - a large part of that - something near $5 million, I think.

SENATOR HAMILTON: It looks like you have that broken out just above it on this list though as a separate item.

DR. KOPLIN: Which list?

SENATOR HAMILTON: On the long list. You have almost $5.9 million under non-state funds under Family Planning and almost $19 million on Maternal and Child Health.

DR. KOPLIN: Let me back up. There are two Family Planning sources of support. Under Maternal and Child Health, there is Title 5 support, which I believe comes to something over a million dollars. This figure you are looking at under Family Planning, I believe is Title 10 and Title 20. There are three programs providing family planning support through the federal government: 5, 10 and 20. This includes the Title 5, which is basically public health funding. Some part of that is Family Planning. Another part of it is the support for Well Baby Clinics around the State. Another part is called Maternal Infant Care Program, which may run into something over a million dollars, which is the provision of services for high-risk mothers and children. That is provided through --- I am trying to remember which one of the hospitals. I will pick that up in just a minute.

Also in that, there is a provision for aiding children and youth. We are required under that Act to provide what is known as a program of projects. We have to provide dental health services. We have to provide maternal and infant care. These are all as sort of a demonstration. We have to provide infant intensive care and family planning.

SENATOR HAMILTON: What do the moneys actually purchase under the Maternal and Child Health Program?

DR. KOPLIN: In the Maternal and Infant Care Program, they pay for pre-natal care and delivery services for about a thousand women. That money is spent --- I am just going to have to look this up. The Medical School in Newark has 900 women under care and we spend about a million dollars a year to provide those services. These are people who are not qualified for any other program.

In the Children and Youth Program, I don't have the amount of money that is involved. But that is paid to the St. Joseph's Hospital in Paterson for doing pediatric care for children.

Some of the money to the Medical School goes for infant intensive care.

The Dental Health Program is mentioned separately. So that would not be included.

The Family Planning amount, I don't know exactly. I haven't added up to $18 million, I realize. I am trying to remember where the rest of that is, Senator. The WIC Program is the explanation. The WIC Program is $16 million of this total. I didn't think it was in this because this year the WIC Program was over $20 million. It is our largest single program. It stands for Women - Infant - Children. Essentially, it provides food for indigent pregnant women and their children up to age 5. This is a national program that is financed through the U. S. Department of Agriculture. We have contracts with local health departments who have subcontracts with groceries and other food stores. These women are entitled to receive this food.

In addition to that, a part of the program involves nutritional advice and medical examination. Every child and woman must have a health examination before they qualify. It is a very, very large federal program.

SENATOR HAMILTON: How old is that program?

DR. KOPLIN: I think it is about five or six years old.

SENATOR HAMILTON: Very honestly, I am surprised to find it in your department as opposed to Human Services.

DR. KOPLIN: Well, because it has a nutritional component, it is in health departments generally. You will find it discussed, Senator, when they talk about food stamps and food. It has been discussed recently at the national level in that context. The new administration is looking at the food stamp program, as you know, and they are looking at the WIC Program, because I think you are talking about six or seven hundred million dollars a year at the federal level. We receive about 4 percent of that, usually about twenty million dollars.

We look at it more as a health program because it gives us an opportunity to get these people under medical care - medical evaluation - and they are constantly in the program. They keep coming back for this food and we can see that they obtain adequate nutritional advice and health services.

SENATOR HAMILTON: Is this actual dollars or is it some sort of scrip?

DR. KOPLIN: They get a voucher and they take this to the food store, the grocery chain, or whatever it is, and we receive the bill from the chain.

SENATOR HAMILTON: This is an instance of direct payment to the consumer, if you will, as are a few of the other situations where you are talking about hospital costs or medical costs. Those are really going to the providers in any event, aren't they?

DR. KOPLIN: Yes. I don't think we have very many examples of this type where the consumer receives something directly from us, with which to purchase something else. I think this is an exception to the rest of them. I am glad you mentioned that because I just couldn't figure out where I was getting with all these dollars.

Anything else on this list, Senator?

SENATOR HAMILTON: Yes. Which of those non-state funds are likely, in your best judgment, to change dramatically up or down in the near term?

DR. KOPLIN: Some of them already have. This list I gave you is 1980. The first one has already changed down. The EMS Program at the federal level was very good to us. We were able to buy a lot of radios and communications equipment and do some things for a lot of counties all over the State for a few years, also to train a lot of emergency medical technicians and paramedics. That figure for this year - that $1.3 million is $300,000.

The anti-inflation budget balancing budget of Mr. Carter, as of April 1st, proposed to eliminate this program in a year or two, and cut it drastically. I don't know what will happen to it, but my hunch is - and it is a strong one - that there won't be any federal money in this program in a couple of years.

SENATOR HAMILTON: Which other ones are going to undergo dramatic change one way or another?

DR. KOPLIN: Several of these have already this year. The TB Program - there is $580,000 in that program. There are several others on this list that were funded by Health Incentive Grants - 314 B. I think we wrote you about that. I don't remember whether we wrote you directly. But we have been working to offset a cutback of that national program in the same budget-cutting exercise that I mentioned earlier by Mr. Carter. There was $68 million in that program for fiscal '80; for this year, it was cut to zero. So we were faced with some $1.8 million of federal funds, after our budget went through all the processes in this State, that were removed from us. Part of that TB money was in there. There were some of our inspection programs in consumer health. The laboratory was involved. Actually, about 100 vital positions in various parts of our department were affected. What

we had to do was to re-evaluate how we were going to live with that kind of a cut-back. As a result of our taking a hard look at all of the programs, we actually reorganized and we eliminated a number of things we were doing. Some things we were not too happy about. But there were some things that we could live without and we wound up having to lay off 36 people of that 100. We saved the rest of them, not in the same functions they were engaged in. That is when we decided more rapidly than perhaps we might have that we didn't need the tuberculosis hospitalization fund any longer. We let that come through the reimbursement system. And we cut back on some of the Crippled Children's money because we thought we could live without a couple of hundred thousand there. I have a complete description of what we did if you would like to have it. We wound up shifting people into other functions and saving about two-thirds of those folks that were jeopardized. That was one tough job.

SENATOR HAMILTON: Since that is information you already have, I think we would like to see it.

I would like to ask one other thing that I am sure you don't have now and I wouldn't want to take the time for you to go down this list. But if we could get on the non-state funds some designation - another copy of this - indicating which are entitlement funds and which are grant funds that you have applied for, I think it would be helpful.

As you may know, Doctor, from our overall charge, there are two things that we will ultimately get around to looking at. One is what we can get from the Medically Needy Program and also what it would cost to implement some form of catastrophic illness program. In very general terms, without going line by line, going first to Medically Needy, if we had such a program at a reasonably substantial level, would it be possible to not commit to you - or commit to you under a different category - some of the State funds or non-State funds that are on this list to providers?

DR. KOPLIN: If you had a Medically Needy Program, it depends on the service component, the scope of the program. In other words, if the program covered the renal-diseased patients I mentioned earlier, if it covered the hemophelia products, I presume except for the delivery system which we think needs to be looked at very carefully - and this, of course, would require some adjustments in State law - that is a possibility. I don't know. I really haven't given any thought to it.

SENATOR HAMILTON: Would it jeopardize our receipt of the non-State funds' portion, recognizing we can do what we want to in terms of appropriating State dollars, but we don't have the same leeway necessarily with the federal dollars?

DR. KOPLIN: That is true. In some programs, it might do that, possibly in Family Planning, possibly in some of the Maternal and Child Health Programs. But, as you can see from this list, there are very few programs where we are actually involved in direct care. Since on the national level - I don't know what it is on the State level, but it is probably around the same proportion - we are only about 2 or 3 percent of the total health budget, I must say you are not going to save an awful lot.

SENATOR HAMILTON: No, but we are told that we could get a fairly substantial Medically Needy Program for a total of $40 million, which would require the expenditure of $20 million of State funds. If we were able to generate five to ten of that at a savings in State funds here, it would be a tremendous start toward

such a program if it were concluded on a broad base that that was desirable and necessary.

DR. KOPLIN: Let me just comment that the $40 million I have to assume ---

SENATOR HAMILTON: That may be low.

DR. KOPLIN: --- that is correct. Somehow for medical care, it sounds very small. But some of the rest of you know that better than I.

In this non-state fund column, if you subtracted $16 million for WIC, which you would not cover by a Medically Needy Program since it is payment for food primarily, you would see what was left. If you removed about half of the Tuberculosis --- Wait a minute. I am looking at the wrong column. I guess it is the $6 million column I should be looking at. Yes, there is about a million and a half dollars in the Renal and Hemophilia Program and some funds in the Tuberculosis Program. Of course, we have cut part of those. That is where you would find some money in the whole list. But I will be glad to supply you with an estimate. I don't think we have any entitlement programs in our department. I don't think we do.

SENATOR HAMILTON: How often do you have to go back on the grant programs - on a yearly basis?

DR. KOPLIN: Yes, usually every year. Sometimes they find some extra money toward the end of the year on the federal programs, which is less likely at the present time.

SENATOR HAMILTON: What part of the time of your total staff is spent going after those federal dollars?

DR. KOPLIN: I don't know; it seems like an awful lot, Senator. I can't quantify exactly, except to say that about 60 percent of our budget is federal money. We have 50 grants from the federal government. So I would venture to say we have some staff in all of our divisions that are involved in those federal programs constantly.

SENATOR HAMILTON: Not on a full-time basis?

DR. KOPLIN: Well, not just in the applying, but in the administration and the reporting. There is a lot of reporting that has to be done. So, we do have a fair amount of administrative work. But, of course, we feel we can use the money well and we need it. Overall, I can't answer that. I will be glad to try for you.

SENATOR HAMILTON: I would like it to the extent that you can.

DR. KOPLIN: You would like to know what proportion of our staff time goes ---

SENATOR HAMILTON: --- total staff time goes to the application process and compliance process of the federal funds, not the distribution of it, not the use of it, but the getting of it and reporting on what you have gotten so you can keep it.

DR. KOPLIN: We give assistance to the local agencies and the hospitals. We visit them. We audit them. We have audit problems. We have to be very careful about how the money is traced and report that to the federal government. So, we do have an active program.

SENATOR HAMILTON: I would like to get a handle on that.

DR. KOPLIN: Okay.

SENATOR HAMILTON: Let me ask you the same kind of a question with respect to the catasthrophic idea, as I did with respect to the Medically Needy. It would

seem to me that with some of these programs, if there were catastrophic coverage that was either provided through the private sector or through government or some mix of the two, there might be savings which would be generated at least at the State-fund side and perhaps out of the total side.

DR. KOPLIN: I don't know how a catastrophic health insurance program could save some of this, say, Crippled Children State funds where we attempt to find the child as soon as possible and get him under care.

SENATOR HAMILTON: Lets' look at Renal. I don't know that it would in each category. Renal is one that jumps out at me immediately.

DR. KOPLIN: It might, except that those patients that we are paying for already are in a catastrophic program. Our program is a catastrophic program because it pays part of the service that can't be paid any other way. We are picking up what might be called the patient's share of a catastrophic illness.

SENATOR HAMILTON: It is the net ---

DR. KOPLIN: We are picking up the first three months - right - and those that we have picked up have been screened very carefully. So, if you had a catastrophic program and you had a $5,000 deductible or whatever you want to call it before the program would come into effect, how would we pick these renal patients up before they get on Medicare the first three months? I am a little concerned that ---

SENATOR HAMILTON: You might still be needed.

DR. KOPLIN: In this particular program, as you know, it is a highly charged emotional issue. There are people there who literally will die if they don't get on this service right away. So I have a little problem with that, Senator. What we do is try to prevent illness. What we do is try to find it early. A catastrophic program, in my opinion, doesn't do any any of that. You can see that I am not very happy about catastrophic health insurance in general for that reason, because we are prevention oriented and we want people to get into care as soon as they begin to have symtoms - and sooner, if necessary.

SENATOR HAMILTON: You are not going to have 100 percent success, no matter how much we gave you, Doctor. There are going to be some people who are going to have just tragic results not only from a physical point of view but on the whole economic fibre of the family if they do end up with cancer or some other illness. While I don't expect you to say, "All right, take all of our money so you can do it," I have to be sympathic to it. Maybe you don't have to be, but I do.

DR. KOPLIN: No, I think you should. But you should also be sympathic to the fact that cost-benefit wise - and we could discuss this, I guess, for a long time - the share of health dollars in this country that can save money and save lives is very, very small in the preventive area. And catastrophic health insurance is the opposite of that. It does the humane thing which I think should be done. I have no argument with you about that, Senator. It is a tough dilemma.

SENATOR HAMILTON: Perhaps I have given you a lot of requests for additional information. Let me say that I appreciate the effort that was made in gathering the information you provided to us and your attitude with respect to giving us some additional information. I am sure we will be seeing you again, Doctor.

DR. KOPLIN: Thanks a lot.

SENATOR HAMILTON: If you would communicate what you have to Mrs. Seel,

I would appreciate it.

DR. KOPLIN: Okay. May I be excused?

SENATOR HAMILTON: You may be excused unless you want to hang on every word of Jerry Reilly.

DR. KOPLIN: Okay, I'll stay.

SENATOR HAMILTON: Jerry, you have heard the general direction in which we are going. I don't know whether you have approached our request in exactly the same fashion, but I will let you start and see where we go.

G E R A L D R E I L L Y: Senator, thank you very much.

I think it is very useful to try to bring together in one room the pieces of a very complex system, which is the national health economy and the New Jersey health economy, to try to lay them on the table and see if they can be rearranged in some fashion or whether other pieces have to be added or subtracted, to say: Well, how do we approach the '80's in health policy from the State? This is a state that in many ways is a national leader in the areas of health policy, many of them under the auspices of the Health Department. We are the site of the national demonstration project in hospital rate-setting, the DRG process. We have had a long tradition of both effective health planning in the State and effective cost containment. If you look at national statistics, you will see that New Jersey, while experiencing rising costs in health like the nation, is trailing the nation, however, by a few percentage points in certain key areas, particularly hospitals.

What I thought I would like to do is, first, present some material on the national health economy; second, the State health economy; and, third, the role that medical assistance plays in it. If you do want to discuss the medically needy, I am prepared to talk about that as well as we move through, and, obviously entertain any questions as we move along. I had planned that we would be in more of a dialogue than formal testimony if that is acceptable.

In terms of the national health economy, in 1979, we were going to spend about $212.2 billion for personal health services in the United States. On the charts in front of you, the column on the extreme lefthand side is the one I really want to spend a minute on. It depicts total health expenditures in the United States in 1979. The base of that bar chart shows private direct-payment health expenditures, which accounted for about 30 percent of all health care expenditures in the United States.

The next block on that bar chart depicts private health insurance, which accounts for another 30 percent. Then there is a very small category called "other private sources," 2.5 percent.

Now, we start to move into the public expenditures. Public programs constitute about 40 percent of all health expenditures in the United States. The largest public health expenditure is in the Medicare Program, which as you know is designed for people who are members of the Social Security System who are either disabled or, normally, over 65, but sometimes over 62. That constitutes about 15 percent of all expenditures in the nation.

Another large block constitutes Medicaid or medical assistance expenditures. That is about 10 percent of all national health expenditures, about $20, $21 or $22 billion.

Then, the third large chunk of public funds is made up of a diversity of things, such as the public health expenditures that Dr. Koplin was speaking about;

expenses of the military; in our own State, general assistance expenditures or expenditures for direct governmental appropriations, such as the State appropriation to Martland Hospital or the State appropriation to Bergen Pines, Jersey City; and, in some cases, county government appropriations to general hospitals within the county. That is a micro-overview of the health care economy in the United States.

SENATOR HAMILTON: Jerry, it is unfair to ask you this because you have obviously taken this as being oriented to a particular point in time. Can you give us, at least, orally a trend line on this? How has this changed in the past ten or fifteen years? Which of these have gone up and which have gone down?

MR. REILLY: Well, the trend line would be for larger and larger public penetration into the bar graph. If you had looked at this 10 years ago, my hunch is you would have seen the public expenditure at perhaps 10 to 20 percent, then trending on up to the present where it is about 40 percent. The thing that really changed the picture was in 1966 with the enactment of the Medicare Law and the Medicaid Law, which, if you look at the congressional history of it, was an afterthought and no one had really looked at the consequences of Medicaid. It came in as a last minute compromise and now is almost as large as Medicare nationally.

I do have some other charts that go to the question that you have raised which I will give to you. I wasn't planning to talk to those charts, but you can certainly have them.

Here is one other chart on the MACRO that I did want to mention. This chart I am now giving you depicts the sources of growth in personal health care expenditures for 1972 to 1979. A very small proportion of the growth is accounted for by population. A fairly substantial portion of the growth is accounted for by what they call changes in intensity. That can be frequency of seeking personal health care. It can be changes in the nature of the workup. In a conventional term, defensive medicine may have a part in that. It also, I think, reflects the revolution in technology which is causing prices to drive up.

SENATOR HAMILTON: Are there things that are now covered that weren't covered before and do they fall into the intensity or do they fall someplace else?

MR. REILLY: This isn't a question of coverage or not coverage. This is all expenditures for personal care services. So, if in 1972, we didn't have CAT scanners and therefore CAT scannings weren't done and today we have CAT scanners, that would be intensity. In 1972, we may have had two or three laboratory tests done; today, we have something called the SMA 16 or the SMA 18, whatever the latest version is. It is a machine that can do 18 kinds of analyses. It is probably good that it does that, but then it leads to other questions which require some further exploration. This is an area that I shouldn't get into.

SENATOR HAMILTON: It is not going to be changes in intensity anyway but the one at the top that is the large one.

MR. REILLY: Well, the largest one is pure price inflation. We all know what the trend in inflation has been and we know that the health care economy is tracking 3 or 4 points more rapidly than inflation across the country.

I have some other pie charts which I can distribute, which depict this in another diagram.

We wanted to do a similar analysis of New Jersey specifics, to give you a snapshot of the New Jersey health economy. As you can see that matrix has more blanks than blocks filled in because we found in a short time period it was difficult

to get this information, but we intend to keep trying if you think that would be useful to you. We found, at least on initial inquiry, that it is not easy. There is a lot of aggregate national data, but it is not disaggregated very well. The only one we really know about with much certainty is the medical assistance expenditures. But if you would find this kind of snapshot of the New Jersey health economy useful to you, we will continue our efforts and try to develop it. I, personally, would find it useful.

SENATOR HAMILTON: I think it would be if it doesn't require an inordinate amount of effort on the part of your department.

MR. REILLY: I don't think it would be inordinate. We are going to have to get some cooperation from the Health Department and their people who have already been working with us on it. I think it would be a useful bit of information.

SENATOR HAMILTON: Is that a million dollars a person in Medicare?

MR. REILLY: Which chart are you looking at?

SENATOR HAMILTON: I am looking at your overview of New Jersey health economy.

MR. REILLY: No, it is about a thousand dollars. That is skewed by the nursing home population which will consume about one-third of our costs. We will get to that on a subsequent chart.

There was one cross check I did quickly simply to see how we compared with the national data on one statistic that we know. If you look at long term care, Medicaid is paying about 50 percent of all the long term care cost in the United States. And, if you look at Figure 3, the bar graph, the second from the last column, nursing home care, Medicaid nationally is running about 48 percent of all nursing home care. So that is fairly consistent. My hunch is that when we complete this data for New Jersey, it will not vary very much from the national distribution. You are going to see it will be pretty much the same. But we can't be certain of that.

The next two charts are the FY '82 projected distribution of medical assistance funds in New Jersey, as well as another chart that depicts for what portions of the medical assistance eligible population these expenditures are going to and how that population breaks out.

I pulled the '82 information, frankly, because it was readily available and we are working on it right now. This is for the period that would begin July 1, 1982. It also assumes the program continuing as it is now operating and not a contracted program that might have to operate as a consequence of the present deficits. But in that pie chart, you can see that the largest item of expenditure in New Jersey medical assistance goes to nursing homes or long term care, about $270 million when you take into account the federal and state shares, 27.8 percent. Hospitals are the next largest sector with 24.3 percent. I won't go through all of the percentages. But hospitals and nursing homes are over 50 percent. This chart also includes PAA expenditures, Pharmaceutical Assistance to the Aged, which are not federally matched. That is a 100 percent State financed activity. It also includes the Lineline expenditure, which is not in a pure sense health related, but it is included within the Division of Medical Assistance and that is why it is here.

If you look at the Medicaid caseloads and cost chart, you can see the SSI population, the aged, blind and disabled, represent 25.4 percent of our population, but account for better than 60 percent of the expenditures. The

reason for that is two fold: number one, the very expensive requirements of long term care, in which about 19,000 people will be paid for medical assistance, and the fact that the aged, blind and disabled population will have more health care needs than the general population. In that population, however, we are assisted by Medicare, of course. If it were not for Medicare, the expenditures would even be greater. But Medicare is a fairly limited program in terms of its coverages. I think for the average person who doesn't have medical assistance, Medicare is only going to meet about 38 percent of their out-of-pocket expenses. So, for the elderly, blind and disabled, medical assistance, if they are poor enough, steps into that breach and meets the rest of those costs.

The children - or the AFDC category constitutes 72 percent of the eligibles and consumes about 37 percent of the expense. That is because it is a younger population and it is a more healthy population and it doesn't have the same kind of requirements as the aged, blind and disabled population does have.

When we were doing analysis of the Medically Needy Program, we had not taken into account any possible trade-offs from the kinds of programs that Dr. Koplin was speaking of. We were thinking of trade-offs mostly from General Assistance, the Special Hospital Assistance Programs, Special Aid to Martland Hospital, and some trade-offs in the PAA Program. There are perhaps some trade-offs in programs he described. One that comes to mind could be the area of Maternal and Child Care. They may be aiding some people now whom Medical Assistance cannot aid because of incomes above the Medical Assistance levels that with a Medically Needy Program we might aid. But you have to look a step further. It may be that there are more favorable federal-state matching relationships under Maternal and Child Care Programs than under Medical Assistance where we are 50-50. So it might be best to leave that alone if they have a special party population. But we, frankly, hadn't considered that.

SENATOR HAMILTON: Doctor, in that context, when you are looking at those numbers, would you indicate to us what these various matches are? That would be significant, as Mr. Reilly suggests.

DR. KOPLIN: If I may comment, Senator. One of the problems that Dr. Halpin has been telling me about is, if you have to curtail payments for outpatients - is that what you are thinking about? - some of these children within the program that we don't now serve may fall back on us again, so that this Medically Needy Program might be a solution for both our problems in that case. If you are short of funds for outpatients of this kind who are now your responsibility, then they fall back on us and we would have to become the last resort payors. This other program may get us both off the hook.

SENATOR HAMILTON: Where would you say - I direct this to you, but Dr. Koplin might have some thoughts on it too - are the gaps now?

MR. REILLY: Well, ---

SENATOR HAMILTON: Either it is services to people or making services reasonably available to them.

MR. REILLY: If you are eligible for medical assistance, you have got a pretty good program in terms of scope of services and most of your needs are going to be met if you are eligible for medical assistance. There are, however, within that program certain problems of access, physician availability in certain parts of the State, nursing home availability for people who have to rely upon medical assistance; but, in general, that population has very, very adequate

health insurance, assuming that the health care provided community is there in sufficient numbers and we can pay an appropriate price. Where you have the large gap is in that population that is just above the medical assistance income levels, people who have sufficient income for their normal requirements of living, but insufficient incomes to meet their health care needs. That is what is described as the medically needy population. You have people in that sector who are what are described as categorically related. That means that it were not for their income, they would be eligible for medical assistance. You could have a mother or a mother and father and several children and they would be eligible for medical assistance if their income were sufficiently low, but they are not. You have a whole other group of people who are called medically indigent and they are not categorically related, the people who are now typically for the most part general assistance recipients, for example, or people who are above the general assistance level but they don't have children, they are not aged and they are not disabled, but they don't have sufficient income for their health care needs. That is the major category.

SENATOR HAMILTON: Before we get into medically needy, what you are saying is that you don't see any gapping holes in coverage. We now have pharmaceutical assistance for the aged. We have Lifeline, which is not really a medical program at all. You don't see a population out there or a particular gap in the coverage that is afforded if there is eligibility. Is that what you are saying?

MR. REILLY: Except in the chronic care system - I would say there are major gaps. For the people who are elderly or disabled who need long term care either in their home or in an institution, there are major gaps in that system. But in terms of general medical care, I don't see gaps.

SENATOR HAMILTON: Let's try to hone in on the chronic and the --- How did you describe the other population?

MR. REILLY: Pardon.

SENATOR HAMILTON: You said the chronically ill. How did you describe the other population?

MR. REILLY: The people who require general medical services.

SENATOR HAMILTON: You said long term care.

MR. REILLY: Yes, people who require long term care either in institutions or in the community - that system is not working well and is not responding to their needs.

SENATOR HAMILTON: Well, in institutions, in part, that is because of insufficient beds, is that right?

MR. REILLY: Yes, I would say it is because of insufficient beds.

SENATOR HAMILTON: And, in part, because we haven't maximized the other side, which is the home health care?

MR. REILLY: I would say that is also true. But I think we have to do both things.

SENATOR HAMILTON: The gap here becomes --- well, one of course, is your cost push in terms of Medicaid, the unwillingness of some institutions to take Medicaid patients and the cost push on your department when they do take them.

MR. REILLY: Yes.

DR. KOPLIN: You have to look at the continuum between acute and chronic care because chronically ill patients become acutely ill. And those who are in your long-term care facilities where there isn't adequate funding, I think a case

could be made for their deterioriating. Now, they may die or they may go through a stage of acute illness and cost us money in the hospital. Isn't that what happens? In other words, our whole incentive is to try to get them out of the hospitals into long term care facilities and get them into ambulatory care. To maintain their continuum is really ---

MR. REILLY: I think the quality of care in a long term care facility in New Jersey is pretty good and that the quality of health care delivered there is pretty good. You don't find people deteriorating as a consequence of that care.

I think you may find people deteriorating as a consequence of the fact that they can't get access to that system, that they may be in the community, and while it is appropriate for some people to be in the community and have support services brought to them, some people are there who don't belong there, who are really too sick to be there. I think in those cases they may tend to deteriorate and they do oftentimes wind up in the acute care institutions.

SENATOR HAMILTON: Jerry, going to that nursing home population that you talk about where, if I recall, we are talking 48 percent Medicare-Medicaid, do we have a time line on that - how that has grown, say, over a ten-year period?

MR. REILLY: I can get that for you. Again, it will parallel the involvement of Medicare and Medicaid in the long term care industry. The big push came after '66 when Medicare began to pay for long term care. Gradually, what we have seen is Medicare has pulled out and assumed a smaller percentage of it; and the state and the federal government through Medicaid have assumed a larger and larger share of it.

SENATOR HAMILTON: The words "has pulled out" means something to you, but it doesn't describe to me the dynamics of what happened. Why is it that when you look at it in 1979 Medicare is maybe 3 or 4 percent and Medicade is the rest of the 48? What is there in the eligibility or in the funding levels that has caused that?

MR. REILLY: I think that Medicare has gotten tougher over the years in defining the nursing care or the long term care that they will pay for and increasingly defined it at higher and higher levels and imposed limits on it in terms of prior hospitalization being required to get into the Medicare funding. What happened is that they began to see a rather enormous expense and it was 100 percent federal expense. There has been the result of shifting expense away from the federal government to the states. Most of that happened, I think, in the early '70's.

SENATOR HAMILTON: Can you chart that out for us and give it to us?

MR. REILLY: Sure. Talking about gaps, I did mention - and I don't want to gloss over it too lightly - that there are serious primary care gaps for medical assistance recipients in the inner city, due to the absence of a system of primary care in the cities, the fact that there aren't enough doctors in Newark and the doctors that are there are oftentimes people who are toward the end of their practice and may be thinking of retiring, and there doesn't seem to be anything on the horizon to replace them. The consequence of that is people moving to the outpatient department as the primary care physician and that is extremely costly. How we correct this is a real riddle. One way to correct it might be more adequate compensation for inner-city physicians, but money is only one barrier. But that is

a problem of access and gaps in the present system.

SENATOR HAMILTON: What are the other barriers besides that?

MR. REILLY: I think perceptions about safety are a problem and that the young physicians are not prone to set up their medical practice in the innercity area. A recent study put out by the Health Care Finance Administration showed that the doctors who gravitate to the innercity tend to be less qualified in terms of credentials. They may tend to be foreign educated, foreign born. The study also indicated that by and large they were providing good medical care. But on the raw criteria of their qualifications, they tended to be less qualified than American-trained, American-born physicians. There is that problem of distribution of physicians in the city. I think the medical profession is no different than any other profession in that there is not a lot of other investment in some parts of the State and this is a very personal kind of investment that a physician or practitioner makes when they say where they are going to make their life's work. And it is a problem.

DR. KOPLIN: May I comment on that, Senator? What Jerry is describing is the failure of marketplace economics to yield adequate distribution of care. This also occurs in rural areas. It doesn't affect New Jersey as much as it does some other states. But even in New Jersey we have three areas that are declared medically underserved in terms of the federal programs which are trying to do something about this problem. There are comprehensive health centers that are supported through one of the facets of the Public Health Service Act, a program, incidentally, which was increased by the administration in its recommendations during the budget-cutting session. So it was considered extremely important for improving primary care. You have about 28 primary care centers supported by those federal grants in New Jersey. One in Newark is a very large one, but it doesn't do the job. It is called North Jersey Union.

That is one remedy that has been attempted. There are about eight or nine hundred of those in the United States and they are limited to areas of great need. But they are not enough and more needs to be done.

While I am speaking, Senator, I would point out that this kind of primary care flies in the face of a catastrophic health insurance program because primary care is needed before you reach whatever level you are reaching. So it is kind of preventive, early detection, keep them well, keep them from going to the hospital and becoming chronic - the argument that I was making previously.

SENATOR HAMILTON: Let's go back a minute to the chronic population, Jerry. What typical kinds of situations do you have in mind when you use that phrase?

MR. REILLY: Typically, a person on admission to a New Jersey long term care facility is about 82 years of age. They have had one or a series of debilitating physical conditions. They may have had a stroke. They may have paralysis. They may be extremely arthritic. They need care chronically. They have a chronic affliction that requires them to have a good deal of assistance every day in the performance of their daily task of living, whether it is feeding, bathing, or some skilled nursing care for a particular medical problem.

SENATOR HAMILTON: Whether you meet that in the institution or at home in the community in some fashion, you are really not describing very much of a different population than the people about whom you say there may be a gap with respect to long term care. With "chronic, long term," it is really a comma rather than "or".

MR. REILLY: Right. It is the same population.

SENATOR HAMILTON: Let's talk a little about the medically needy then because I know you are prepared to do it. It may or may not have a role here, but it is certainly worth investigating. Which of these needs could we alleviate? How much would it cost? How would it be administered?

MR. REILLY: The Medically Needy Program, per se, would do very little in improving the chronic care system nor would it do very much in dealing with the primary care access problems. They are problems that would persist in either situation. What Medically Needy would do would be to provide coverage to 90 to 100 thousand additional people who now do not have sufficient resources to pay for the care and who either forego care, don't get it, or who get care in a variety of other ways in New Jersey that are subsidized from a variety of sources. In developing such a Medically Needy Program, one significant advantage is that we do have the federal government assist us with half the cost. In terms of Dr. Koplin's discussion, an argument could be made in terms of providing some primary care access for this population or preventive care that may prevent greater illness and acute hospitalization, etc. I don't have any good statistics for that. In fact, I have never seen anybody who could develop a good model that really predicts a pound of cure for an ounce of prevention. But I think we all intuitively have a feeling that that kind of dynamic is operative.

If we had a Medically Needy Program, there would be some savings in some of our current health programs. For example, the State spends a significant amount of money in the Martland Hospital. The last time I looked it was $15 or $16 million a year. You might assume that at least one-third of that goes for population that would be eligible under Medical Assistance. Therefore, we would be able to save that $5 million expenditure from the State appropriation. But to save that five, you are going to have to spend two and one-half. So you have a net of two and one-half in the Martland situation.

There are similar situations in the General Assistance Program where there are some people in General Assistance who would be categorically eligible but for their high income, they are not on Medicaid and, therefore, the State is paying 75 percent of their hospital cost and the municipality is paying 25 percent.

Another area that we should now bring into the calculation is the relationship to the DRG program. Under DRG, the indigent costs of a hospital, once they have made reasonably diligent efforts to collect and are unsuccessful, are spread to the other payors. They are spread to Medicaid, Medicare, Blue Cross, and private insurance. To the extent that any subset of that indigent cost could be met through Medically Needy, we could substitute 50 percent federal support for that cost where now that cost gets spread 100 percent, for example, to Blue Cross subscribers or the people who pay Prudential Insurance premiums for hospital costs, etc.

Any analysis I have seen of Medically Needy comes to the conclusion that it is going to cost the State some direct appropriation to do it. One, the plan that would make most sense to me would cost about $21 million in net State costs after taking some offsets and would have a total project cost of about $64.7 million.

SENATOR HAMILTON: What would that provide?

MR. REILLY: That would provide essentially the same coverage as the basic Medical Assistance Program, except that it would not cover long term care. Long

term care would continue to be covered on the present basis. In long term care, we have what is called the institutional cap. That means you can have income three times the SSI level in a nursing home and be eligible for medical assistance. So there is no reason to include long term care in New Jersey under a Medically Needy Program because that population and more is covered, at least in the institutions.

This is one cause for a lot of confusion about Medically Needy estimates. Many other states include long term care in the Medically Needy Program which raises the price that one hears attributable to medically needy because they are including the long term care. But the $21 million net cost is the number based upon 1979 data that seems to make most sense. However, ---

SENATOR HAMILTON: That is after you have achieved certain assumed savings at Martland and General Assistance and DRG?

MR. REILLY: Right. However, I would feel more comfortable if it became clear that we might really begin to move in this direction, that somehow or other the Department or the Legislature or we jointly - or perhaps through the appropriations process - commission an external "look-see" at all these assumptions, perhaps with an accounting firm or something like that --- to take a look at all these assumptions and turn them this way and that way and make sure that they are on the mark, because I think it is going to be a good bet when it is examined in all its facets. However, at this particular time we are in, I think people understandably are very concerned about getting the best possible estimate of what it is going to cost. That might be one way to do it, so that we can have some numbers that we can really be confident in, if you want to consider that down the road.

SENATOR HAMILTON: Looking at your bar graph, your Figure 3, where is the kind of Medically Needy Program that you have just described? Under which of these categories of services is it going to start appearing?

MR. REILLY: I think the largest area of expense in Medically Needy is going to be hospital care. I would say hospital care would be the big one because under a Medically Needy Program you have to have something called "spend down," which is analogous to a catastrophic at a very low level. If you set it at 133 percent - let's say the income level is 100 for ease of example, $100 - anybody between $100 and $133 a month would be eligible. But if I go into a hospital this particular month and I have very large hospital bills and, therefore, my effective income is driven down below $133, I am eligible. So that tends to make a lot of hospital expenditures more significant items under a Medically Needy Program because of the spend-down provision.

SENATOR HAMILTON: But to the extent that a Medically Needy Program is going to help meet the people who are now getting medical care that they need, it would seem to me that that is kind of directly opposite to what you are saying here. If they are already in there, it is a question of how it is being paid for. Are they ending up in the indigent care policy in the hospital's rate reimbursement?

MR. REILLY: I think in the area of primary care services, however, for that group that swept in under the 133 percent - let's say a working mother and three children, the mother working in some marginal employment, but sufficient to keep her above the public assistance level --- those children may not now be seeing the dentist regularly or they may not now be seeing a physician regularly for checkups. If that family were in a Medically Needy Program, that family

would have a medical assistance eligibility card and that mother might be more able to pay for the dental services and the physician's services. Fo I think for the base population it is an important leg up on access. But for the people who are above the 133 percent, it becomes more important when they have a catastrophic situation.

I think if we look at what happened in the Medical Assitance Program over the last ten years, we can see that access to health care has been significantly aided by the program for poor people and minority people in the United States. So people who are on medical assistance now use health services at about the same rate as the whole society; whereas, ten years ago, they would have used them at 50 or 60 percent of the rate of the whole society. That has begun to show up in mortality and morbidity statistics in our population. It is now a healthier population. Infant mortality is down a good deal, etc.

So I think you could predict that same kind of effect in that population between 100 and 133 percent. But you are right, for the population above that, it is really going to be an aid to the people who pay for it, not to their care, because they are going to be in the hospital one way or another.

SENATOR HAMILTON: So the hospital care is one area where you would see it. I take it from what you say physicians' services would be another. But you would say not to the extent you would see in hospital care.

MR. REILLY: I think you would see a normal impact on all the other services, consistent with increased population. But where you would see it higher than normal is in hospital care because of the spend-down.

SENATOR HAMILTON: How about the nursing home care?

MR. REILLY: You won't see much in nursing home --- you probably won't see anything in nursing home because our eligibility criteria in nursing homes is already significantly above the basic medical assistance eligibility. You could have income of three times the supplemental security income level. For ease of example let's say it is $250 a month. So you could have income of $750 a month and be eligible in a nursing home. One hundred and thirty-three percent of the AFDC for a family of one is going to be down around two hundred and some dollars. So it is not going to have an effect. Where it might have an effect conceivably is for some people who maybe have a thousand dollars of income a month now and cannot meet their nursing home bill. It might have some effect there. But, by and large, I don't think it would have too much effect on nursing homes.

SENATOR HAMILTON: To go back to something that we raised at the first meeting, your estimate - and I don't know whether it is the department's estimate or your estimate - of $21 million I recall was somewhere in the ball park of what the ICF Program was estimated to cost in the first year. Am I right?

MR. REILLY: I really don't know. Which ICF?

SENATOR HAMILTON: The ICF-MR Program.

MR. REILLY: No, I don't know. The basis of the estimate is a report done by Medical Assistance that they revise every year or so - I think the first one was done in '75 - where they look at Medically Needy, and this was the 1980 version. Was it a statement or a graph?

SENATOR HAMILTON: You probably were not there.

MR. REILLY: I wasn't there.

SENATOR HAMILTON: I raised the question, not to be argumentative, but to

try to understand from a policy point of view the importance you would put on this Medically Needy Program if we moved in an ICF-MR direction, in part because of the 50 percent federal reimbursement and in part because of our concern about the direction we wanted to go in providing services, to assist something on the order of 8,000 people if I remember correctly. This program, if I copied it correctly, is about the same numbers I think we heard the last time, that it would help 90 to 100 thousand people, basically with a 50 percent match.

What were the policy considerations that led whoever made the ultimate decision or the recommendation to go in the direction of ICF-MR, that if we are going to spend $20 million, we are going to do it ICF-MR - we are not going to do it Medically Needy?

MR. REILLY: In the ICF-MR financing, when you sort it all out, actually it involves very little, if any, additional State appropriation because of the involvement of county funds in the care of targeted individuals. So we were able to accomplish ICF-MR essentially using existing State and county funds and then drawing upon the federal funds, and the counties were willing to continue participating on that basis because of the long view that eventually it will be state and federal financing and we will have a much enhanced system. But I remember seeing that question in the testimony and I did mean to speak to you about it, but I didn't have a chance.

It wasn't really an either/or proposition. Nobody ever looked at ICF-MR and then looked at Medically Needy. They proceeded down two paths. But when you sort out ICF-MR, you will see that there is really very little incremental State money involved. The money that went into ICF-MR, even if it were considered, would not have been sufficient to fund a Medically Needy Program.

The other consideration is that the ICF-MR opportunity is one that, if not taken at that point, may have not been available because the federal government, I think, has been fairly adamant about 1982 being the deadline wherein they would let you into the program and operate under waivers of some of the requirements and pay you while you were getting in shape. I think that window closes in 1982. That was probably one of the considerations. It was never really an either/or proposition.

SENATOR HAMILTON: I am sure it wasn't and I posed the question because I wondered if it shouldn't have been. I heard what you just said about incremental State dollars. I have the recollection of sitting in a room at the time the first bond issue that provided money for the ICF-MR program went through of hearing someone talk about the need in a relatively short period of time - in fact, it may have been in the Institutions Committee - of providing for recruiting and training of 2000 to 2200 additional State employees. I assume that means some incremental State cost. Certainly the capital funds don't provide for it.

MR. REILLY: I think I could give you on a sheet of paper the financing that I can't carry in my head and you will find that there is very little, if any, incremental State costs in ICF-MR because of the fact that we were able to use the present State and county contributions to draw the additional funds without any increases in State funds. In fact, I think you will find the State appropriations to MR for the past three or four years have been relatively stable, as a consequence of ICF-MR. That is now going to change because we just bought a period of time when we were able to deal with both the reform movement and inflationary costs

through the ICF-MR Program. A couple of years we had that opportunity. That won't happen.

SENATOR HAMILTON: Maybe we will have a chance to go over those numbers.

MR. REILLY: Fine.

SENATOR HAMILTON: Where in your list of priorities or the department's list of priorities is the implementation of the Medically Needy Program?

MR. REILLY: Well, we have not been able to recommend it in the budget because of serious problems in just funding the activities that we now operate. It is a very major concern of the department. It is an area that we think New Jersey ought to move in. We and Texas are probably the only industrialized states who do not have a Medically Needy Program. We think it makes economic sense for New Jersey. But we are unable to recommend it at the present time within the revenue constraints in the State. It is the kind of decision that I think has to collectively be made by the Legislature and the Executive. We have always been in favor of the particular enabling legislation that Assemblyman Deverin introduced. But we have not been able to recommend it in the budget simply because we are having a difficult time funding base activities.

SENATOR HAMILTON: Are there any other initiatives, new initiatives, of the department in terms of the expansion of existing programs or new programs that are of any significant dollars at all that come ahead of the medically needy on, whatever you want to call it, your wish list, dream list, or priority list?

MR. REILLY: Nothing in the way of a new initiative. We are interested in and our number one priority for the past several years has been reasonable public assistance levels. That has been one of our number one priorities. If you are asking is there another program under consideration that would be an either/or proposition, there isn't anything like that. I think this is really the major piece of unfinished business in terms of an opportunity to put in place a fairly complete health care program for poor people that hasn't been acted upon.

SENATOR HAMILTON: Without getting into the whole issue that I think is being addressed elsewhere of the details and the "whys" of the present Medicaid shortage, what is the number that is talked about either today or for fiscal '80? The budget is not yet struck for fiscal '82. Give me a number to work with.

MR. REILLY: In terms of the present deficit?

SENATOR HAMILTON: Yes.

MR. REILLY: The present deficit in its most extreme terms would be in the area of $53 million, of which about $13 million would be a current deficit; that is, that in fiscal '81, we have $13.5 million short of meeting all of our commitments by the end of the year. Then there is about $40 million that represents carry-forward problems, wherein this year - in July, August and September - we had to pay bills for the May-June period of last year. Within that there are some $10, $11 or $12 million kinds of carry-forward obligations that one would describe as normal retroactive payments to hospitals, etc. Then the balance of it is really abnormal. It is a carry-forward into this year that we have to clear up this year and we can't carry it into the next fiscal year.

SENATOR HAMILTON: What is the number for this year?

MR. REILLY: Thirteen five.

SENATOR HAMILTON: Thirteen and a half. Annualized, that becomes twenty-seven plus the inflation factor. Or do you look at it that way?

MR. REILLY: I don't understand what you mean.

SENATOR HAMILTON: Is that really a half a year?

MR. REILLY: No. On July 1 of this year, let's say we had $350 million available to us to meet our obligations for this year. We needed $363.5. I just pulled those numbers out, but that is what I mean.

SENATOR HAMILTON: With the fifth that would exist when you superimpose the Medically Needy Program on top of a Medicaid Program, would that number be ameliorated in any way if you had Medically Needy now?

MR. REILLY: No, there would be no offset in the basic Medical Assistance Program. They don't substitute; they would be complementary.

SENATOR HAMILTON: What savings, if any, are there elsewhere in your budget?

MR. REILLY: The In-Service budget or the Medical Assistance budget?

SENATOR HAMILTON: Human Services budget, if you moved toward a Medically Needy, that you could either do as a direct thing or as a matter of policy where you could afford to make a reduction.

MR. REILLY: There are not offsets -- well, one offset area I did mention would be in General Assistance. That is the only one within the Human Services budget. There would be some offset in the PAA Program as well. They are the two principal ones. I don't see any major offsets in other Human Services activities.

SENATOR HAMILTON: Can you give us in gross terms the way that Dr. Koplin did some bottom line numbers out of your present budget?

MR. REILLY: Sure. You mean right now in terms of present expenditures?

SENATOR HAMILTON: In terms of present expenditures this fiscal year.

MR. REILLY: These are State dollars. So, pretty much, you multiply them by two and you get the gross expenditure. This year, we will spend $120 million in long term care facilities; we will spend $21 million in mental hospitals, most of that being in our own mental hospitals; we will spend $94 million in acute care hospital; we will spend $27 million in outpatient departments; we will spend about $5 million in home health service; we will spend $30 million for physicians; $11.5 million for dentists; we will spend $24 million for the Medical Assistance Pharmacy Program; we will spend approximately $40 million for the PAA Program. They are the major items.

SENATOR HAMILTON: In the acute care hospital item of $94 million, your second largest, how is that expended?

MR. REILLY: Well, that is expended through either Blue Cross or Prudential for medical assistance eligible people who need acute care hospitalization.

SENATOR HAMILTON: That is all Medicaid money?

MR. REILLY: That is Medicaid money, yes.

SENATOR HAMILTON: Are there any of these items that are not Medicaid money as you go down that list?

MR. REILLY: Other than PAA, they are all Medicaid. This is the Medicaid component of the mental hospital expenditures. For instance, there will be in a given month 12 thousand people who will need hospital in-patient services. Fifty-four thousand will be out-patient services; 173 thousand will use physicians, etc.

SENATOR HAMILTON: All of these are reimbursements to providers whether it is long term care --- mental hospitals would be primarily your own, so they really wouldn't be providers, that you allocate as the State's share there; is that

right?

MR. REILLY: Yes.

SENATOR HAMILTON: Acute Care Hospital, again, is provider reimbursement; Out-Patient Department is the same. Home Health is reimbursement or contractual the way the Department of Health is?

MR. REILLY: Basically on the reimbursement basis to home health agencies.

SENATOR HAMILTON: Has that been a constant number over the years?

MR. REILLY: No, that has increased dramatically. It has increased something like 300 percent over the past three or four years. It is still a small percentage of the total expenditure.

SENATOR HAMILTON: You heard the question I asked Dr. Koplin before, the cost-effective or ratio figures that are available there.

MR. REILLY: That is a question for the '80's. There is some good work that has been done. The Congressional Budget Office has recently done a very good report on the cost of home health versus institutional care, etc. I have a somewhat unpopular view on this, particularly among advocates of home health, in that I think a well developed home health system will, in fact, be very expensive. On the other hand, I think we should do it because I think it is consistent with a set of values and you have to have a value system to apply to this situation. A person who is very, very disabled and very, very sick, the least expensive way of providing good care for him is in an institutional setting, a congregate setting. I think sometimes we wish that weren't so and we wish we could keep people home. But to bring all the supports necessary to take care of a person that ill at home is very, very expensive. On the other hand, I think there are some mid-ground things we can do, emphasizing congregate housing, for example. And this is one of the premises of Bruce Vladeck's very good book on nursing home policy, that we need to find a half-way house where we can have people who are disabled and who do need special help in as homelike and normal environment as possible. But if people come together in groups, then it is less expensive to bring in the support services.

SENATOR HAMILTON: Let me pose a question generated by my reading of yesterday's newspaper along that line. There is about to be opened a group home in Woodbridge in Middlesex County for some number - I have forgotten how many - of mildly retarded people, who from the picture I gather are females. The staffing that was reported in the newspaper did not specify paid staff. The staffing included in the newspaper indicated a director, a full-time person on premises, and aides on a one-to-one ratio. The thing that struck me about the article was that it was primarily presented in terms of reluctant community acceptance of giving this a try. There was a long news story about it. The thing that struck me was that one-to-one ratio. Unless you have a whole lot of hand-in-hand type volunteers, it has to be an extremely expensive way of providing that kind of care; albeit, perhaps, care that you would like to provide in terms of integrating somebody back in the community. But is that a typical model, a one-to-one?

MR. REILLY: The group home is something different than the primary care system for the elderly. It is trying to do different things. I am not familiar with the particular group home that you are talking about. You have to see what its function is. If its function is that people move there and stay there for some period of time while they get reoriented to the community and then perhaps move on to more independent kinds of living, that may be the kind of investment you

have to make in transition. I am not familiar with the home. If that is the kind of staffying ratio that would persist for a long period of time, that is very expensive. I don't know how that would compare today with kinds of staffing ratios in an MR facility. I would think it was probably less rich. I would think the staffing inside is more than that right now. I really can't answer you specifically. But that is not really what I am talking about. When I talk about a chronic care system, typically, I am talking about a person who may be in a home and be visited by a home health aide or a homemaker and a nurse and occasionally a podiatrist, etc., as opposed to providing those same kinds of services to a person who is an institution.

SENATOR HAMILTON: I am going to ask you one other question. Then we are going to take a break for lunch. While I didn't think we would go beyond one o'clock, with our late start, I think we ought to come back and try to do a little bit more this afternoon.

You gave us a figure of $24 million of State moneys for Medical Assistance.

MR. REILLY: In pharmaceuticals - drugs.

SENATOR HAMILTON: Would you be able to come back?

MR. REILLY: Sure.

SENATOR HAMILTON: And any of the rest of you who are available, I would like to reconvene at two o'clock fairly promptly and go for just a little bit this afternoone, at least.

We are getting a lot of detail I didn't know we would get. But it is very helpful. It may or may not be to all of you. But since we are to educate me, that is more important perhaps than educating you. I understand you have other commitments, Doctor.

DR. KOPLIN: Yes. May I make a comment since I can't come back?

SENATOR HAMILTON: Certainly.

DR. KOPLIN: I think part of the difficulty you are having with this consideration - this very practical consideration of where we are going to find the money to do all these things - Senator, is that there tends to be a focus on that which is understandable and not on the delivery system we are talking about.

One of the things that I would urge in a specifical practical way, if you are considering taking on a new group of the medically needy, is that you make some allowance if it is possible under the law for some demonstrations of putting some of the medically needy or some of the Medicaid patients into the hands of a delivery system as sort of a contractual methodology which has been used. There are group practices in the United States that have taken on the medically needy for the City of Washington, for the City of Seattle; and they have actually shown less hospitalization and less costs in the long run. In other words, take a group in New Jersey and try it for ourselves and see if that proves or disproves what Jerry has been saying about whether primary care will actually make any difference in the long-run cost. I think a total system like an HMO might. You can pay a premium for a medically needy person to an HMO if they are developed in the system. With very little cost, I think, you could do it on a demonstration basis to see and prove it for yourself, because I think it will show that.

It is just that we get caught up in the nuts and bolts of these terribly expensive dollars and we don't think about integrating the entire system.

I also agree with Jerry. I think you have a basic philosophical question, which we don't talk about very much anymore, as to whether people have a right to care and whether they have a right to the value judgments that you make about what

kind of institutions we would like our parents to be in and maybe ourselves some day when we can't live alone.

But I just want to emphasize that one fact - some demonstrations of a systematic approach to care. See if it makes any difference.

SENATOR HAMILTON: Has that approach been tried anywhere?

DR. KOPLIN: Yes, it has. I can supply you with some of the literature. It has been tried, as I said, in Seattle and Washington, D. C., with the Group Health Association.

SENATOR HAMILTON: On a Medically Needy Program or ---

DR. KOPLIN: Actually, Medicaid patients. Some thousand patients were injected into this system in Washington, D. C. some years ago and it did show a big difference.

MR. REILLY: That kind of technique has merit and applicability to the basic Medical Assistance population as it is, independent of the question of the medically needy. We have been working with some HMO's and we do have something on the drawing boards right now on group practice participation with Medical Assistance clients.

I would be more interested in seeing a good search of the literature around the impact of the medically needy rather than a demonstration, per se. A demonstration group gets very, very complicated and convoluted because of the federal requirements involved in demonstrations. But if that is the only way to go, I could understand that. I am a little skeptical about demonstrations in this area right now.

SENATOR HAMILTON: In the medically needy, but not in the basic Medicaid population.

MR. REILLY: No.

SENATOR HAMILTON: We will reconvene at two o'clock and thank you all very much.

(Recess for Lunch)

Afternoon Session

SENATOR HAMILTON: In the interest of not prolonging the meeting and taking into account some people have projected 3 to 7 inches of snow that we are going to get, which might make travelling from Trenton to sundry other places less than enjoyable, I would like to go ahead without Jerry Reilly and listen to Jean Kraemer. Jerry may be a good one to wrap it up at the end anyway.

J E A N K R A E M E R: Senator Hamilton, I thank you very much for the opportunity to talk to you today about home health care in New Jersey. I have a prepared written statement which I will hand in for the record. But if it would be all right, I would prefer to summarize my comments for you.

SENATOR HAMILTON: That would not only be all right; it would be appreciated.

MS. KRAEMER: I represent 47 home health care agencies in the State of New Jersey who are certified by the State Health Department and who receive reimbursement through Medicaid and Medicare. As you heard, we really are a very small percentage in the overall health care picture if you talk in terms of dollars spent. But we really feel that home health care can contribute towards a number of these problems that you are addressing today, in particular, towards the difficulty that New Jersey citizens find in getting into nursing homes and also on maintaining reasonable costs for health care in the State.

So, what I have done is outline five very specific points which I think

point up some ways that the State of New Jersey can go ahead and improve the delivery of home health care in the State. They are rather specific and technical, but I would like to share them with you if I might.

The first one deals with coordination. I don't want to go into a great deal of detail on this, but there is a multiplicity of funding sources from the federal level for home health care services. If we are going to reform this, a lot of the reform has to be initiated federally. We did have a conference on home health care recently in New Jersey and a lot of emphasis was on federal reform. But, in New Jersey, those State agencies who pay out funding I think should coordinate their efforts somewhat more than they are doing now. There are problems where patients may not have their care coordinated because it may be provided by several agencies. We really think that for the benefit of the patients that New Jersey should more coordinate the care - the different departments that give the different care. For example, the Department of Human Services administers the Medicaid funding and also Title 20 funding, which are two major sources. Human Services has home health care funding out of the Division on Aging. And, a third one, Medicare is essentially under the purview of the Department of Health. That is one thing that we feel should be addressed in New Jersey. We have been talking about this for a long time. We just don't feel it has been sufficiently resolved.

The second thing that we would like to see New Jersey do is to support programs for monitoring health care for senior citizens. Our agencies perform a number of public health functions. Some of our agencies have had very effective programs for senior citizens who are in senior citizen housing or at other sites where seniors congregate. These programs monitor and initiate health care for people and act to prevent them from going into more acute care and, therefore, more expensive care situations. Presently, these programs are funded mainly through grants and some of them are through State aid to public health departments. But the funding is precarious, as all grant funding is, and the aid to the State Health Department is inadequate to support these or expand them. We feel that this really could be very cost effective. It delays the onset of serious illness for this particularly vulnerable group.

SENATOR HAMILTON: Are there some successful models?

MS. KRAEMER: Oh, yes. We would be glad to show you if you would like to come and visit some of them.

SENATOR HAMILTON: I think I might like to see one or two, but I also would like to have whatever written summary you have of some of those successful models.

MS. KRAEMER: Okay. I will be glad to supply you with that.

Now, the three remaining points that I want to make for the promotion of home health care in New Jersey are all legislative items which we feel should be enacted to help promote home health care.

The first one deals with commercial insurance for home health. Whereas, Medicaid, Medicare and the Blues - Blue Cross and Blue Shield - now cover home health care, commercial insurance policies for the most part do not. This is a particularly difficult situation for the middle-aged working person who is, for example, in a group health insurance policy, who because of DRG's may be discharged from a hospital needing care at home. You know that the DRG system is meant to have hospitals give patients care as needed. But if a patient doesn't have to be

in an acute care facility and it is proper to have followup care at home, they have an incentive to discharge the patient. We think this is really good policy. It is proper use of health care facilities. But, unfortunately, if this patient is discharged needing the care, then he may not have health insurance to cover it. We would like to see legislation passed which would fill this gap and that particular bill is A 1672. And I have mentioned that in my testimony.

The second piece of legislation ---

SENATOR HAMILTON: Before you get to that, the mandated feature is something, of course, that always generates some opposition. We ought to be realistic enough to talk about that. You said, except the "newly written" policies. How many written?

MS. KRAEMER: We tried to have legislation passed in New Jersey which would have the effect of mandating home health coverage for commercial hospitalization policies. When the law was written, it specified "newly written" policies. As the Department of Insurance has interpreted it, any policy which is renewed does not fall under the law as it is now written - as the law is now written. It seems that most group policies are not "newly written" butare "renewed" policies. So the effect is that almost no policies fall under current New Jersey law for mandated home health insurance.

SENATOR HAMILTON: You are saying there is - and I should know the answer to this, but I don't --- there is currently a mandating, but only on newly written policies.

MS. KRAEMER: That's right.

SENATOR HAMILTON: As a result of what law?

MS. KRAEMER: I don't know the number offhand. It has been in effect for about three years. But by checking with the Department of Insurance and by looking at the claimants, the patients whom we serve, we really see no increase in payment through commercial insurance policies, even though this law has been in effect. It would mean, if an individual took out an individual policy in the past three years, that policy would have to have coverage for home health care.

SENATOR HAMILTON: But from your end of it, which is the payment end, you do not see that there have been increased third-party payments as a result of the law.

MS. KRAEMER: That's right. So we are trying to modify an existing law by changing it from saying "newly written" policies to saying "all existing" policies.

Senator, the law also says that the insurance company would have the right to raise the premium. But in other states where there is mandated home health insurance, the cost has been virtually negligible.

SENATOR HAMILTON: We are not going to be able to get the kind of data we like in New Jersey because we don't really keep it. We don't have the same regulatory system for health insurance that we do for automobile or fire or some other coverages.

MS. KRAEMER: The second piece of legislation that we would support is the Medically Needy Program that you have been discussing already. It has particular interest to us because, as Mr. Reilly mentioned, the federal law is biased in favor of institutional care over home health care under the Medicaid Act. What this means is that a person who has a certain ---Let me put it this way. You can go into a nursing home with three times the monthly income that would be required for you to stay home on home health benefits under Medicaid. While we don't think that a Medically Needy Bill would completely solve this problem,

at least it would increase the population that would be able to choose to stay at home under Medicaid rather than enter an institution under Medicaid. Also, because we are advocates of preventive health care, we have to support a Medically Needy Bill for all those services that people would get which would be preventive in nature instead of waiting until they had to go to a hospital for an acute episode because they couldn't afford to have the care in advance. So, the Medically Needy Bill is the second legislative item on our agenda.

SENATOR HAMILTON: Do you have any suggestion to us as to how, short of a new revenue source, we could find the kind of money we would need for this?

MS. KRAEMER: I would say that the Home Health Agency Assembly of New Jersey is a member of a medically needy coalition. We have been looking into this problem. We would like to see ACR 139 passed. That is a bill which would place a public question on the ballot as to whether the casino revenues could be open for this kind of purpose. That is one avenue we would suggest.

SENATOR HAMILTON: Is there a perception that that goes that far?

MS. KRAEMER: Yes, I would say so because, Senator, many of the people who would fall into the category of medically needy are senior citizens.

SENATOR HAMILTON: There was and perhaps still is a time when a part of the senior citizen community in the State was opposed to ACR 139.

MS. KRAEMER: We don't share that view.

SENATOR HAMILTON: Neither you nor I are yet senior citizens and I guess they are entitled to their own viewpoint. I don't know whether that is still the situation or not, but certainly it was.

MR. REILLY: There was some active debate among the senior groups. The New Jersey Federation of Senior Citizens was very much in favor of ACR 139 and the New Jersey Council of Senior Citizens, as I understand it, was opposed to it. The Federation still is strongly in favor of the notion of ACR 139. I think it failed to come out of the Senate last week, so the likelihood of ---

MEMBER OF AUDIENCE: It is out of committee.

SENATOR HAMILTON: It is in position for a vote. If we had voted on it, all it would have done would be allow it to go on the ballot on the second of the two alternative bases on which a referendum can go. If it doesn't get three-fifths, it doesn't go the first year; but if it passes two consecutive Legislatures - and that has been interpreted apparently as the same people voting two different times - then it can go on the next ballot. It looks like it may not happen.

MR. REILLY: It could pass by three-fifths next time.

SENATOR HAMILTON: Yes.

It is unfair to ask you the question about the senior citizen community, except to note that there is that problem.

MS. KRAEMER: We are well aware of it.

The third legislative item which we would like passed to help promote home health care is a technical part of the Cap Law. The Cap Law covers our public home health agencies. In other words, about a third of our member agencies are public agencies. The Woodbridge Department of Health near where you live has a public home health agency. This means that they are under the Cap Law. Much of the services that these agencies perform for the citizens of Woodbridge would be reimbursed by Medicaid and Medicare because home health care is a benefit under those two programs. However, because of the Cap Law, these agencies have been constrained from hiring people to provide service, even though there may be an increase

in the need for service. So I say it is a catch 22 situation. It is a question of having an exemption from the Cap Law for those funds which would be in reimbursement for services that are performed by these public agencies.

SENATOR HAMILTON: Taking the Woodbridge example, is that covered by the Cap Law because its funds in part come from the Woodbridge municipal budget or is the Woodbridge Health Department capped on their total budget as a separate entity?

MS. KRAEMER: I am not sure I understand your question. Could you go over it again.

SENATOR HAMILTON: We have imposed caps at the school board level, the municipal level, the county level and the State level. Do we pick up Woodbridge Health Department because it is part of the municipal budget or is it separately capped?

MS. KRAEMER: No, it is not separate. Our public health agencies are both county and municipal. There is a slight difference in the law, of course, as you know. The Cap Law on municipalities is on appropriations and in the counties I believe it is on the tax basis. But in either case, the effect is the same for our agencies; and, that is, that even though they would produce revenue from a third party, such as Medicade, Medicare or even private insurance, especially Blue Cross in this case, that doesn't count for purposes of the cap; the income brought in does not count . It is only the expenditures that come under the cap. So they are finding it difficult to increase their staff. Does that make it clear?

SENATOR HAMILTON: It makes it clearer. I am not sure I grab it all. But I have a better handle on it than I had before.

These bills that you talked about - you mentioned five of them in your written testimony. You talk about modifying the Cap Law.

MS. KRAEMER: There was a Joint Committee of the Senate and the Assembly Taxation Committees. We testified before them about this particular problem and the report agreed that this was a legitimate concern. The legislation suggested by that committee suggested that this exemption be written.

SENATOR HAMILTON: I will take a further look at it. There are a number of legislative measures to change the caps. I have my own. Senator Dumont has the same thing for the boards of education. None of them seem to get a whole lot of support. We really don't need more. We want to agree, to the extent we want to make caps work, what is the best way to make them work better. I will certainly take a look at these. I think I understand your position and what you want to accomplish. I am not sure I understand the exact workings of it.

MS. KRAEMER: Perhaps I ought to send you a clearer explanation of it.

In summary, those are the specific suggestions we have for improving and expanding home health care in the State of New Jersey.

(Written statement submitted by Ms. Kraemer can be found in the appendix.)

SENATOR HAMILTON: I do not doubt it myself, but what data would you point to to show the cost effectiveness of home health care as opposed to institutional care the way we are doing things now?

MS. KRAEMER: Well, I have to tell you that the studies are conflicting because they don't always compare the same things. I really cannot say that there has been definitive work that says that home health care is definitely ---

SENATOR HAMILTON: I am only asking you for what would support your

thesis that it is. I am not asking you to disprove the other. Are there some studies or some data that you could supply us?

MS. KRAEMER: Of course, there are studies that show that in the long term that patients who have been kept out of expensive care facilities have shown savings. Mr. Reilly has spoken to this point and I have to say that there are times when it is inappropriate for a person to stay home and it may be necessary for that person to go into an institution. We talk about postponing the onset of institutionalization as one of the things we can do.

SENATOR HAMILTON: But you can cite to us or furnish us with studies that are supportive of your viewpoint so we can try to convince somebody else who is not here today.

MS. KRAEMER: I will try to find some studies that will support that point.

SENATOR HAMILTON: You see if all we come up with are add-on items, whether it be medically need or be it catastrophic or home health care, we are playing the game that the Legislature has played for years and years and years, and there isn't any way to play it because there isn't any consensus to make any major new increases in revenue available. What we are looking for is: How do you accomplish some of the things that ought to be accomplished in terms of policy? How do you bring additional coverages either for groups, income levels, illnesses, diagnoses, what you want to have, on line without it straining the ability of the State beyond basically the existing levels or existing resources with whatever growth is built into it? It is not to say that there couldn't be any change, but I think it is fair to say that the present mood is not for any significant change. Jerry Reilly knows that. Lou Gambaccini knows it better than most. And that is the reality. Whether that is good public policy or bad public policy, I think it is a reality.

MS. KRAEMER: I can understand what you are saying, Senator. But I also have to say that wherever possible the State would benefit fiscally if people are appropriately placed; that is, if it is appropriate and if it makes economic sense in a particular situation for a person to be with home health care, then that home health care should be available and the system should work towards making it available rather than towards ---

SENATOR HAMILTON: I agree with you and I don't understand that Mr. Reilly would disagree with you. I understand him to say that there are places where home health care is appropriate. I have not yet heard him say, however, that he is prepared to take a million dollars or six million dollars of his budget and allocate it for home health care. So I have been saying that in order to show that effectiveness, we really need something to put our hands on if we are going to say to him, "Hey, maybe you are not going to give it to us, but we are going to take a million and half. We are going to take three million of your dollars and we are going to allocate it in another direction because we think we are going to get more value for the buck." We really have to have that. Viscerally, I subscribe to that. Viscerally, I think he subscribes to that. But he isn't prepared to give up anything he has got because he says he hasn't got enough now for the things he has to do. So we do have to ask you for whatever will support that, not as a humane care kind of thing but as a cost-effective tool.

MR. REILLY: Could I comment on that for a minute?

SENATOR HAMILTON: Have I misquoted you, Jerry?

MR. REILLY: No, that is accurate. But we about tripled what we put into home health care over the past three or four years. That is because we have taken the Medicaid regulations to their maximum extent under the law. Where they used to be very narrow and paralleled Medicare, we try to emphasize home health care as much as we possibly can. If, as Jean suggests, you always knew what was the most cost effective for any particular client and you applied it, and all things were equal, then home health care would clearly be less expensive in some situations.

There are two problems with that. Number one, we have a current backlog of 3,000 people for whom we are not providing adequate care, who have been adjudged as needing institutional care. So, theoretically, if there were one or two thousand people - we say maybe 10 percent of the people - presently in nursing homes that could exist with appropriate home health, that would be about 1800 people. But if you could match them up and get those right 1800 out, you don't save any money in the budget because those beds immediately get filled with people waiting. That is one problem.

The other problem is that once you rationally organize a system of home health, which I think we should have - there is no mistake about that and I think that is the way we should be going --- once that system is organized, the concern is that many more people will want to avail themselves of that system. Then you will have a replacement of family- and friend-given care now by publicly supported care. There is some reason to believe our fears of that are a little bit exaggerated because there has been the Monroe County experiment up in New York called "nursing home without walls" where they have found that less of that happened than they thought would happen. They thought that many more people would become eligible and come forward for service once you had this very nice system. It didn't happen. More people came, but not as many as they anticipated. That is the other problem.

I think you are absolutely right, that we only have so much resource to go around and it is hard to not do this and do that. I think perhaps if we take a longer view and say that over the next 20 years, with the demographics of aging, etc. - and I think this figure is right - we are going to be spending $70 billion a year as a nation on the chronic care system, let's say at the mid-point in 1990. And we are going to spend some $24 billion on capital to build additional nursing homes.

We have choices today. We can choose what kind of system we want to have in 1990 and 2000. We should choose to move more toward a system that has a balance between home health care, congregate care, and institutional care and plan on spending perhaps the same $70 billion that we are going to spend anyway because if we do nothing today, if we make no changes, that is inevitably what will grind out at the other end of the machine simply by taking the number of people coming down the pike, their ages, the cost of care in institutional care and what it is going to be.

Then we have to make a value judgment as to what kind of system we want to have. It is not so much choosing to do A and not B in the short term, because that is impossible to do without incremental resources, but it is trying to think 10 years down the road. My advice to people who are advocates of home health care is that they stop trying to sell it on a purely cost-effective basis because,

if they say that to the committees of Congress and then the committees of Congress discuss it with their staff, their staff may shake their heads and say, "Well, Congressman, I wish that were so, but this is the data and it just doesn't look that optimistic." So, I think you have to change the basis of the discussion and ask, "What kind of a system are we going to build," not that it is going to be cheaper than the present system because I just don't think it will be.

SENATOR HAMILTON: Isn't there another way, Jerry? I understand what you are saying that if you freed up 1500 people today in nursing homes, they would be replaced by 1500 people tomorrow. To the extent that some of the people who are displaced because of whatever cost effectiveness there may be or in spite of the fact that there is none, depending upon whatever viewpoint you take -- to the extent that any of those are being paid for by the people themselves or their family, first of all, the press on you and the press on the industry for nursing home beds for Medicaid patients is alleviated to some extent. In other words, some of the people who could take advantage of home health care might well be people who are self-pay - might be self-pay in home health care. Some of them who are released are going to be Medicaid and would be covered by the Medically Needy or whatever other kind of envelop you put them into under the Medicaid system. Isn't there some element of that involved here?

MR. REILLY: The eighteen hundred I spoke of, that was Medicaid. That is the only stat I have seen of that. So we did it ourselves. It possibly gets misquoted, people saying as much as 30 or 40 percent. Really it is about 10 percent. We don't have the basis to do a study of the private-pay patients. There are some people who believe that a higher proportion of the private sector patient may be inappropriate because they don't have the same scrutiny as the Medical Assistance proportion does.

In a perfect world with a perfect allocation of all the resources, you want to have people in the least restrictive, most appropriate, cost-effective environment. And when you shop all around, we probably have 10 or 15 percent of the people at any one time in the wrong place.

SENATOR HAMILTON: It's not a perfect world. Let me ask you this: Who makes and on what basis do they make a judgment about appropriate placement. Maybe Jim Cunningham wants to listen to this. Now, if somebody has an elderly parent, to what extent does a medical judgment about most appropriate placement enter in if they are either A, Medicaid, or B, self-pay? Is it based on the appropriateness of the placement or is it based on the fact whether you are able to pay the bill?

MR. REILLY: I can only speak with some confidence to the Medical Assistance side. In that case, it would involve a physician, a social worker and a nurse in making the determination as to what care this person needs. We have tried more and more to have that team ask the questions about alternative care and community care, etc.

SENATOR HAMILTON: In what way?

MR. REILLY: That should be part of the workup that the social work person contributes to that team.

SENATOR HAMILTON: How do you superimpose that on --- You know, everybody is comfortable with the status quo, whatever it is. Now, we are trying to change thinking, incrementally at least. What does your department do to at least make that mental exercise be conducted? Are there questions on the form? Is there a

set of instructions? I don't know.

MR. REILLY: Well, I don't know whether the questions are on the form. I haven't looked at that material lately. But that is a part of the training of an assessment team, to be concerned about the alternative systems. I would say that it doesn't work very well, that the tendency is for people to move in familiar paths and that is to move in the institutional path.

SENATOR HAMILTON: You and I are saying the same thing.

MR. REILLY: But it is not that we have given up the ghost. It is only in the past couple of years that we have begun to try to emphasize the other as well. The community system is fragmented. It is more difficult to put together a package of services for somebody who is going to stay in the community.

One thing I should mention in this respect is that New Jersey is one of twelve states that recently received something called a channeling grant. A channeling grant is designed to do exactly this: to do case assessments, what does the person need; and case management, help them get what they need throughout the various systems. New Jersey is one of twelve states which received this and its purpose is to do just this in a more organized way: try to make sure that the people get exactly what they need.

The question about private admissions - I don't know the basis for private admissions to a long term care facility. I don't know whether one has to have a medical diagnosis associated with it. Perhaps Jim could respond to that.

SENATOR HAMILTON: I think maybe you and I have gotten a little bit far afield - maybe not inappropriately so.

MS. KRAEMER: We believe that there should be a continuum of care, that a person should stay home as much as possible. We want that system that will enable that person to stay at home to be as easy for the person to deal with as possible. And we have a lot of problems right now.

SENATOR HAMILTON: Thank you very much.

Jerry, I think we are probably back to you for a continuation of our dialogue or for whatever other comments you may have.

What is the process now for Medicaid admisssion? I have never had the experience of going through a nursing home admission for a member of my family, for a client or for anyone else. Tell me how that comes about?

G E R A L D R E I L L Y: It can happen two ways. At the present time because there is such a shortage of long term care beds, many people move on to Medical Assistance, having entered the home on a private basis. They have agreed to pay a year or two years - in some cases, three years. Their funds are exhausted. They then apply for Medical Assistance. If they apply for Medical Assistance, there is both an income determination that is done by the municipal or county welfare agency and there is a medical necessity review that is done through the Medical Assessment Team, which normally will involve a nurse, a physician and a social worker. Our physicians will not necessarily see every patient, but they will see some of the patients, plus the patient's own physician is involved in the process.

If a person is converting to Medical Assistance and they are already in the home, obviously, there is an inherent tendency of that system to not disrupt that person, even if they are perhaps marginal in terms of medical necessity. It is a very difficult thing to tell someone, "You have to leave." When I was Medicaid Director, I used to get involved in this because I used to have to sign

off on fair hearings when people were asked to leave and didn't want to leave. It was very difficult.

There are three levels of nursing home care. There is ICF-B, which is the lowest level. That means that you need relatively little, but you do need nursing care every day. I think it is 1.25 hours. There is level A, which is 2.25 or whatever. Then there is skilled, which is a higher level of nursing care. Your area where there is going to be a gray area and a choice will be in the B sector. The B sector totals about 20 percent of the whole population, the lowest level. Once a person is there, I think it sometimes happens that it is pretty difficult to recommend against them on a medical necessity basis.

If a person is in the community, they will apply normally through the county welfare agency and that process of assessment will occur, but that will occur through our people going out and visiting the person in their home.

SENATOR HAMILTON: What is the private physician going to have to say on a Medicaid patient about the need and/or the appropriateness in order for the person to be accepted on Medicaid?

MR. REILLY: The medical necessity, not the eligibility. He has nothing to do with the eligibility. The physician is going to have to say that the person needs nursing care. There is a problem of educating physicians too. The physicians aren't necessarily oriented to thinking about the possibility of assembling a package of service that can keep someone at home.

SENATOR HAMILTON: Does he say that when he writes a letter? Does he say that when he picks up the telephone? Does he say that when he signs a form that says,"I have examined Mrs. Smith on such and such a day, and have determined in my medical opinion that she needs nursing services"?

MR. REILLY: There is a form that physicians do have to fill out for this kind of placement.

SENATOR HAMILTON: Does that form, going back to Mrs. Kraemer -- does that form raise the question, either before he signs his name or someplace on the form: Could this patient be handled at home with appropriate availability of certain services?

MR. REILLY: I don't know. I'll get the form and look at it.

SENATOR HAMILTON: Is there anything else that you want to say?

MR. REILLY: On the matter of coordination between service from Title 19 and services from Title 20 and services from Title 3, they all emanate from different acts of the Congress and they have different eligibility criteria and they have different services which they cover. For example, Medicaid can cover home health aides - Visiting Nurse, etc. - but it can't cover at the present time chore services and the services of a homemaker. Both of those things go hand in glove. That is the difficulty in trying to coordinate these things at the local level because they do come out of different laws with different sets of administration, different sets of criteria.

We have done quite a lot to try to coordinate 19 and 20 for a very practical reason. Title 20 is capped and we are essentially out of money. So we have attempted, wherever possible, to charge people to Title 19 when it is appropriate to do so. A lot of that has been going on in the counties. But there is no organic, centralized, coordinated mechanism in place to do that. That relies upon the goodwill and cooperation of the various people in these agencies at the local level.

The channeling grant, per se, has as one of its objectives trying to put together these various titles. There are also several other federal initiatives - Packwood-Bradley, which we call in New Jersey Bradley-Packwood - Title 21, which is trying to pull together the long term home care-home care aspects of these three titles. It is kind of an endemic problem that people are working on.

SENATOR HAMILTON: What will you do with the channeling grant that you weren't doing before?

MR. REILLY: We will do two things - or really three things. Number one, the assessment process will come to the fore and ask some clear questions as to whether a community alternative is available, rather than be perhaps a secondary concern in a system that is biased toward institutions.

Number two, it will have a patient-client management function that once the appropriate recipe of services is identified will help see to it that the client gets it. We will develop some expertise in sorting through the currently fragmented system. And I think it will have more of an emphasis upon community than the present system.

The third thing it will do: There is a small amount of money in what is called the gap-filling funds where a person needs something that is not covered by any of the programs in order to maintain the least restrictive appropriate environment. For example, if someone needs a lift built and installed to aid in bathing and none of the other programs provide that, this program could provide that kind of service - things that fall between the cracks.

SENATOR HAMILTON: When was this first available, the channeling grant?

MR. REILLY: Oh, I guess it was around sometime last June.

SENATOR HAMILTON: Is it for fiscal 1981?

MR. REILLY: Yes. We applied the first available opportunity. I think it began formally December 1, at least the planning part of it.

SENATOR HAMILTON: Of this year?

MR. REILLY: Of this year, yes.

There are two sites in New Jersey that are candidates. There is a site in Middlesex and there is a site in Essex. The federal government is supposed to decide by the end of this month which site. We know that we have the grant.

SENATOR HAMILTON: How much is the grant?

MR. REILLY: $950,000.

SENATOR HAMILTON: How many years is it for?

MR. REILLY: I think it is three.

SENATOR HAMILTON: At the end of that period of time, you either don't do channeling or you pay for it out of State money.

MR. REILLY: Yes, that is the dilemma. I have testified various places saying that the channeling grant is nice and we are glad for it and we will try to avail ourselves of it. But, in some senses, it may be unnecessary because the things that we are going to demonstrate in New Jersey have been demonstrated elsewhere. I am not going to be terribly surprised at anything that comes out of channeling, I don't expect. What we have also said to the federal government is, "You should continue to fund other successful demonstrations rather than let them die after three years and then go on and tinker someplace else." Some of this may be a substitute for confronting the issue.

Why the national government is unwilling to move into this area with

a full head of steam is just what I have been alluding to before: they fear that it is going to be tremendously expensive. And that is why we continue with the demonstrations. But there seems to be some momentum really building up on the national level. People are beginning to focus on this issue as the health care issue of the '80's. It is probably important that we are there and we are in the forefront of it.

SENATOR HAMILTON: One thing I have not asked you anything about today is catastrophic, where you put that in the catalog of things that are needed, how it would help and who it would help?

MR. REILLY: I don't know that much about it. I haven't really thought about it that much, catastrophic and health insurance. I know that a lot of people who are thinking and writing in the area of health policy are skeptical about catastrophic because their philosophical concern is that it deals with the symptoms of a system that doesn't emphasize the proper side of the spectrum. It doesn't emphasize prevention etc. Their concern is that it becomes a substitute for hard-thinking and appropriate public policy in those areas of prevention access that perhaps come before catastrophic.

Catastrophic is not something I have done a lot of thinking about because it is somewhere five or six rungs above the Medical Assistance population. Although in some sense, we are a catastrophic program of last resort. And people who have catastrophic disablement that affects their income will eventually wind up with us. But I really can't contribute too much to it.

SENATOR HAMILTON: Let me say thank you to you. Let me be very honest with you. You have given us a whole lot of facts, but I don't consider -- and it is not through any fault of yours -- but I don't consider that we are an inch closer in trying to clear anything up. You have given me a whole lot more to chew on. Maybe that is not so bad, just to have something more to chew on and look at.

I don't think we have anyone else here who indicated a desire to be heard today. If there is, we will certainly hear you briefly. I am not going to announce now when we will reconvene, only that we will. To the extent that in the dialogue that has gone on there have been some things suggested and there have not been questions posed by me or by anyone else who participated that may be helpful, we would be happy to hear from any of you by way of comment, informally or otherwise.

Thank you for your interest. We will back on this, if not in December, certainly in January. There is a remote chance it will be again in December, but I think not. Thank you very much.

- - - -

SUBMITTED BY DR. KOPLIN Department of Health

Medical Care Cost (In thousands, $)

For the Fiscal Year Ended June 30, 1980

Cost Category	State Funds	Non-State Funds	Total Funds
Tuberculosis	$1,625	$ 586	$2,211
Chronic Diseases	134	63	197
Cardiovascular & Diabetes Program	1	533	534
Crippled Children	2,067	1,542	3,609
Dental Health Program	10	179	189
Maternal & Child Health	98	18,878	18,976
Hemophilia & Renal	1,572	12	1,584
Venereal Disease	380	981	1,361
Alternative Health Systems	279		279
	$6,166	$22,774	$28,940

Department of Health

Health Care Cost (In thousands, $)

For the Fiscal Year Ended June 30, 1980

Cost Category	State Funds	Non-State Funds	Total Funds
Emergency Medical Services	$ 300	$1,321	$1,621
Tuberculosis	1,625	586	2,211
Occupational Health & Cancer Control	257	160	417
Chronic Diseases	134	63	197
Cardiovascular & Diabetes Program	1	533	534
Biological Services	128	958	1,086
Drug Device Cosmetics	483	3	486
Field Operations	425	496	921
Food and milk	195	148	343
Consultation Services	4	3	7
Accident Prevention & Poison Control	42	99	141
Crippled Children	2,067	1,542	3,609
Dental Health Program	10	179	189
Family Planning	182	5,885	6,067
Maternal & Child Health	98	18,878	18,976
Hemophilia & Renal	1,572	12	1,584
SSI Disabled Children Treatment		1,017	1,017
Communicable Disease	149	199	348
Immunization Program	218	403	621
Venereal Disease	380	981	1,361
Special Epidemiological	157	358	515
Cancer Registry	242		242
Pesticides		216	216
Treatment and Rehabilitation	5,780	9,172	14,952
Alcoholism	1,284	4,658	5,942
Clinical Laboratory Improvement	380	56	436
Vital Statistics Registration	530	159	689
Laboratories	2,028	1,461	3,489
State Support for Public General Hospitals	9,795		9,795
Public Health Priority Funds	2,504		2,504
Alternative Health Systems	279		279
	$ 31,249	$ 49,546	$ 80,795

SUBMITTED BY GERALD REILLY

OVERVIEW OF NEW JERSEY HEALTH ECONOMY, 1979

	Population Served	%	(Millions) Dollars* Spent	%	Hospital In	%	Hospital Out	%	(Millions) Long-Term* Care	%	Ambulatory	%
Medicaid	662,700		659		162		35		219		230	
Medicare									17			
Non-Covered												
Blue Cross/ Shield												
Private									201			
Total									437			

*Dollars spent are State and Federal share of Medicaid.

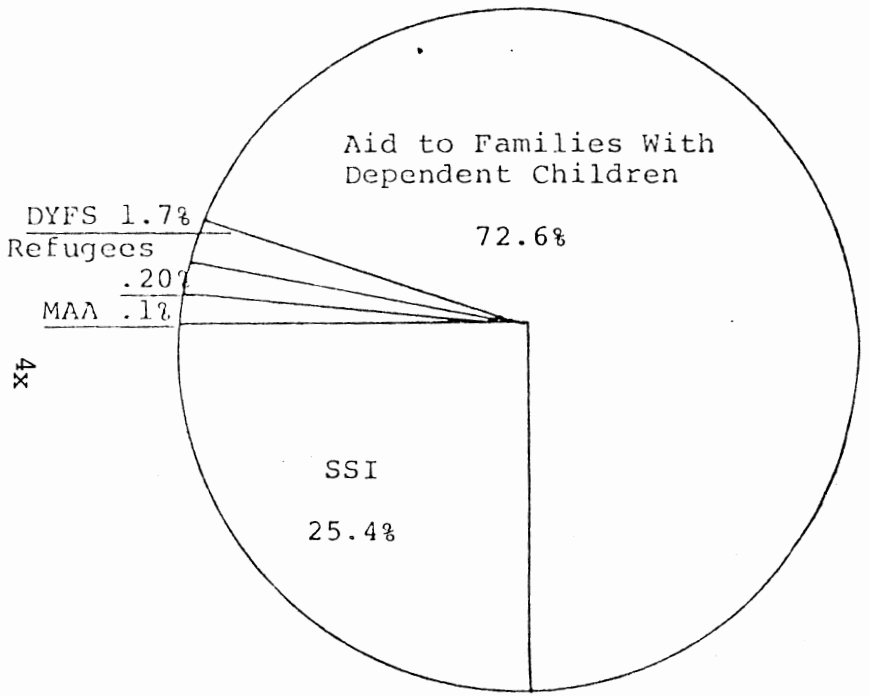
3x

MEDICAID CASELOADS AND COST

PROJECTED DISTRUBTION

FY 1982

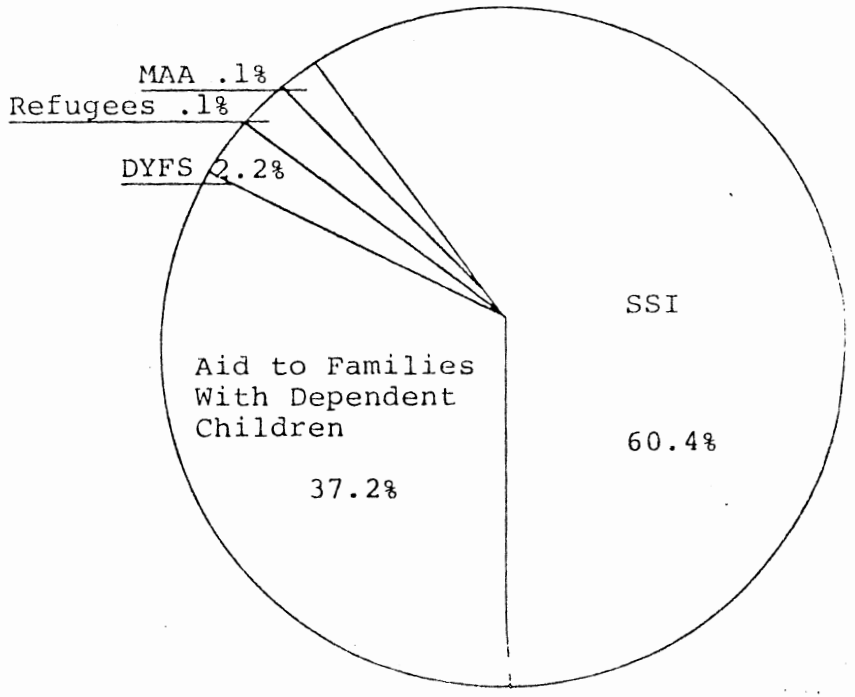
RECIPIENTS



TOTAL MEDICAID CASELOAD

315,000

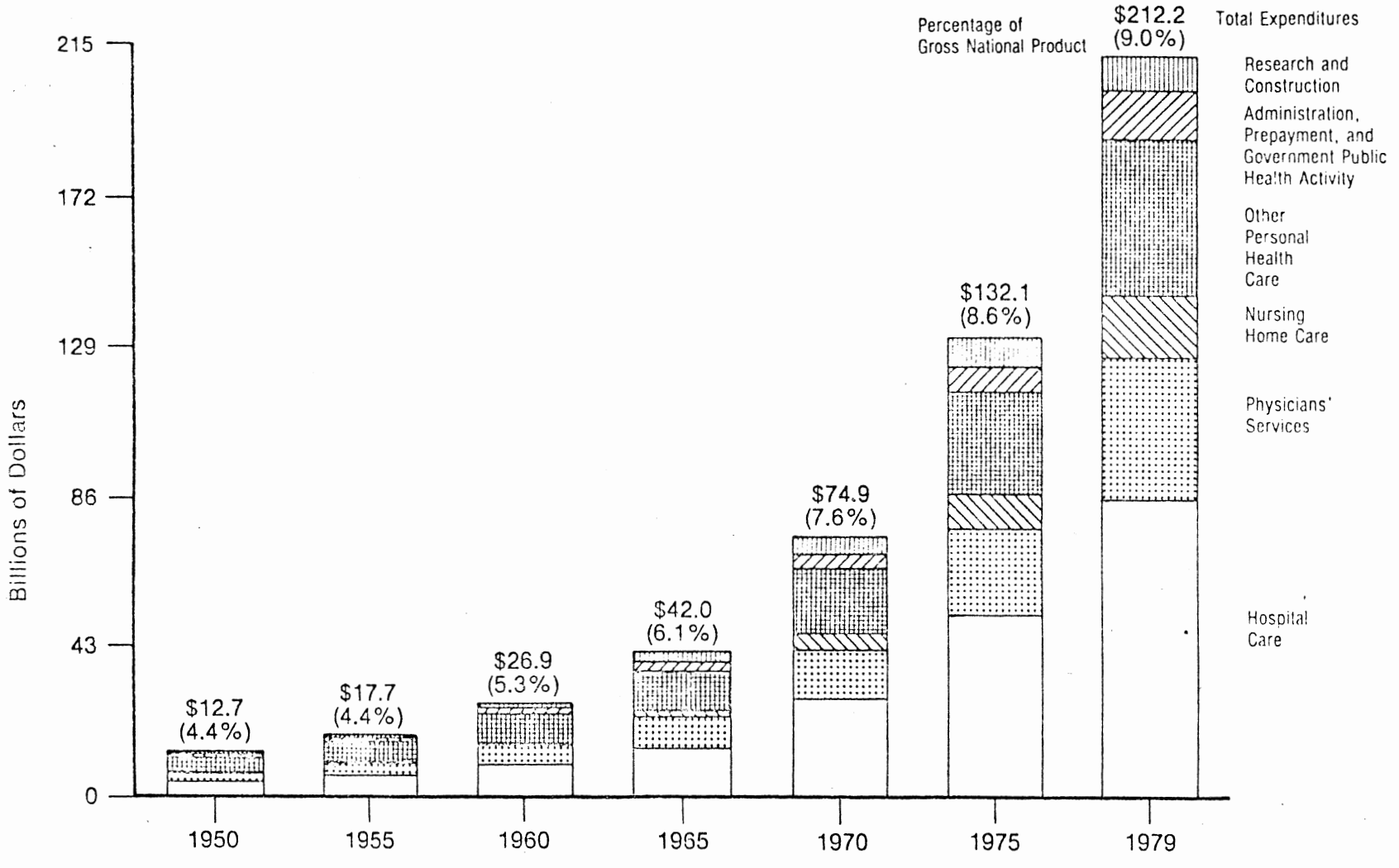
COSTS



TOTAL MEDICAID EXPENDITURES

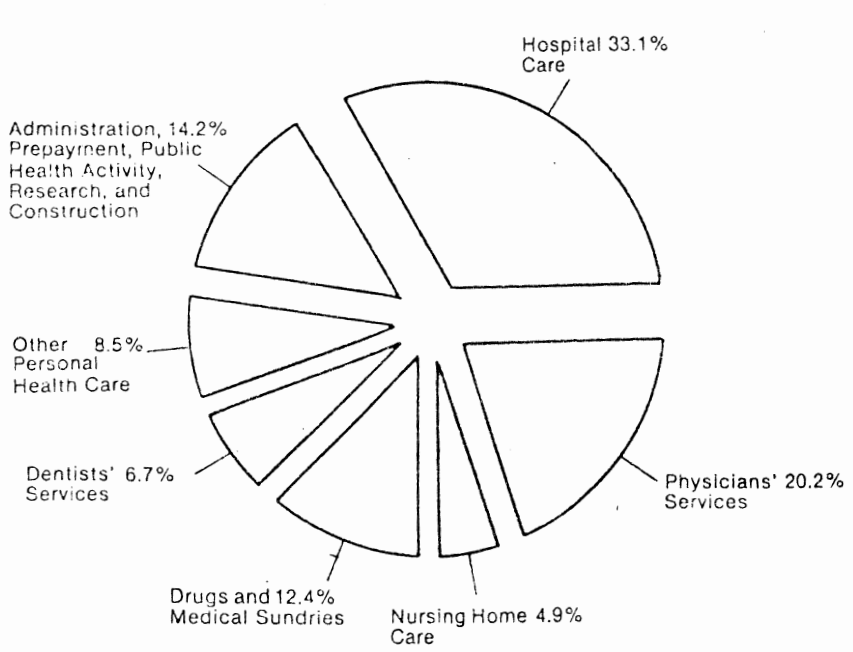
$870,894,000

FIGURE 1
National Health Expenditures
Selected Calendar Years 1950-79

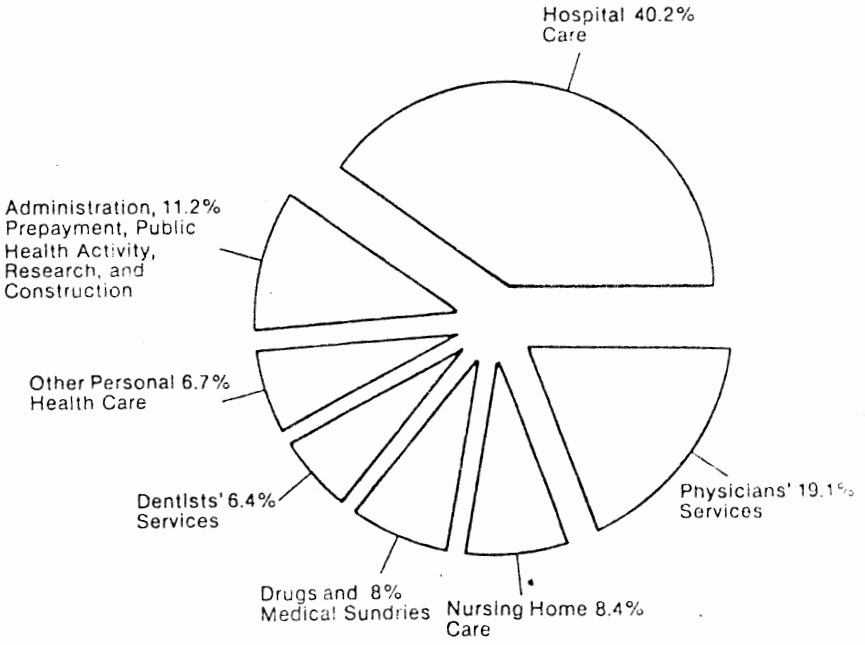


Source: Tables 1 and 2

FIGURE 2
Distribution of National Health Expenditures
By Type of Expenditure



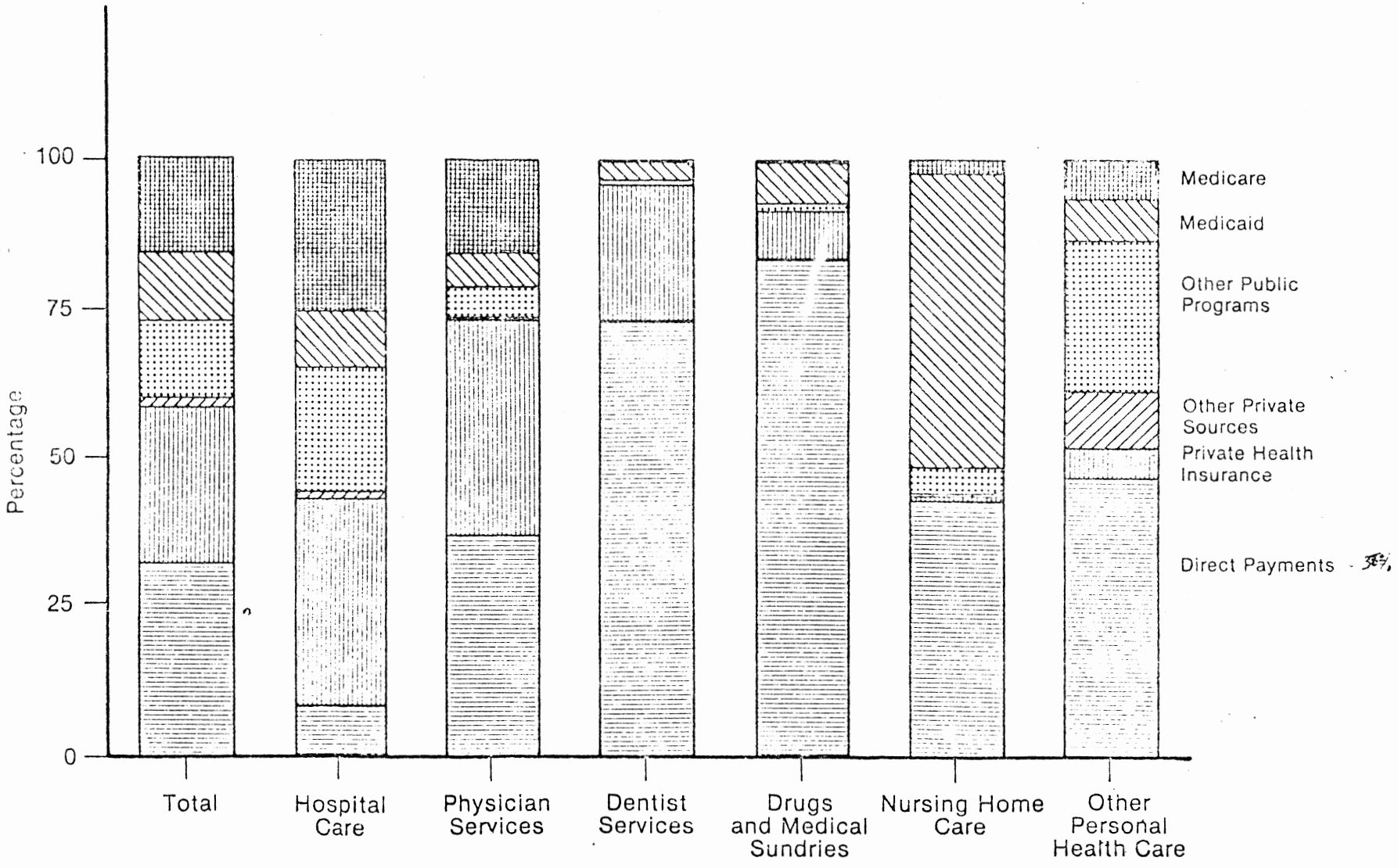
Calendar Year 1965



Calendar Year 1979

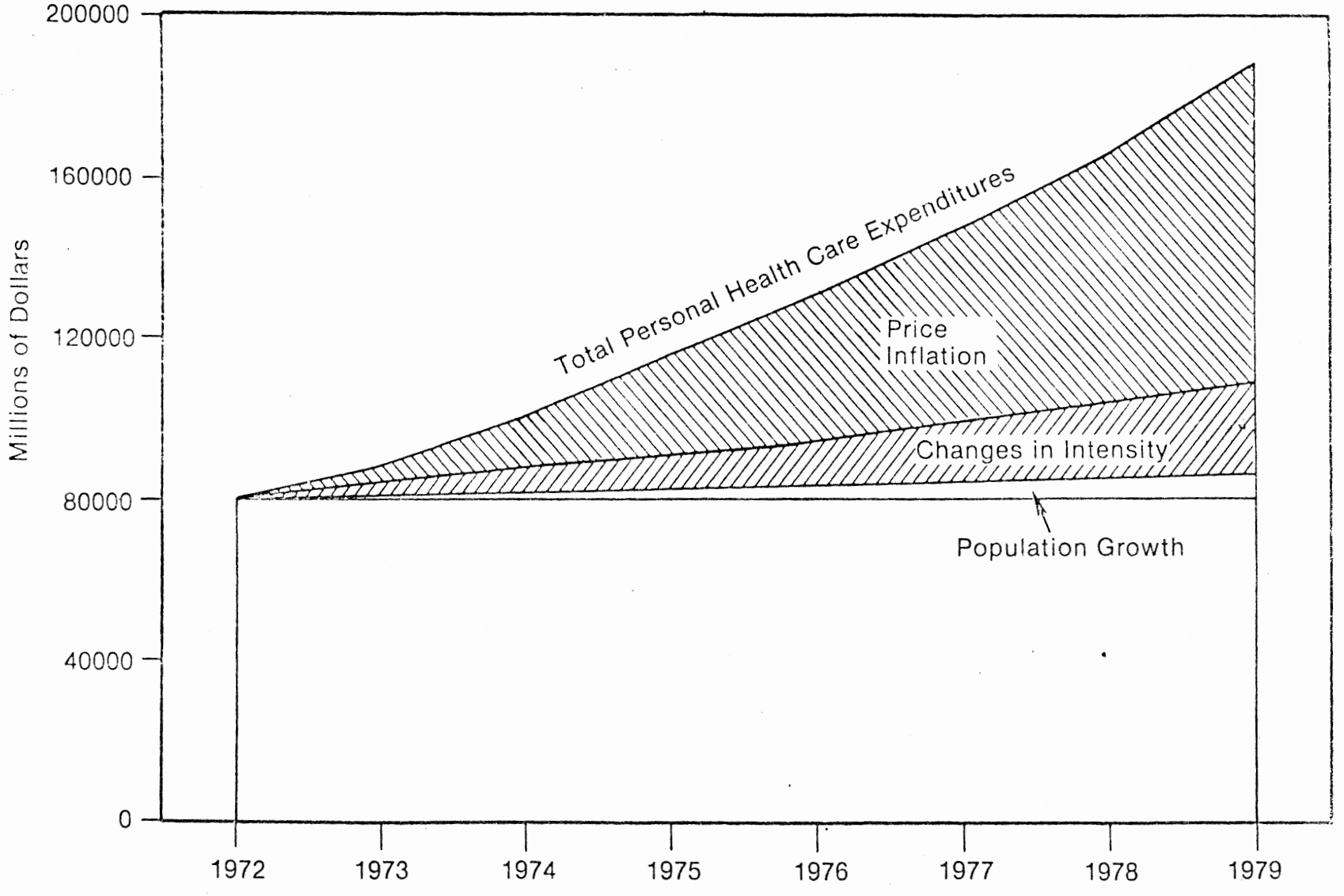
Source: Table 2

FIGURE 3
Sources of Funds for Personal Health Care Expenditures, by Type of Expenditure
1979



Source: Tables 3 and 5

FIGURE 4
Sources of Growth in Personal Health Care Expenditures,
1972-1979

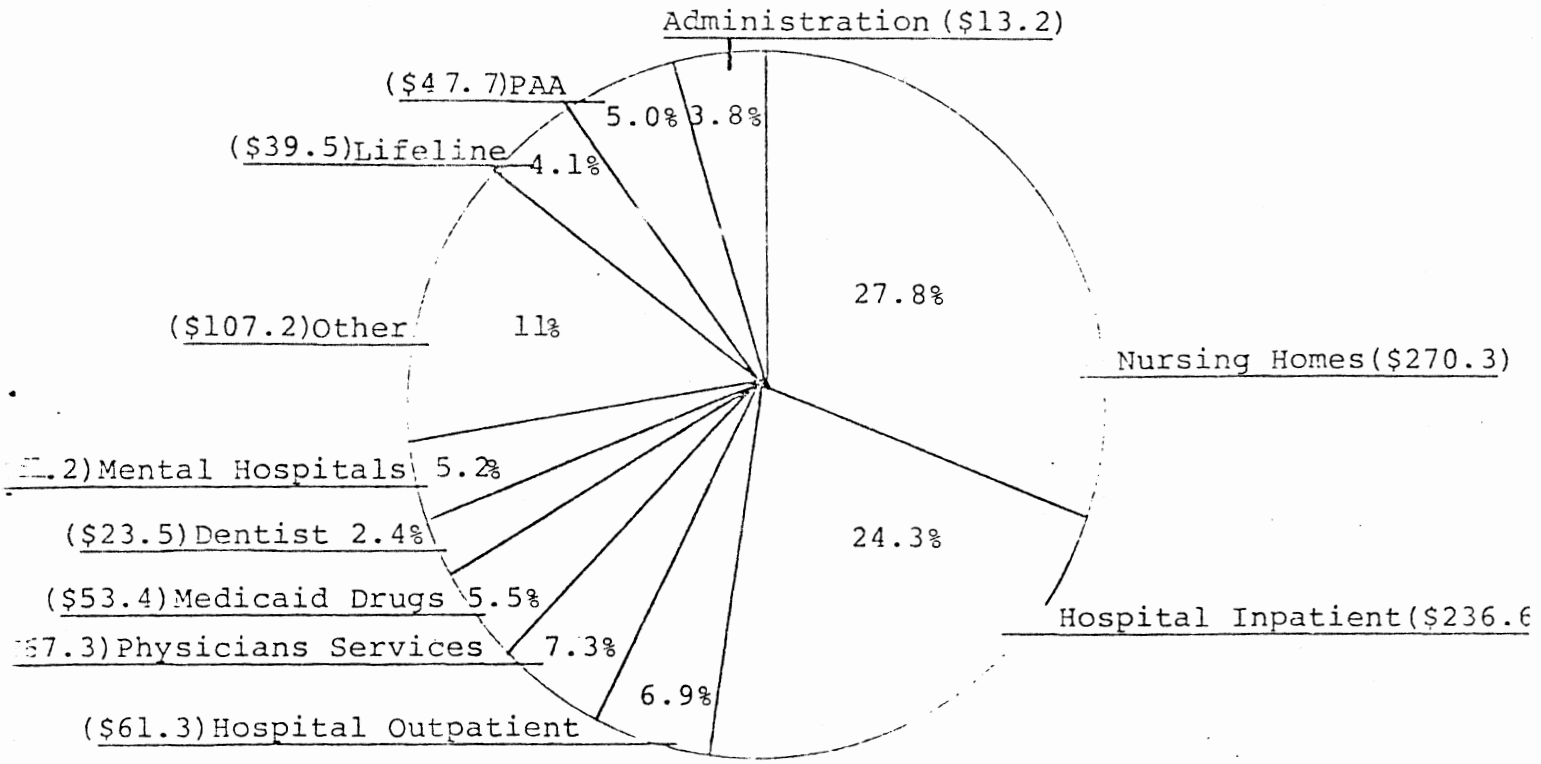


Source: text table A

Fiscal Year 1982

Program Expenditures by Service Categories

($Millions-State and Federal)



Total Program Costs = $971,230,000

STATEMENT

ON

HEALTH CARE COST

before the

Senate Institutions, Health and Welfare Subcommittee

Monday, December 15, 1980

by

Jean Kraemer
Director/Legislative Affairs
Home Health Agency Assembly of New Jersey, Inc.
760 Alexander Road CN-1
Princeton, N.J. 08540

The Home Health Agency Assembly of New Jersey represents the forty-seven home health agencies who are certified by Medicare and Medicaid to provide and coordinate care for the sick at home in New Jersey.

Insufficient nursing home beds and soaring costs are major concerns facing health care planners in New Jersey. While the Home Health Agency Assembly of New Jersey does not claim to offer panaceas, we believe that expanded home health care delivered by our agencies would help alleviate both these problems. From our perspective, institutional care is the more costly and less humane alternative to home health care in those situations where the patient can appropriately be treated at home. Our agencies also actively promote cost effective preventive health care through their public health programs. The route to expanded home care and preventive care must include the following: better coordination of home care benefits, health monitoring programs for seniors; and legislation for home health insurance coverage, Medically Needy, and CAP relief.

1. Coordination. Last month, Governor Byrne and Senators Bradley and Williams co-sponsored a conference on home health care in New Jersey. Much of the conference focused on the need for more coordination from a federal perspective. The federal government now funds home health care through four different programs, each with its own eligibility standards and reimbursement policies. The federal programs are: Title XVIII, Medicare; Title XIX, Medicaid; Title XX, Social Services; and Title III of the Older Americans Act.

While much reform must be initiated federally, coordination of home care benefits is a distinctly New Jersey problem. The various state departments responsible for home health care in New Jersey are not sufficiently aware of who is serving whom. For example, a patient might be receiving homemaker care one day under Title XX from one agency and additional homemaker care another day under Title XIX. Surely, no one wants duplication of services.

At the hearing, Under Secretary of Health and Human Services, Nathan Stark, further added that "a much greater cause for concern than potential duplication is poor coordination of services for clients who might be served by more than one program". People need continuity of care providers and services when they are sick and disabled.

2. Health Monitoring for Seniors. Another issue is the funding of health monitoring programs for senior citizens. Some of our agencies have had great success in postponing the onset of serious illness among the frail elderly through their preventive health monitoring programs. Community health nurses go to senior citizen centers and housing sites, where they screen patients, provide counseling, monitor health status, and refer to a physician when necessary. This consistent monitoring and follow up prevents the development of expensive acute episodes of illness.

Most of these health monitoring programs have been funded through grants; others, insufficiently funded under the state aid to local health departments. As a result, their future is precarious and expansion of these programs throughout the state is impeded. We strongly urge that an adequate and permanent funding source be established for such programs as an effective, cost-efficient way to keep people in their homes.

There are a number of bills now pending in the New Jersey Legislature, whose passage would enable increased home health care. The three specific areas for legislative reform are: mandated commercial insurance coverage for home health care; a Medically Needy Program; and modification of the CAP law. The details of each area follow:

3. Mandated insurance coverage. Towards the end of a period of hospitalization, there are often times when care can be appropriately given at home, rather than in the hospital. Currently, Medicaid, Medicare, and Blue Cross all provide coverage for a wide array of home health care

services. Commercial hospitalization insurance in New Jersey is not mandated, except for "newly written" policies. A New Jersey citizen whose commercial hospitalization policy is not "newly written", generally does not receive coverage for the multiple home health services provided by our agencies. Thus, his insurance will pay for care in an expensive acute care facility, but not for the same care which might be done at home.

Further, in New Jersey, those hospitals who are under the DRG Rate setting system have an incentive to discharge patients as early as possible, rather than to have them linger unnecessarily in the hospital. This policy, designed to promote proper use of health care resources, unfortunately creates a fiscal hardship for the patient who is sent home and needs follow-up care, but who does not have home health insurance benefits.

A-1672 is a bill which would mandate home health care provided by home health agencies in all commercial hospitalization insurance policies. It has already passed the Assembly; and we would urge its passage through the Senate and signing into law by the Governor.

4. Medically Needy Program. The existing Federal Medicaid law is biased against home health care in favor of nursing home care. It states that to be eligible for home health care under Medicaid, a person's income must not excede $263 a month, while the same person can enter a nursing home with three times that income, or $789 a month. The New Jersey legislature cannot, itself, change this federal law; but it can lobby Congress to do so, as by passing ACR 47. This resolution addresses the specific problem explained above.

Creation of a Medically Needy Program in New Jersey would, however, have an immediate impact on this problem. Such a program would raise the Medicaid income eligibility qualifications for some categorically eligible persons, such as the frail elderly, who would prefer to stay home rather

than enter a nursing home, but who are not poor enough for home health coverage under the current Medicaid Program in New Jersey.

A Medically Needy Program would also further preventive health care. It is better and less expensive for patients to receive care when they need it, rather than to wait for a costly medical crisis because they could not afford to pay for needed services earlier. A Medically Needy Program, in both these cases, would be humane and cost effective. We urge that the legislature support such a program.

5. The New Jersey CAP Law. Ironically, the CAP law, meant to cut costs, has been a deterrent to expanded cost-effective home health care. There are sixteen county and municipal public home health agencies in New Jersey. They provide services which are reimbursed by Medicare and Medicaid and do not add to county and municipal costs. Yet, because of the CAP restrictions, these agencies are not able to hire additional staff to expand their services when there is increased need.

We urge support of legislation which would ameliorate this "Catch 22" situation. The two bills which have addressed this specific problem are Scs (S 77,399,400,770) and A-2009. Passage of either would modify the CAP law to exempt federal and state supported programs from local CAPS.

When Brahna Trager, a nationally prominent figure in home health care, addressed the recent New Jersey Conference on Home Health Care, she said: "A formidable barrier exists in the legislative structure on which Home Health Services are based. Funds for service reimbursement must be sought from a dozen or more sources; public programs differ from one another in their eligibility requirements, in the services they provide, in the definitions of these services and in federal-state-local matching arrangements. There has been very little standardization in the claims review process.

What is reimbursable in one locale may be rejected in another. The insecurity that this fragmentation engenders adds to the problems of the consumer, the planner and the provider. The consumer, of course, is the ultimate sufferer in this fragmented and uncoordinated system; the costs are human, but they are also costs in practical terms, and however willing the general public may be to support its vulnerable populations, the disarray in the arrangements for such support is less than encouraging.

To the key question: What is to be done? There may be several answers. Years ago Franz Goldman, the father of theory in home health care said that effective services begin with sincerity of intent. He called it "the will to do", and while this may sound somewhat naive in view of much of the cynicism that is prevalent today, it would be difficult to find a substitute for the action that flows from a determination to achieve an objective which is essential to the public good".

We concur with Ms. Trager's analysis and her call for action to do what is essential to the public good. We urge this committee to accept its responsibility towards promoting home health care, for the public good.

STATEMENT OF

THE CITIZEN'S COMMISSION ON HUMAN RIGHTS

BEFORE THE

SENATE INSTITUTIONS, HEALTH AND WELFARE SUBCOMMITTEE

ON HEALTH CARE COSTS

December 15, 1980

Submitted by:

Patrick Burns
Acting Regional Director
Citizen's Commission
on Human Rights
101 W. 85th St.
Suite 1-1
NY, NY 10024

Mr. Chairman and members of the Committee, I regret that I am unable to attend the Subcommittee meeting in person, but I appreciate the opportunity to present the views of The Citizen's Commission on Human Rights concerning health care costs.

CCHR has long been aware of a serious gap in health care for mental patients. This was recently confirmed by a paper submitted at this year's American Psychiatric Association convention which showed that approximately 50% of all patients admitted as "psychiatric" cases have undiagnosed medical illnesses which cause or aggravate their mental problems, and only 2% of patients were conclusively shown to be suffering from mental disorder only.

It is reasonably safe to assume that the mental problems of many of the remaining 48% could be alleviated to some degree, and certainly all would benefit from more extensive medical examination and care. Unfortunately, at present the stress in mental health facilities is on controlling the manifestations of the patients' mental problems and not on correct diagnosis and treatment of their medical problems. We insist that this is harmful to the patients as well as a great waste of health care funds, in that more thorough medical examination leading to short term medical care rather than commitment would reduce the number of mental patients, the length of term of their care, and thereby reduce the total cost by what we estimate to be 50%, much of which could be covered by third party insurance payments. All this in addition to supplying the kind of medical care that is most conducive for the patients' recovery.

This matter relates directly to Senate bill 352 regarding involuntary commitment. Screening services which detect medical illness would most likely filter out of the commitment process persons whose erratic behavior may be due to or worsened by organic causes. Also, since non-psychiatric medical facilities exist all over the state, new monies for alternatives to psychiatric services would not be needed.

We respectfully maintain that the interests of patients and taxpayers as well as the State could best be served by medicalizing the treatment and commitment of mental patients in this fashion.

Attached find a summary of research along these lines as well as CCHR's guidelines for the treatment of mental patients, some of which have been incorporated into President Carter's mental health reform.

If you desire more detailed documentation, feel free to contact me.

PHYSICAL ILLNESSES LABELED AS PSYCHIATRIC ILLNESSES

There is growing recognition in the medical community and the psychiatric field, that a large percentage of the institutionalized "mentally ill" are in fact suffering from undiagnosed medical illnesses, which should be treated with standard medical treatments, not psychiatric treatments.

Currently, it is a well publicized fact that our mental hospitals are overcrowded and that there are not enough psychiatrists nor enough money available to adequately care for the "mentally ill".

Closer inspection shows from an analysis of psychiatric and medical studies that as many as 50% of these patients, if correctly diagnosed as to medical difficulties could be released from the mental institutions and returned to standard medical care.

Mental institutions as a rule do not provide medical care for their patients. Mental institutions usually have inadequate medical equipment and diagnostic facilities for caring for the medical needs of the patients. Mental institutions fail in general to provide adequate screening facilities and diagnostic proceedures for the detection of physical illnesses. Psychiatrists, although they purport medical training, fail to use the standard physical illness diagnostic tests on their patients, and instead rely on the unscientific and non-uniform diagnoses of "mental illness".

The Citizens Commission on Human Rights, sponsored by the Association of Scientologists for Reform, has compiled the following statistics which clearly show the extent of the problem with faulty diagnoses of physical illnesses by psychiatrists.

In a study released at the 1980 American Psychiatric Association Convention entitled, Unrecognized Physical Illness Prompting Psychiatric Admission: a Prospective Study", it was stated that of 100 psychiatric patients admitted to a research ward, 46% of these had previously unrecognized medical illnesses which either caused or excarberated their psychiatric illness. 80% of the patients had physical illnesses requiring treatment.

A 1965 study entitled " Physical Illness in Psychiatric Out-Patients" published in the American Journal of Psychiatry , found that a study of 36 patients attending a psych out-patient clinic 21 showed physical disease. The study found the need for full facilities for physical investigation essential.

A further study entitled, Diagnostic Error in Emergency Room Medicine: Physical Illness in Patients Labeled " Psychiatric" and Vice Versa" published in the International Journal of Psychiatry in Medicine in 1975 also found that of 8 out of 469 patients, less than 2% presented clear cut psychiatric entities with minimal somatic components. The study stressed that medical education is sorely decifient and that special care must be taken not to jump to a conclusion on the basis of a single fact which has "pre-labeled" the patient as "psychiatric" or "organic".

Again Dr. Robert Phillips found in his study "Physical Disorder in 164 Consecutive Admissions to a Mental Hospital" published in the British Medical Journal in 1937, that of 164 patients admitted, 112 were considered physically unfit. Even as early as 1937, Dr Phillips conclusion was that a miniature general hospital, with all it's numerous departments was a necessity, along with a resident House physician to care for the bodily ailments of patients. He noted at that time that it is too often assumed that the physical condition of the mental patient is good; thuse examination is far too often brief and cursory.

The British Medical Journal again in 1949 found in a study entitled "Incidence of Physical Disorders Among Psychiatric In-Patients" after a review of all cases admitted to the hospital in 1948, that of 175 patients studied, 77 patients or 44% had some physical condition. Those over 40 years of age had a 61% incidence of physical illness. Again, he stressed in his conclusion that a full physical investigation of all psychiatric patients is needed.

Dr. Koranyi, from Canada did a similar study entitled" Physical Health and Illness in a Psychiatric Outpatient Department Population"- Canadian Psychiatric Association.Journal. Again the statistics of 49 patients out of 100 were found to have physical illnesses. 34 of these had not previously had the condition diagnosed. His study showed that half of the patients were suffering from some sort of physical illness. 2/3 were not diagnosed properly and half were not diagnosed at all before admission to psychiatrists. He found that diagnosis was poor by general and psychiatric practioners, and that medical supervision of patients with organic illnesses was insufficient. Many instances showed the physical illness was the main cause of the emotional problem.

As can be seen from the above studies, the psychiatric community themselves have since 1937, admitted that approximately half(50%) of the mental patients are physically ill. In the majority of studies, extensive medical examination by medical(not psychiatric) personnel was recommended. Again in 1980 the same observation has been made with the 50% rate still continuing.

A brief review of psychiatric hospitals shows no increase in medical facilities, physical illness diagnostic proceedures, nor an increase in medical staff. despite the fact that studies have been done indicating the vital need for this since 1937.

The Citizens Commission on Human Rights has been advocating the vital need for medical examinations by non-psychiatric personnel since 1969, when it's Declaration for Human Rights for Mental Patients was first adopted.(Copy attached). As little progress has been made since this time on getting the psychiatric community to take responsibility for the physical condition of it's "mentally ill", and the cries for more money and more staff have escalated, CCHR is now beginning a full scale investigation into the actual facilities available for diagnosis of physical illnesses, the documentation of individual cases where people have been involuntarily held in psychiatric institutions against their will, subjected to psychiatric treatments, when in fact physical illnesses existed, and into the actual medical qualifications of the psychiatric community to diagnose physical illnesses. This information is being compiled for use to present to legislators with a demand for legislative change, implementation of medical not psychiatric examinations, and an investigation into percentage of commited patients who are medically ill with the solution of medical treatment to the problem of rising costs of mental health care.

"CCHR is a secular organization sponsored by the Church of Scientology, whose founder is L. Ron Hubbard, (or by the Associations of Scientologists for Reform in the U.S.), which works to secure the rights of mental patients and to guard against their abuse. It is a national organization composed of Scientologists and non-Scientologists who are concerned about psychiatric violations. The banner of the Citizens Commission onHuman Rights is the Church of Scientology Declaration of Human Rights for Mental Patients which was researched and formulated by Mary Sue Hubbard."

A DECLARATION OF HUMAN RIGHTS FOR MENTAL PATIENTS

Drafted by the Church of Scientology World Wide, January 1970

A. No person, man, woman or child, may be denied his or her personal liberty by reason of any mental illness or deficiency, so-called, without a fair jury trial by laymen and with proper legal representation. This to be supplied by Legal Aid if such is available and requested.

B. If properly committed in a fair jury trial by laymen, and with proper legal representation, a mental patient has the following necessary rights and may not be deprived of any civil, political, personal or property rights without due process of law.

C. 1. Any patient has the right to be treated with dignity as a human being.

2. The right to equal hospital amenities without distinctions as to race, color, sex, language, religion, political opinion, social origin or status by right of birth or property.

3. The right to have a thorough and competent physical clinical examination by a registered general practitioner and not a psychiatrist, to ensure that one's mental condition is definitely not caused by any physical illness, injury or defect, and the right to seek a second medical opinion from a general practitioner of one's own choice - if so desired.

4. The right to choose the kind or type of therapy to be employed, and the right to discuss this with a general practitioner of one's own choice, at which time the side effects of any treatment must be made clear.

5. The right to accept or refuse treatment, and in particular, the right to refuse, or one's relatives to refuse, sterilization, electric shock treatment, insulin shock, narcosynthesis, lobotomy, transorbital leucotomy, aversion therapy and any drugs producing unwanted side effects.

6. The right to make complaints officially without reprisal to an independent board, in no way connected with the hospital or its personnel, as to any torture, cruel treatment or inhuman or degrading treatment or punishment received. Such complaints may not be ignored by any independent board on the specious basis of "mental condition."

7. The right to have a legal advisor, to take legal action and to have private interviews with a legal advisor.

8. The right to seek discharge in a fair jury trial by laymen, and with proper legal representation if an involuntary patient, or the right to discharge oneself at any time if a voluntary patient.

9. The right to manage one's own property and affairs with a legal advisor, if necessary, or if deemed completely incompetent by jury trial to have a State appointed executor to manage such until one is adjudged competent. Such executor to account to the patient's next of kin, or legal advisor, for the actions taken by such executor.

10. The right to see one's hospital records and to take legal action with regard to any false information contained therein which may be damaging to one's reputation.

11. The right to sue relatives, associates, the institution or doctors for unlawful commitment, false reports of condition or damaging treatment.

12. The right to have no stigma attached to one's reputation by reason of having been in a mental institution.

13. The right to work or to refuse work, and the right to receive just compensation on a pay-scalecomparable to union rates in similar work, for any work performed while hospitalized.

14. The right to education or training so as to enable one better to earn a living when released, and the right of choice over what kind of education or training is received.

15. The right to receive visitors and a Minister of one's own faith.

16. The right to make and receive telephone calls and the right of privacy with regard to all personal correspondence to and from anyone.

17. The right to freely associate or not with any group or any person in the mental institution.

18. The right to a safe environment without having in that environment persons placed there for any criminal reasons.

19. The right to be with others of one's own age group.

20. The right to wear personal clothing, to have personal effects and to have a secure place in which to keep them.

21. The right to daily physical exercise in the open.

22. The right to a proper diet and to three meals a day.

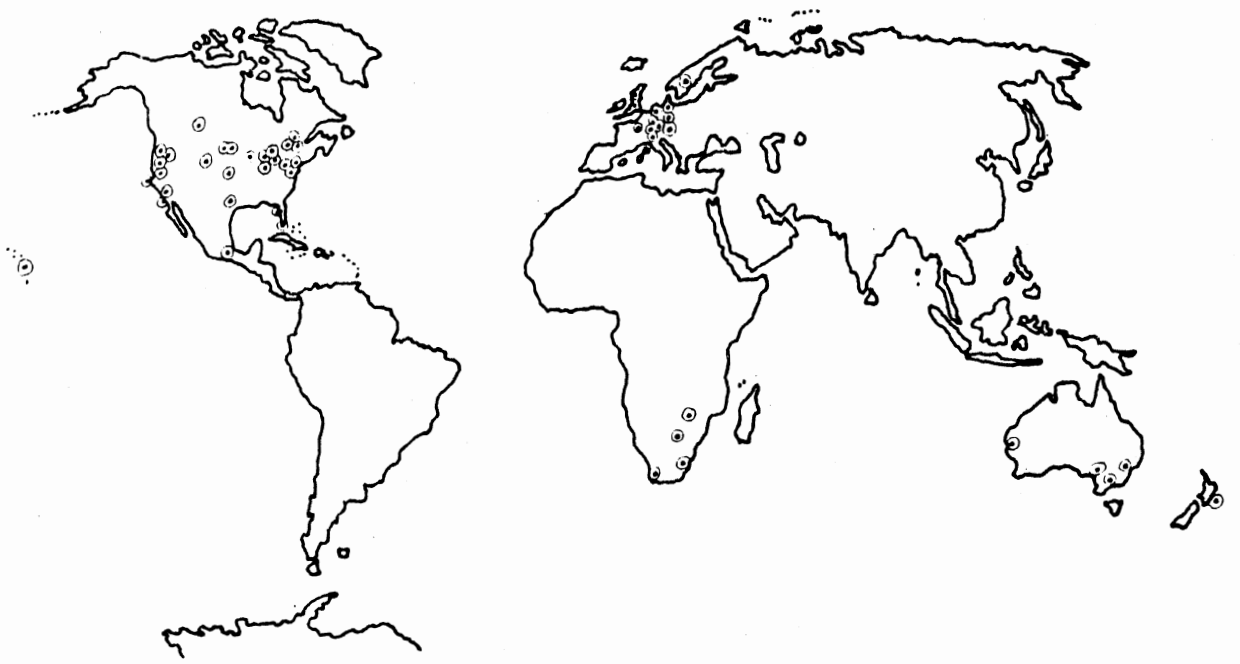
23. The right to hygienic conditions and non-overcrowded facilities.

24. The right to sufficient, undisturbed leisure and rest.

25. The right to medical treatment for ordinary physical illness.

These rights may in no way be violated by anyone for whatever reasons and in particular these rights can not be subjected to modification by reason of professional or political opinion. If the State has determined through a fair jury trial that it has the right to detain anyone for mental illness or deficiency, so-called, then it must provide the services, facilities and staff to properly care for those whom it has detained. If the State can not properly provide such, then it has no right to so detain anyone on the basis that it is for the individual's welfare that he is detained. The above rights are deemed absolutely essential for human conditions. Any other conditions are inhuman and should not be tolerated, condoned or supported.

CCHR OFFICES AROUND THE WORLD



NORTH AMERICA

CANADA

Edmonton
Montreal
Quebec
Toronto
Ottawa
Vancouver

MEXICO

Mexico City

USA

Austin
Boston
Buffalo
Chicago
Clearwater
Columbus
Denver
Detroit
Honolulu
Los Angeles
Miami
New York
Portland
Sacramento
St. Louis
San Diego
San Francisco
Seattle
Twin Cities
Washington

EUROPE

Copenhagen
Amsterdam
Stockholm
Paris
Milano
London
Edinburgh
Berlin
Munich
Vienna
Zurich
Bern
Oslo
Brussels

AFRICA

SSMH — Society for Safety in Mental Healing

Cape Town
Durban
Johannesburg
Bulowayo

AUSTRALIA — NEW ZEALAND

Adelaide
Perth
Melbourne
Sydney
Auckland