MEDICAL CARE FOR LOW INCOME PERSONS IN NEW JERSEY

A Report to the General Assembly

of the State of New Jersey

by the

Assembly Committee on Institutions and Welfare

September 10, 1968

MEMBERSHIP
OF THE
ASSEMBLY COMMITTEE ON INSTITUTIONS AND WELFARE

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LETTER OF TRANSMITTAL

TO THE HONORABLE MEMBERS OF THE GENERAL ASSEMBLY OF
THE STATE OF NEW JERSEY

The Assembly Committee on Institutions and Welfare herewith submits its report and recommendations, with minority views, on the advisability and practicability of implementing Medicaid in New Jersey.

Respectfully submitted,

Richard J. Vander Plaat
Chairman

INTRODUCTORY COMMENTS

From the beginning of our study of Medicaid, it was recognized that the single, most important fault of our sister states in adopting this program, was a failure to understand its full impact on the administration of state medical assistance programs. It was this failure, coupled with inadequate legislative controls over development of state programs, that resulted in the now well known troubles of our sister states as they sought to cope with the program.

With this background well in mind, the committee has sought to understand the program and its impact, to develop cost estimates with a higher degree of accuracy than was available when the program was adopted elsewhere, and to generally profit by the experience of others. This process has been difficult, tedious, and at times impossible.

Throughout our study we have had the assistance and cooperation of many public officials and private individuals with experience in the furnishing and administration of medical assistance and health care services. The committee

would like to express its appreciation to the many people whose patience, understanding and tireless efforts have assisted us in our work.

As will be made apparent in the body of this report, the members of the committee regard our report and recommendations as a beginning and not an end. Certainly one of the most obvious weaknesses of programs adopted in other states has been a lack of legislative control and oversight over the program for which statutory authorization was given. The committee believes that such control and oversight is absolutely essential to the development and operation of a sound program of medical assistance for eligible persons in the State of New Jersey. Accordingly, we have attempted to provide for such continuous legislative review. It is our hope that this approach will result in a more effective and efficient program, consistent with fiscal responsibility, and at the same time furnish us with the type of information that will be essential in the future in making policy decisions in this area.

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

1. It is in the public interest that statutory provision be made which will enable the State of New Jersey to implement a medical assistance program under Title XIX of the Federal Social Security Act beginning on January 1, 1970.

2. At its inception, the program should cover the following New Jersey residents who are determined to need medical care and services:

   (a) recipients of old age assistance, assistance for the permanently and totally disabled, assistance for the blind or assistance for dependent children;

   (b) those who would be eligible to receive public assistance under the State categorical assistance programs except for failure to meet an eligibility condition or requirement imposed under the State categorical assistance program which is prohibited under Title XIX of the Federal Social Security Act such as a durational residence requirements, relative responsibility, consent to imposition of a lien;

   (c) a child between 18 and 21 years of age who would be eligible for assistance for dependent children

living in the family group except for lack of school attendance or pursuit of formalized vocational or technical training;

(d) a spouse of a recipient of old age assistance, assistance for the permanently and totally disabled, or assistance for the blind who is living with such recipient and whose needs are taken into account in determining the amount of cash payment made to the recipient;

(e) a child in foster placement under supervision of the Bureau of Children's Services;

(f) those who meet the standard of need under a categorical assistance program but who are not receiving such assistance and elects not to receive it.

3. The plan shall provide for furnishing the following basic medical care and services:

(a) In-patient hospital services (other than services in an institution for tuberculosis or mental diseases);

(b) Out-patient hospital services;

(c) Other laboratory and x-ray services;

(d) (1) Skilled nursing homes services (other than services in an institution for tuberculosis or mental diseases) for persons 21 years of age or older;

(2) Such early and periodic screening and diagnosis of individuals, who are eligible under the program and are under age 21, to ascertain their physical or mental defects and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations of the Secretary of the Federal Department of Health, Education and Welfare and approved by the Commissioner;

(e) Physicians' services furnished in the office, the patient's home, a hospital skilled nursing home or elsewhere;

4. The plan may further provide for furnishing the following basic medical care and services:

(a) Medical care, not included in subsection (e) above, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law; provided, however, at the program's inception such practitioners shall be limited to podiatrists and optometrists;

(b) Home health care services;

(c) Clinic services;

(d) Dental services;

(e) Physical therapy and related services;

(f) Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(g) Other diagnostic screening, preventive, and rehabilitative services, and other remedial care;

(h) In-patient hospital services and skilled nursing home services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases.

5. The plan shall be formulated by the Department of Institutions and Agencies, with provision for legislative oversight. The program will be administered by the Department of Institutions and Agencies through a Division of Medical Assistance and Health Services, which the committee recommends be created.

6. It is recommended that so many of the recipients of Medical Assistance for the Aged as can be transferred to the Old Age Assistance Program be so transferred. Those persons in the Medical Assistance for the Aged Program who cannot be so transferred, will continue to receive medical

assistance to the same extent as was made available to them prior to the initiation of the Medicaid program under a separate program to be financed by the State.

7. It is recommended that in the operation of the program, that so much of the program as can be underwritten, be underwritten by a carrier, and that the same carrier shall act as fiscal intermediary for the balance of the program.

MEDICAL CARE FOR LOW INCOME PERSONS IN NEW JERSEY

INTRODUCTION

Few subjects have received as much attention and concentrated study by public officials and private groups in New Jersey as the implementation of Medicaid by the State. In view of the potential benefits to be derived from such a program by the citizens of this State, and the need for fiscal responsibility, careful study was, and still is, warranted. The much publicized experiences of our sister states with Medicaid present ample evidence of the need for caution in preparing a program under Title XIX.

New Jersey has a long standing tradition of providing needy persons with a wide variety of medical and health care services. Table I, in the Appendix to this report, prepared by the Department of Institutions and Agencies, shows the extent to which the 14 mandatory and optional services under Medicaid are already being provided to recipients in our categorical assistance and medical assistance for the aged programs.

However, the medical benefits available to the various classes of recipients are not uniform. As things

now stand in New Jersey, a separate plan exists for each category of recipient under the various public assistance titles to the Social Security Act. For example, whereas the participant in the Old Age Assistance Program (OAA) will get in-patient hospitalization, out-patient hospital services, skilled nursing home services, laboratory and X-ray services, the participant in the Aid to the Blind Program (B.A.) will get all these services except in-patient hospitalization.

MEDICAID AND MEDICARE

Medicaid and Medicare are two separate programs that are frequently confused. Both were created by amendments to the Social Security Act in 1965, Medicare as Title XVIII, and Medicaid as Title XIX.

Medicare is a federally administered program of health insurance for the aged. Basically the program affords 2 kinds of benefits for persons aged 65 or older: hospital insurance (for hospitalization and related care) and supplementary medical insurance (for physicians' services and some other medical services). Benefits are the same throughout the nation. Eligibility for hospital insurance is a right for almost all aged persons, but medical insurance

is a voluntary program.

Medicaid is a program that is designed to pay medical care costs for people with low incomes. It is a federal-state program, intended to provide medical care for needy persons of all ages under a definition of need defined by each State. Eligibility is determined for the individual or family according to state provisions. The program is administered by the states and financed in part by the state (or state and local) governments and in part (50-83%, depending on state average per capita income) by the federal government. Since each state determines eligibility and benefits, there are differences--state by state--in who is eligible and for what benefits. Medicaid complements the hospital insurance provisions of Medicare by paying the deductible amounts for needy aged persons who are insured. It may complement the voluntary medical insurance provisions if a state wishes to pay the monthly premiums for recipients of old age assistance. It supplements the insurance program by providing services for persons aged 65 or over in addition to those made available under the insurance provisions and also by providing medical services to persons under age 65.

Briefly, Medicaid ties together all federal assistance for medical services to welfare recipients under a single program. The Secretary of Health, Education, and Welfare has required that by January 1, 1970, federal financial participation in vendor payments for medical services will not be available under any of the other public assistance titles of the Social Security Act. Thus, New Jersey is obligated to develop a State plan to implement Title XIX or lose federal funds for medical assistance. Under Title XIX, the federal government will pay for approximately 50% of the medical care costs incurred for low income families eligible for federal reimbursement under Title XIX. The committee had many questions about the extent to which the federal government shared in meeting the costs of affording benefits under the Medicaid program. It would appear that the percentage of federal participation varies with the type of recipient and the type of services afforded. This subject will be discussed in greater detail at a later point in this report.

The Federal legislation, within the limits of certain guidelines, leaves to the states the persons to be covered and the services to be furnished. These two areas, at least

initially, represent the major variables in defining the magnitude of the State's program. As will be seen later, the Federal legislation does not leave the states as much discretion in determining people to be covered and services to be furnished as one would be led to believe from the language of the act.

WHO IS ELIGIBLE FOR TITLE XIX BENEFITS

There are two principle classes of participants under Title XIX, i.e., the "categorically needy" and the "medically indigent". There is general agreement that, in order for a state plan to receive federal approval, the state plan must provide coverage from its inception, on or before January 1, 1970, for all individuals and families who receive financial assistance for basic maintenance from the federally aided public assistance programs for the aged, the blind, the disabled, and families for dependent children. These programs are Aid to the Blind, Aid to the Permanently and Totally Disabled, Aid for Families of Dependent Children and Old Age Assistance. In addition, the approved plan must include the "categorically related"; for example, all those persons who would be eligible for the foregoing categorical assistance except that they do not meet New Jersey's 1 year

residence requirement and children from AFDC families ages 18-21 who are not in school. This description of the "categorically related" is an oversimplification. The groups which we are required to cover at the inception of the program are more fully set out in section 3.f.(1), (2), (3), (4) and (6) of the recommended bill appended to this report.

Once the committee determined what groups had to be covered in the initial program, it was essential to attempt to estimate the number of people in the groups to be covered. The latest population estimates of the persons who will be "at risk" in 1970 are set forth below.

	1969-70 Department	1970-71 Department
Old Age Assistance	15,000	15,000
Disability Assistance	11,000	11,500
Assistance for Dependent Children	212,000	242,000
Assistance for the Blind	1,000	1,000
Categorically Related	11,000	12,000
Sub-Total	250,000	281,500
ADC-Unemployed Parent	19,000	23,000
Presumptive Eligibility	16,300	18,000
Medical Assistance for the Aged	11,600	12,200
Sub-Total	296,900	334,700
Foster Care	12,000	13,000
TOTAL	308,900	347,700

Prepared by the Department of Institutions and Welfare, July 30, 1968

In dealing with these estimates, it is important to note at least two facts, i.e., the rate of growth of the various categorical assistance programs and the inability to identify at this time the people who would qualify as categorically related before a claim is filed. As is apparent, we now have no contact with the "categorically related". The rate of growth factor is readily seen from the recent enactment of legislation to cover under the AFDC program the unemployed and underemployed parent in the home. Inasmuch as these people are now under AFDC, they must be included in our Medicaid program.

If we want an approved Title XIX program in New Jersey, we must cover at least these people.

The Committee chose toadd one group not required to be included by the Federal statute, i.e., children who are wards of the State under the foster care program. We have been informed by the Federal authorities that this group could be separately added and we would be eligible for Federal matching funds. We are already providing hospital care for these children, under an insurance policy, without Federal matching funds.

In addition, the Federal matching under the Medical Assistance for the Aged program will terminate on December 31, 1969. Several alternatives were available to the committee. The MAA program could be terminated on that date and medical assistance terminated for the more than 10,000 New Jersey residents receiving assistance under the program. This approach was regarded as unreasonable and not a valid alternative. Another approach would be to continue the program entirely at State expense. However, it is estimated that the gross dollar commitment to this program by 1970 will be about $53.5 million, with more than $21 million coming from Federal funds. Continuation of the program at the 1970 level will require the State to contribute the $21 million just to maintain the status quo for these people.

A third approach would be to completely cover the recipients in the MAA program by the Medicaid program beginning January 1, 1970. The majority of the committee members did not approve of this approach because such inclusion would have required coverage of additional persons, not now receiving MAA, without Federal matching funds.

Another alternative would be to transfer those MAA recipients to the OAA program as can be transferred, which would be the great majority of the MAA people, and to continue to provide medical assistance for the MAA recipients who could not be transferred, at the current level of services, under a separate program, at State expense. This approach was regarded as the most practical by the majority of the committee members and therefore it is recommended that the appropriate legislation be enacted to authorize this transfer and continuation of service.

Insofar as the second major classification, the "medically indigent", is concerned, it now appears clear that the program need not provide medical care and services for this classification at the program's inception, to avoid the penalty of the loss of Federal funds. It would appear that the Federal government requires that the State plan, in order to be approved on or before January 1, 1970, must include provisions for both the categorically needy and medically needy; that the plan provide for a phase-in of the other than mandatory groups by July 1, 1975; that medical care and services must actually be provided for the categorically needy under the plan on or before January 1, 1970; and that the State must show reasonable progress under the plan to phase-in the medically needy on or before July 1, 1975.

The majority of the committee has recommended that the New Jersey plan provide for a strictly controlled phase-in of the medically indigent. The controlled phase-in will permit us to expand medical and health care facilities to meet the expanded demand for services in an orderly manner, allow us to gather additional experience and information on utilization rates as well as further cost and population data so that the addition of large numbers of people will not cause serious disruption of the program and jeopardize the furnishing of quality care and services to other recipients.

Officials of the Department of Institutions and Agencies have indicated how the inclusion of one group will automatically operate to require inclusion of another group by the following example that appeared in the report of the Commission on State Aid to Hospitals for the Care of Indigent Patients:

> "... A State Medicaid program may provide medical assistance to groups of otherwise non-dependent persons who would be eligible for categorical public assistance except for the fact that their income and resources are in excess of New Jersey's standard for maintenance assistance. If the State includes any of these medically-dependent, it must include all medically needy who are blind, disabled, aged, or in families with dependent children. Put another way, if the State pays for medical care for elderly persons over 65 who are self-supporting except for medical

> care, the State also must pay for medical care for medically needy blind and disabled persons and for medically needy children and adults in families who would qualify for the basic assistance programs if their incomes were low enough."

CLASSES OF HEALTH CARE SERVICE TO BE PROVIDED

Federal law requires that, as an absolute minimum, the following 5 basic services must be included in the State's program:

1. In-patient hospitalization (which must be reimbursed to the hospitals on the basis of full reasonable costs.)
2. Out-patient hospital services.
3. Physicians' services (whether furnished in the office, patient's home, hospital, nursing home, or elsewhere).
4. Skilled nursing home services.
5. Laboratory and X-ray services (other than hospital-based).

These five basic services have been expanded by the 1967 amendments to the Social Security Act so as to require the inclusion, not later than July 1, 1970, of a sixth; namely, home health services.

Federal law also requires that where any state is already providing any of the additional "optional" services under its categorical assistance programs, it may not continue such additional services for a selected group or groups only. It must either extend that particular class of service to all categorically-related groups that are to be included under the Title XIX program proposed by the State; or it must completely drop or eliminate such class of service for all groups. Table I, discussed earlier, lists the 14 major classes of services, which are already being provided in New Jersey in their respective programs.

ADDITIONAL LIMITATIONS ON STATE DISCRETION

At this point it would be appropriate to discuss several of the important provisions of the Federal law which serve to limit the discretion of the State in developing the Title XIX program.

One of the most important features of the new legislation is that Congress has prohibited states from using Federal funds as a substitute for state money. This feature, known as the requirement for "maintenance of state fiscal effort", means that the state participating in the medical

assistance program must continue to spend at least as much state money for public assistance as it did before. Consequently, portions of state money "released" by the availability of increased Federal matching funds under Title XIX must be used to broaden and liberalize the state's public assistance programs by at least an amount equal to the Federal increase in funds.

The Federal legislation further requires that by July 1, 1970, the non-Federal share of the cost of a medical assistance program must be financed entirely from state funds and not involve any requirements for a share to be borne by "local" funds unless safeguards are included in the law and operating procedures to assure that a scarcity of local tax funds does not impede the program's operation.

The federal legislation also contains requirements concerning equal treatment which are basic to a consideration of the scope of a state program. Except for the specific exclusion of persons under 65 who are in mental or tuberculosis hospitals, all medical services offered by the State's program must be equal in amount, duration and scope for all beneficiary groups included in the program. Thus, service made available to one group of the needy must be the same for all the other

categories. The State may, however, provide services for all persons who are "medically needy" only, which are of lesser amount, duration and scope than those provided for all persons receiving public assistance for maintenance.

The basic principle of the Medicaid program is that the income an individual or family needs to use for basic support other than medical care must be protected for such use. However, the legislation requires each state to set its own level of income or resources needed for basic maintenance and this level must be comparable for all groups included in the state's program. Persons whose income and resources are below this level, and who are otherwise eligible, must, therefore, be included in the state's Title XIX program. Although the Federal law provides considerable latitude to the state, this level cannot be lower than the level of maintenance now in effect for the most liberal of the state's money payment maintenance programs.

The Federal law also sets further limitations on the kinds of eligibility tests that the state may impose. Only available income and resources may be considered, and if the income is not certain or irregular, only that income which is actually in hand may be counted. If income is

in excess of the amount set by the state for ordinary living expenses, the amount in excess must first be applied in a way to enable the person to pay for any medical care or services which are not within the scope of the state's medical assistance program.

Another important change effected by the Title XIX program is that the state, for purposes of the medical assistance program, can no longer hold adult children responsible for the medical expenses of their aged parents. The Federal legislation permits the state to consider a spouse responsible for a spouse and parents responsible for children under 21 or children of any age if they are blind or diabled, but no other "relative" responsibility may be legally imposed. This is in contrast to our present Kerr-Mills Program.

In addition, as in Kerr-Mills, the state may not impose a durational residence requirement as a condition of eligibility for medical assistance. Consequently, under a Title XIX program, the state must find eligible all otherwise eligible persons who are residents of the state,

without regard to the length of the residence. The state must also make arrangements to provide medical assistance to residents of the state who are temporarily absent from it.

Another important requirement for a Title XIX program is that the state, for its aged assistance recipients, must pay the deductible portion of the medical costs under the Hospital Insurance for the Aged, commonly called Medicare. In addition, the State may pay these deductibles for medically needy old people who are otherwise unable to pay them. The State may also pay the co-insurance costs of the Hospital Insurance plan but such optional payments for aged persons may be made under the Title XIX program only if services of the same duration are also furnished under Title XIX to all other eligible persons. Title XIX also permits payment of the deductibles and co-insurance of the Supplementary Medical Insurance, also known as Part B of Medicare, but as in the case of co-insurance under Part A of Medicare, payments of such costs for aged persons is possible only when equivalent services are provided under Title XIX to otherwise eligible individuals.

THE RISING COST OF HOSPITAL CARE

Chapter 140 of the Laws of New Jersey 1965, approved July 13, 1965, provided for the creation of a commission to study the advisability of a program of State aid to public and non-profit private hospitals for the care of indigent patients. This legislation, which was introduced before the enactment of the 1965 amendments to the Social Security Act, which provided for a Medicaid Program, provided that the duties of the commission would be to define the term "indigent patient" for the purpose of any possible State aid for the cost of care therefor, determine the total cost of hospital care for indigent patients and make a study of the advisability of State aid to public and non-profit hospitals for the care of indigent patients. The commission's principle concern was the reportedly substantial annual deficits experienced by hospitals. The commission's study continued through December 1967 and because of the obvious relationship of the new Federal Title XIX Program, the commission devoted a great deal of its time and attention to the Federal legislation.

At the request of the Hospital Study Commission, the New Jersey Hospital Association undertook a comprehensive study and survey of the extent of the deficit being experienced

annually by non-profit, private hospitals in New Jersey. The results of this study are reported in Table II in the Appendix. For the year reported, the total unrecovered cost of hospital care (both in-patient and out-patient) for indigents was estimated to be $16,210,022. This total figure was reduced by slightly more than $2 million because of funds received from undesignated sources; thus bringing the net cost of indigent care to a little more than $14 million.

The commission, chaired by then-Assemblyman Norman Tanzman, reported that there were three alternatives which suggested themselves if fiscal relief, by way of government aid, was to be provided New Jersey's public and non-profit private hospitals for the care of indigent patients. These alternatives were:

"1. County Boards of Freeholders and/or municipalities where these medical institutions are located can increase their lump sum grants to hospitals or revise their reimbursement formulas for payment for indigent persons who receive care from them. Since a number of New Jersey counties already make lump sum grants equal to the maximum which the law permits, statutory revision would be necessary if any of these counties indicated a wish to pursue this alternative.

2. The Department of Institutions and Agencies and the County Welfare Boards could expand their program of providing hospitalization insurance for persons served by federal categorical programs of public assistance. It was estimated two years ago by the Division of Welfare, Department of Institutions and Agencies, that to include all persons not otherwise covered by hospitalization insurance in the various federal categorical programs the cost to New Jersey would be

approximately $11 million. If present formulas for providing for the non-federal portion of these costs were continued, State costs would be approximately $5.5 million with an equal cost to the counties. Since this estimate was made two years ago and hospitalization insurance has risen sharply since that time, this figure would necessarily be revised substantially upward by the Department's actuaries.

3. Substantial relief is available to public and non-profit private hospitals from another area--the implementation in New Jersey of a Title XIX program authorized by the 1965 amendments to the Social Security Act. Because of the complex character of such a program and the financial cost associated with it, this Commission devoted much of its time to discussion of issues related to the implementation of a Title XIX program in New Jersey."

THE PROBLEMS OF COST DATA DEVELOPMENT

In April 1967, while the Tanzman Commission was engaged in its study, the State Department of Institutions and Agencies published a preliminary draft of cost estimates for health services under Title XIX in New Jersey. This document, prepared by the statisticians of the Division of Public Welfare, represented the principle, comprehensive attempt at developing cost estimates in this highly problematical area. These cost estimates were prepared for

3 eligible groups based on income. The low cohort group covered that portion of the population with an income standard of between $1600 and $130; the intermediate group with an income of $1,799 to $3565; and the high group with an income of from $1999 to $3999. The low figure was the annual income for a single person whereas the high figure represented a family of 4. When these income standards were applied to the 1960 New Jersey population, it was found that under the low standard 13.11% , under the intermediate standard 16.42%, and under the high standard 20.24% of the population would be potentially eligible for medical services. These cost estimates were based upon population and service cost estimates projected to 1968.

At the request of the Tanzman Commission the Hospital Service Plan of New Jersey and the Prudential Insurance Company of America jointly agreed to evaluate the

Department's preliminary estimates. In an attempt to be consistent, Blue Cross and Prudential made their evaluation of the Department's estimates based on an assumed effective date of January, 1968. In addition, Blue Cross and Prudential altered some of the data used in making the computations to reflect their own experience and to add several judgemental factors.

Typical of the changes made in the figures used by the insurance companies is the hospitalization utilization rate and the per diem cost. The Department used a utilization rate of 2,389 days per thousand population for that portion of the population age 65 and over and 811 days per thousand population for ages under 65. The Department's anticipated patient days were priced at an estimated hospital per diem cost of $50.00. Based upon utilization experience under the Blue Cross program, Blue Cross and Prudential used a utilization rate of 4,000 days per thousand population for ages 65 and over and 1,000 days per thousand population for under age 65. In addition, based on the assumption that with the advent of Title XIX people would use private hospitals instead of governmental institutions, a per diem cost of $55 for 1968 was used.

The Blue Cross-Prudential cost estimates, prepared in June 1967, related only to the "low income standard" cohort. Their cost estimate, exclusive of cost of administration, indicated that the Division of Public Welfare's estimates were conservative, approximately 43% under the Blue Cross-Prudential estimates.

In August 1967, the two sets of estimates now available were sent to the United States Department of Health, Education and Welfare for appraisal. This appraisal was completed and returned to the Department on October 12, 1967. The following comments, made by HEW officials at the time of their appraisal, are worthy of note:

> "We believe that estimating medical care costs, especially during this period of greater utilization of medical services by a larger proportion of the population and at what appears to be a never ending rise in medical service unit costs, is a particularly hazardous venture.
>
> These difficulties which include the 'many imponderables' aluded to by the fiscal intermediaries inevitably result in honest differences in opinion on the different aspects of medical economics including predicting medical care costs both with regard to estimating techniques and concerning types and costs of medical data used in the estimating procedure. However, all of us should agree that medical care estimates must be derived from logical, systematic estimating procedures based on objective, pertinent information. Moreover, these estimating procedures must be amenable to evaluative testing under actual operating conditions with modifications in

hypothesis and data formulation if estimates prove to be in error. For this reason, we are impressed with the systematic estimating approach employed by your Welfare Division in determining the parameters regarding the potentially eligible population in the three different income groups, the utilization rates for the different medical services, appropriate medical service unit costs, and the offsets generated by provisions in the Medicare-Title XVIII-Law. The estimates derived from this systematic approach can be evaluated on the basis of actual operations with modifications, if necessary, of the estimating assumptions and techniques. On the other hand, the estimates shown in the summary statement prepared by the fiscal intermediaries are based in part on 'judgemental factors' which cannot be objectively evaluated. We realize that the intermediaries may have used supporting detailed data for their calculations but these were not shown in their statement and therefore could not be evaluated for appropriateness, etc.

We wish to reiterate that estimating costs of medical services exceedingly difficult even when data on potentially eligible populations, utilization rates, unit costs, and Title XVIII offset are available; the difficulties are multiplied when data are scarce or unavailable. Medical economists are in agreement only with respect to the fact that medical costs are expensive, and will continue to become more so in the future; however, 'how high is up' concerning medical care estimates depends on the predilections and affiliations of individual estimators."

The appraisal made by the Department of HEW was again for the "low income standard" cohort only. Their cost estimate fell between the Division of Welfare's and the Blue Cross-Prudential estimate.

Upon receipt of HEW's estimate, the statisticians of the Division of Public Welfare extended the Federal estimates, based on HEW's assumptions, and developed cost estimates for the intermediate and high income standard classifications. The extended Federal estimates and the comparative estimates from the three major sources appear in Tables III and IV.

With the inception of this current study began a new round of cost estimate attempts by the Department, Prudential, Blue Cross-Blue Shield, and the committee. Throughout these attempts, the committee has sought to keep in mind that the vast majority of our sister states who have adopted Medicaid underestimated the cost of the program by an average of 25 per cent. With this in mind, the committee members have sought to make available to their colleagues reasonable cost estimates. These estimates are found in Tables V and VI.

It is hoped that between the time any proposed legislation is adopted and the program will begin, that further attempts will be made to improve these estimates.

MEDICAID PROGRAM FOR NEW JERSEY

In view of the existing medical assistance programs being offered in New Jersey now and the requirements contained in the Federal legislation, what are the possible programs or courses of action that could be taken by New Jersey?

1. We could reject Medicaid and continue the operation of our medical assistance programs without Federal financial cost sharing.
2. We could adopt a "minimum" program under Medicaid effective January 1, 1970, with a phase-in of additional participants and services to July, 1975.
3. We can adopt an above "minimum" Medicaid program.

There is a general consensus that if we decide to adopt a Medicaid program, the decision should be made in the near future, since time is of the essence. Prospective carriers, fiscal intermediaries, departmental officials, and interested public groups have testified before the committee that 18 months lead time would be desirable to "tool-up" and make the transition into a Medicaid program with a minimum of disruption. The experience of many of our sister states,

particularly New York and California, clearly shows that a major source of difficulty has been the failure to provide adequate time to prepare for implementation.

What then can we reasonably expect under each of the three alternatives.

1. According to the Department of Institutions and Agencies, medical care expenditures for categorical assistance programs and medical assistance for the aged for fiscal year 1966-67 totaled $30,788,000. As shown by table VII, the Federal government's share of these funds was $11 million, the State share $11 million and the county share approximately $8.6 million.

   The medical care expenditures will increase substantially during fiscal year 1967-68 to close to $50.5 million. By fiscal year 1969-70 it is exepcted that these expenditures will be about $66 million, with the Federal government contributing $26.6 million.

   Failure to implement Medicaid by January 1, 1970, barring a change in Federal law, will probably result in losing 1/2 of the Federal funds ($13.3 million)

expected during fiscal year 1969-70. This share will probably have to be picked up by the State, so that the State will probably pay $35.88 million for medical care for the beneficiaries in these programs. In addition, counties will pay $16,780,000. These figures do not reflect the true magnitude of medical care cost for the needy because the counties are already making additional payments to hospitals for the care of indigents in excess of $10 million annually and the State and municipalities are also paying for medical care for needy persons on general assistance. In addition, these figures do not take into consideration the substantial deficits experienced by non-profit private hospitals which exceeded $16 million in 1965 and which can be expected to continue.

It is reasonable to expect that medical expenditures for the needy will continue to rise in the years after 1969-70, and so will the State's commitment to these programs. These programs will have to be carried on without federal assistance and the State will have to provide for the furnishing of the type of quality medical care to which our citizens are entitled.

In addition, having rejected Medicaid, under existing law, we would not be able to change our minds and adopt a Medicaid program after January 1, 1970.

More than forty states have already adopted Medicaid programs. Federal funds to support these programs are derived from general tax revenues. Failure to adopt a Medicaid program will result in New Jersey residents paying for the operation of Medicaid in almost all of our sister states without any opportunity to recoup any of these funds for the operation of our own medical assistance programs.

Lastly, without a Medicaid program, counties and municipalities would have to continue to expend large sums of money for medical assistance, and private hospitals will continue to operate with substantial annual deficits.

2. What would happen if we adopted a "minimum" program in terms of people covered to go into operation on January 1, 1970?

   a. Who would we have to cover?

      (1) All persons in the Old Age Assistance Program — 15,000

      (2) All persons in the Disability Assistance Program — 11,000

(3) Persons in the Aid for Dependent Children Program including ADC-Unemployed Parent	212,000 19,000
(4) Persons in the Assistance for the Blind Program	1,000
(5) The Categorically Related	11,000
(6) Those persons in the Medical Assistance for the Aged Program who will be transferred to the OAA program. (For the sake of this analysis we have not separated those MAA recipients who will have to be provided for in a separate program).	11,600
(7) Presumptive eligibility. (This aspect of the categorical assistance programs was added by recently enacted New Jersey legislation effective January 1, 1969. We have been informed by Federal officials that if presumptive eligibility exists for a categorical program, it must also be applied in the Medicaid program.)	16,300
	296,900

Accordingly, an absolutely minimum program, in terms of number of potential persons eligible for medical care will have about 296,900 people "at risk".

b. What will such a program cost?

The most complete cost estimates that we have been able to secure indicate that the annual per person cost for the services outlined in the attached recommended bill will be $330.00, exclusive of those persons who are institutionalized, and assuming the calculation of physicians costs on a prevailing fee basis. If physicians were placed on a fee schedule basis, this figure would be $295.00 per person per year.

Adoption of a "minimum" number of people program now will allow the State to continue to develop a medical assistance program to commence on January 1, 1970. It would keep us in position to accept or reject the program and expansion thereof at some future date. Although adoption even now would not give the full lead time requested by the State administering agency, it would still afford the time to plan adequately for operation of a program under Title XIX. Adoption of a program would further permit the State to alleviate the deficits experienced by private, non-profit hospitals and pick up the

major share of the local public expenditures now being made for those persons who will be covered by the program.

Whether adoption of a "more than minimum persons" program beginning with January 1, 1970, may or may not be a sound policy in the opinion of the majority of the committee members, depends on what other persons you are planning to include. Certain groups of people can be included as a separate group with Federal matching and without requiring expansion of the program to include other persons for whom Federal matching would not be available. Examples of these types of groups have been discussed earlier in this report.

The majority of the committee members believe that at the inception of the program, no group should be covered which would require the inclusion of other groups without Federal matching. This position is taken in order to keep the program at a modest level, at least at its inception, until more information is available as to utilization rates and other cost factors. However, the foster care program is an example of a group that can be included as a

separate entity. It is a group for which we are now furnishing hospital care without Federal funds and for which we can receive Federal funds by inclusion under Medicaid.

For the foregoing reasons, the majority of the committee believe that the 13,000 children in the foster care program be included under Medicaid from its inception. The modest cost of furnishing full health services to this group is far outweighed by the benefits to be derived from furnishing such care.

The attached tables (Tables V & VI) prepared by the Division of Public Welfare, dated July 22, 1968, July 30,1968 as amended August 10, 1968, are the latest available cost estimates for the Medicaid program as recommended by the committee majority for the first 6 months of operation (January 1, 1970 to June 30, 1970) and for fiscal year 1970-71.

For the first 6 months of operation of the recommended program, at an annual rate of $295.00 per recipient, the estimated additional cost to the State will be $20,238,500. During the same period, county

medical care expenditures are expected to be reduced by $4,913,500 in terms of money spent on existing programs and exclusive of contributions being made to non-profit private hospitals.

For the first full fiscal year of operation, additional State costs for the recommended program are estimated to be $51,794,000 and county expenditures are expected to be reduced by $12,170,500.

A NEW APPROACH TO PAYMENT FOR SERVICES

The Federal legislation allows the use of several methods to pay providers of services. The two most commonly employed methods are direct payment by the State and the use of a fiscal intermediary. Under the former method, the State receives the bills from providers and makes direct payment. Under the latter method, an intermediary receives the bills, conducts all review and audit, and pays the bill with State funds advanced to the intermediary. For this service the intermediary will receive payment for performing these services. It is generally believed that this latter approach is less expensive than requiring the administering agency to perform these additional functions.

A third approach is the use of underwriting. Under this method the State will pay a fixed premium for medical care insurance and the insurance carrier will be responsible for payment of the cost of the services provided. Although most states have considered using the underwriting method, only 1 state, Texas has actually been able to have a small portion of their Medicaid program underwritten. The reason for the limited use of this method is largely due to the inability of carriers to estimate costs to the degree of accuracy necessary to assume the risk of underwriting for a fixed premium and the general reluctance of carriers to assume these risks.

The majority of the committee believe that underwriting is the most desirable method to employ in the New Jersey Medicaid program. The committee has been informed that at least one carrier is now willing to underwrite the largest portion of our Medicaid program for a flat premium and without profit. The portion of the program that cannot be underwritten is medical care for those persons who are institutionalized. The reason for this is obvious. However, these persons can be handled by the carrier as fiscal intermediary.

The majority of the committee believe that this device affords New Jersey an opportunity to add an element of stability to the cost of medical care under Medicaid hitherto unavailable in any other state with a Medicaid program. In addition, we have been informed that the premium will be kept constant for 18 months and, should actual medical care costs be less than the premium during the period, such excess will be returned to the State of New Jersey.

In view of the foregoing, the committee recommends that the New Jersey Medicaid program be underwritten to the greatest extent possible, and that such underwriting be undertaken by the lowest responsible bidder.

Should we be unable to have the program underwritten to the extent now anticipated, the majority of the committee recommends that the administering agency return to the Legislature for further instructions and authorization.

WHY NEW PROPOSED LEGISLATION?

The Legislature has had occasion this year to consider other proposals for the implementation of Medicaid

by New Jersey. The major legislative proposal so considered has been sent to the United States Department of Health, Education and Welfare for evaluation. The attached letter indicated in great detail the areas of deficiency of this proposal. As is apparent from this analysis, it would not be possible to prepare a Medicaid program that would receive Federal approval with the authorization contained in that proposal.

In addition, the principal proposal does not provide for coverage of those persons recommended by the committee majority, it does not provide for adequate legislative controls over program development deemed essential by the majority of the committee, no does it provide for the type of payment method deemed desirable by the majority of the committee.

In total, the majority of the committee believes that the proposed legislation now pending be discarded and that favorable consideration be given to the new proposal recommended by the majority of this committee.

AN ACT providing for the establishment of a medical assistance program for eligible persons and providing for the administration thereof.

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

1. Short Title. This act shall be known and may be cited as the "New Jersey Medical Assistance and Health Services Act."

2. Declaration of Purpose. It is the intent of the Legislature to make statutory provision which will enable the State of New Jersey to provide medical assistance, insofar as practicable, on behalf of persons whose resources are determined to be inadequate to enable them to secure quality medical care at their own expense, and to enable the State, within the limits of funds available for any fiscal year for such purposes, to obtain all benefits for medical assistance provided by the Federal Social Security Act as it now reads or as it may hereafter be amended, or by any other Federal act now in effect or which may hereafter be enacted.

3. Definitions. As used in this act, and unless the context otherwise requires:

a. "Applicant" means any person who has applied for medical assistance under this act.

b. "Commissioner" means the Commissioner of the Department of Institutions and Agencies.

c. "Department" means the Department of Institutions and Agencies, which is herein designated as the single

State agency to administer the provisions of this act.

d. "Medical assistance" means payments on behalf of recipients to providers for medical care and services.

e. "Provider" means any person, public or private institution, agency or business concern lawfully providing medical care, services, goods and supplies authorized under this act, holding, where applicable, a current valid license to provide such services or to dispense such goods or supplies.

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

(1) is a recipient of old age assistance, assistance for the permanently and totally disabled, assistance for the blind or assistance for dependent children; or

(2) would be eligible to receive public assistance under the State categorical assistance programs except for failure to meet an eligibility condition or requirement imposed under such State program which is prohibited under Title XIX of the Federal Social Security Act such as a durational residence requirement, relative responsibility, consent to imposition of a lien; or

(3) is a child between 18 and 21 years of age who would be eligible for assistance for dependent children living in the family group except for lack of school attendance or pursuit of formalized vocational or technical training; or

(4) is a spouse of a recipient of old age assistance, assistance for the permanently and totally disabled, or assistance for the blind who is living with such recipient and whose needs are taken into account in determining the amount of cash payment made to the recipient; or

(5) is a child eligible under Title IV of the Federal Social Security Act, in foster placement under supervision of the Bureau of Children's Services; or

(6) meets the standard of need applicable to his circumstances under a categorical assistance program but who is not receiving such assistance and elects not to receive it.

g. "Recipient" means any person who is determined to be eligible to receive medical assistance under this act.

h. "Resident" means a person living, other than temporarily, within the State. Temporary absences from the State shall not cause a person to lose his status of a resident of this State.

4. There is hereby created in the Department of Institutions and Agencies a Division of Medical Assistance and Health Services. The Division shall perform those administrative and operational functions vested in the Department pursuant to the provisions of this act and any other functions that the State Board of Control may, from time to time, elect to assign to such Division. The Division shall consult with and coordinate programs related to medical assistance and health care services being furnished by other state agencies to avoid duplication of effort.

5. Medical assistance program. The Department, which is hereby designated the single State agency to administer the provisions of this act, through the Division of Medical Assistance and Health Services, by rules and regulations, shall implement and administer the program of medical assistance to provide necessary medical care and services for qualified applicants as provided by this act.

6. Basic medical care and services.

a. Subject to the requirements of Title XIX of the Federal Social Security Act, the limitations imposed by this act and by the rules and regulations promulgated pursuant thereto, the medical assistance program shall include authorized services within each of the following classifications:

(1) In-patient hospital services (other than services in an institution for tuberculosis or mental diseases);

(2) Out-patient hospital services;

(3) Other laboratory and x-ray services;

(4)(a) Skilled nursing home services (other than services in an institution for tuberculosis or mental diseases) for persons 21 years of age or older;

(b) Such early and periodic screening and diagnosis of individuals who are eligible under the program and are under age 21 to ascertain their physical or mental defects and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations of the Secretary of the

Federal Department of Health, Education and Welfare and approved by the Commissioner;

(5) Physicians' services furnished in the office, the patient's home, a hospital, skilled nursing home or elsewhere;

b. Subject to the limitations imposed by Federal law, by this act, and by the rules and regulations promulgated pursuant thereto, the medical assistance program may be expanded to include authorized services within each of the following classifications:

(1) Medical care not included in subsection a(5) above, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law, provided however, at the program's inception such practitioners shall be limited to podiatrists and optometrists;

(2) Home health care services;

(3) Clinic services;

(4) Dental services;

(5) Physical therapy and related services;

(6) Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(7) Other diagnostic, screening, preventive, and rehabilitative services, and other remedial care;

(8) In-patient hospital services and skilled nursing home services for individuals 65 years of age or over in an

institution for tuberculosis or mental diseases;

(9) Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary of the Federal Department of Health, Education and Welfare, and approved by the Commissioner.

c. Payments for the foregoing services, goods and supplies furnished pursuant to this act shall be made to the extent authorized by this act, the rules and regulations promulgated pursuant thereto and, where applicable, subject to the agreement of insurance provided for under this act. Every provider making a claim for payment pursuant to this act shall certify in writing that no additional amount will be charged to the recipient for the services, goods and supplies furnished.

d. Any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability on a prepayment basis), who undertakes to provide him such services.

e. Anything in this act to the contrary notwithstanding, no payments for medical assistance shall be made under this act with respect to care or services for any individual who

(1) is an inmate of a public institution (except as a patient in a medical institution), or

(2) has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases.

7. Duties of Commissioner. Under general policies established by the State Board of Control, the Commissioner

is authorized and empowered to issue, or to cause to be issued through the Division of Medical Assistance and Health Services all necessary rules and regulations and administrative orders, and to do or cause to be done all other acts and things necessary to secure for the State of New Jersey the maximum Federal financial participation that is available with respect to a program of medical assistance, consistent with fiscal responsibility and within the limits of funds available for any fiscal year, and to the extent authorized by the medical assistance program plan; and otherwise to accomplish the purposes of this act, including specifically the following:

a. Subject to the limits imposed by this act, to submit a plan for medical assistance, as required by Title XIX of the Federal Social Security Act, to the Federal Department of Health, Education and Welfare for approval pursuant to the provisions of such laws; to act for the State in making negotiations relative to the submission and approval of such plan, to make such arragnements, not inconsistent with the law, as may be required by or pursuant to Federal law to obtain and retain such approval and to secure for the State the benefits of the provisions of such law;

b. Subject to the limits imposed by this act, to determine the amount and scope of services to be covered, that the amounts to be paid are reasonable, and the duration of medical assistance to be furnished; provided, however, that the Department shall provide medical assistance on behalf of

all recipients of categorical assistance and such other related groups as are mandatory under Federal laws and rules and regulations, as they now are or as they may be hereafter amended, in order to obtain Federal matching funds for such purposes and, in addition, provide medical assistance for the foster children specified in section 3,f,(5) of this act. The medical assistance provided for these groups shall not be less in scope, duration, or amount than is currently furnished such groups, and in addition, shall include at least the minimum services required under Federal laws and rules and regulations to obtain Federal matching funds for such purposes.

The Department is authorized and empowered, at such times as the Department may determine feasible, within the limits of appropriated funds for any fiscal year, to extend the scope, duration, and amount of medical assistance on behalf of these groups of categorical assistance recipients, related groups as are mandatory, and foster children authorized pursuant to section 3,f,(5) of this act, so as to include, in whole or in part, the optional medical services authorized under Federal laws and rules and regulations, and the Department shall have the authority to establish and maintain the priorities given such optional medical services; provided, however, that medical assistance shall be provided to at least such groups and in such scope, duration, and amount as are required to obtain Federal matching funds, but in no event shall medical assistance be furnished under this act on behalf of any individuals or groups not enumerated in section 3.(f.) for whom federal matching funds cannot be obtained, nor in any scope, duration, or amount in

excess of those for which federal matching funds can be obtained;

c. To administer the provisions of this act;

d. To make reports to the Federal Department of Health, Education and Welfare as from time to time may be required by such Federal department and to the New Jersey Legislature as hereinafter provided.

e. To assure that any applicant for medical assistance shall be afforded the opportunity for a fair hearing by the Department should his claim for medical assistance be denied or not acted upon with reasonable promptness;

f. To provide safeguards to restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with administration of this act.

g. To recover any and all payments incorrectly or illegally made to a recipient or provider from such provider, the recipient or his estate;

h. To recover any and all benefits incorrectly paid to a provider on behalf of a recipient from such recipient or from his estate except that no lien may be imposed against property of the recipient prior to his death except pursuant to the judgement of a court;

i. To take all reasonable measures to ascertain the legal liability of third parties to pay for care and services (available under the plan) arising out of injury, disease, or disability; where it is known that a third party has a legal liability, to treat such legal liability as a resource of the individual on whose behalf the care and services are made available for purposes of determining eligibility; and in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual, to seek reimbursement for such assistance to the extent of such

legal liability. In any case where such a legal liability is found the Department shall be subrogated to the rights of the individual for whom medical assistance was made available.

j. To determine the method of payment of claims for medical assistance as follows:

(1) To contract with non-profit organizations, incorporated in New Jersey, and authorized to do business pursuant to Chapter 48 or 48A of Title 17 of the Revised Statutes of New Jersey or with insurance companies incorporated and licensed to do business in the State, to underwrite, but not for profit, on an insured premium approach, that portion of the program covering all cash grant beneficiaries plus all other State certified recipients of medical assistance within the classes set forth in section 3(f)(1) through (6) of this act, with the exception of those persons who are confined in institutions for tuberculosis and mental care or who are required by medical necessity to be confined on a presumably permanent basis in other medical care institutions by reason of disease or injury;

(2) Any contract executed pursuant to section 7,j,(1) shall provide that for those persons included in the program but not covered on an underwritten basis, the same carrier selected under section 7,j,(1) shall act as fiscal agent for the Department, but not for profit, for such medical assistance benefits as may be made available;

(3) In selecting any underwriter and fiscal agent, the Department shall be guided by such considerations as:

(a) The lowest responsible bid;

(b) the experience of the underwriter and fiscal agent in carrying out the scope of medical assistance benefits in

accordance with contractual arrangements with providers whereby payments are made on behalf of subscribers or policy holders directly to various providers of medical serivces under cost reimbursement formulas or in accordance with fee schedules agreed upon in advance;

(c) The demonstrated effectiveness of control mechanisms to assure quality of care, appropriate utilization of service, and claims cost control.

(4) To provide that the contract shall include the following:

(a) the method of payment;

(b) that either party may cancel such contract upon reasonable notice to the other;

(c) that the State shall have the right to audit the financial records of the carrier and providers.

(d) that should a premium surplus develop, such surplus and any interest thereon shall accrue to the benefit of the State. Any such funds held on behalf of the State shall be invested by the Director of the Division of Investment in the Department of the Treasury or invested in a manner prescribed by such Director;

(e) that the carrier and fiscal agent shall quarterly and at such other times as the State Treasurer may require and in such form as he prescribes, render an account of the expenditures of money advanced pursuant to this act.

k. Where necessary, to advance funds to the underwriter or fiscal agent to enable such underwriter or fiscal agent, in accordance with the terms of its contract, to make payments to provider;

l. To contract with and to pay the appropriate county welfare boards for investigating and determining whether applicants for benefits under this act are eligible therefor under the standards prescribed by the Department;

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

8. Subject to the limitations provided in section 7 of this act, the Department shall (a) develop and employ such methods and procedures relating to the utilizaton of and the payment for medical care and services available under the plan as may be necessary to safeguard against unnecessary utilization of such care and services;

(b) assure that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges (reasonable costs in the instance of inpatient hospital services) consistent with efficiency, economy and quality of care; and

(c) prescribe standards that participating providers must meet.

9. Subject to the limitations set forth in section 7 of this act, the Department shall assure that no enrollment fee, premium or similar charge is imposed on an applicant as a condition of eligibility for medical assistance under this act.

10. Pursuant to the limitations provided in this act and the Federal Social Security Act, the Department shall prepare a comprehensive medical plan whereby the benefits of this program will be extended in accordance with the mandatory schedule for providing benefits required by the Federal legislation. This plan shall include alternative means of expanding the medical care benefits and coverage provided in this act. Such plan shall be re-evaluated from time to time but no less than annually and shall be based upon a documented review of medical needs of low income families in New Jersey, a detailed analysis of priorities of service, coverage, program costs and an evaluation of progress.

11. Eligibility determination. The Department shall assure:

(a) that all individuals wishing to make application for medical assistance shall have the opportunity to do so;

(b) that the processing of applications shall be simplified to the end that medical benefits shall be furnished to recipients as soon as possible.

12. The State shall provide such funds as may be necessary to meet its share of the costs incurred under this act.

13. Penalty. (a) It shall be unlawful for any person to wilfully obtain benefits under this act to which he is not entitled, or in a greater amount than to which he is entitled, and, further, it shall be unlawful for any provider to receive medical assistance payments to which he is not entitled, or in a greater amount than to which he is entitled, or to falsify any report required under this act.

(b) Any person who violates the provisions of subsection (a) of this section shall be guilty of a misdemeanor.

14. Reporting and Oversight. The Commissioner shall report to the Governor and the Legislature, no less than once each year, which report shall include a summary of its activities for the preceding year and any recommendations or suggestions for legislative consideration.

The Senate and Assembly Standing Committees on Institutions and Welfare shall review, on a continuous basis, the development, administration and operation of the program provided for in this act. To facilitate this review and oversight, the Commissioner shall submit to the Committees the report provided for above, the report of the Department's program for the progressive implementation of Medicaid in New Jersey and such other reports as shall be called for by the Committees from time to time.

In addition, the Commissioner of the Department of Institutions and Agencies shall submit to the Committees, at least once each year, a statement of eligibility requirements under the various categorical programs, any contemplated modification in requirements, and estimates on the relationship of such modifications to case loads and costs under this program. Prior to making any such modification of eligibility requirements under the various categorical programs, the Commissioner shall report to the Committees in detail the nature of such proposed modifications.

15. Severability clause. If any provision of this act or the application thereof to any person or circumstance is

held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are declared to be severable.

16. Effective date. This act shall take effect January 1, 1970, but all arrangements necessary or appropriate to enable this act to become fully effective on said date shall be made as promptly as possible as though this act were effective immediately.

A P P E N D I X

TABLE I

Table 1. SERVICES NOW PROVIDED IN NEW JERSEY UNDER CATEGORICAL AND MEDICAL ASSISTANCE FOR THE AGED PROGRAM

Department of Institutions and Agencies (March 27,1968)

SERVICES	PROGRAMS				
Minimum Required	A.F.D.C.	O.A.A.	B.A.	D.A.	M.A.A.
1. In-Patient Hospitalization	No	Yes	No	No	Yes
2. Out-Patient Hospital Services	(a)	(a)	(a)	(a)	(a)
3. Physicians Services	(b)	(b)	(b)	(b)	(b)
4. Skilled Nursing Home	Yes	Yes	Yes	Yes	Yes
5. Laboratory and X-ray	Yes	Yes	Yes	Yes	Yes
6. Home Health Services	(c)	(c)	(c)	(c)	(c)
"Optional" Services					
7. Other remedial care by licensed practitioners	Yes	Yes	Yes	Yes	Yes
8. Clinic Services	(c)	(c)	(c)	(c)	No
9. Dental Services	Yes	Yes	Yes	Yes	No
10. Physical therapy	Yes	Yes	Yes	Yes	Yes
11. Prescribed drugs, dentures, prosthetic devices and eyeglasses	Yes	Yes	Yes	Yes	Yes
12. Other diagnostic services	Yes	Yes	Yes	Yes	Yes
13. Mental and T.B. hospitals for persons over 65	No	No	No	No	Yes
14. Private Duty Nursing	No	No	No	No	No

(a) Yes, in some counties and in some hospitals, at county option.

(b) Yes, for home and office visits, but not for services in hospitals or clinics.

(c) Yes, in some counties where such services are available, at county option.

TABLE II

Table II. COST OF INDIGENT CARE NEW JERSEY NON-PROFIT PRIVATE HOSPITALS FOR YEAR ENDING DECEMBER 31,1965

New Jersey Hospital Association

	Hospitals Reported	Per Bed	Projection for Hospitals not Reported	Total
Bed Capacity	7,887		12,408	20,295
Inpatient - Cost of Care	$9,160,762	$1,161.50	$14,411,881	$23,572,643
Recovered for this care	4,155,840	526.92	6,538,001	10,693,841
Unrecovered cost	5,004,922	634.58	7,873,880	12,878,802
Outpatient - Cost of Care	1,895,930			
Recovered for this care	601,374			
Unrecovered cost	1,294,556		2,036,664	3,331,220
Total Unrecovered Cost	6,299,478	798.72	9,910,544	16,210,022
Received Undesignated	793,786		1,248,703	2,042,489
Net Cost of Indigent Care	$5,505,692	$ 698.08	$8,661,841	$14,167,533

TABLE III

REGIONAL OFFICE, HEW, ESTIMATES OF NEW JERSEY TITLE XIX COSTS FOR 1968

SUPPLEMENTED BY "INTERMEDIATE" AND "HIGH" COHORTS

Type of Services	"Low"	"Intermediate"	"High"
In-Patient Hospital	$ 35,992,532	$ 47,839,296	$ 61,697,316
Nursing Homes	$ 49,634,645	$ 51,569,190	$ 53,018,460
Physicians	$ 39,688,484	$ 49,940,008	$ 61,772,908
Prescriptions	$ 24,246,851	$ 27,355,033	$ 30,715,316
Hospital O.P.D.	$ 347,296	$ 448,700	$ 566,598
Dental	$ 18,922,309	$ 24,241,096	$ 30,411,420
Other Special Services	$ 2,080,768	$ 2,463,171	$ 2,893,350
Total	$170,912,885	$203,856,494	$241,075,368

Note: The HEW estimates do not include administrative costs.

TABLE IV

COMPARATIVE ESTIMATES, TITLE XIX, NEW JERSEY, 1968, BY SOURCE OF ESTIMATE

		ELIGIBLE POPULATION COHORTS		
Source of Estimate* -and-	Date Prepared	"Low"	"Intermediate"	"High"
Division of Public Welfare	Oct.-Nov. 1966	$151,064,915	$177,325,896	$212,074,03(
HEW Region Office	Oct. 1967	$170,912,885	$203,856,494	$241,075,36(
Prudential-Blue Cross	June 1967	$215,000,000	**	**

*For consistency of comparison, the above figures do not include costs of administration (as not included in HEW Region II estimate). Generally, however, such costs may be estimated at 15% of the above totals.

**Data not provided.

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TABLE V

July 22, 1968

DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF PUBLIC WELFARE
BUREAU OF BUSINESS SERVICES

MEDICAL ASSISTANCE PROGRAM
SUMMARY OF COST FACTORS INVOLVED IN IMPLEMENTATION OF PROGRAM

The attached exhibits, A through DD, represent estimates of costs for a Medical Assistance Program which includes the indigent persons listed below and all persons presently eligible for the Medical Assistance for the Aged program. The estimates exclude any concept of "medically indigent only".

Money payment and categorically related (A, AA)	250,000
ADC-Unemployed Parent (B, BB)	19,000
Presumptive Eligibility (C, CC)	16,300
Medical Assistance for the Aged (E)	11,600
Sub-Total	296,900
Foster Care (D, DD)	12,000
Total	308,900

Exhibits A through E are based on 308,900 recipients at a cost of $330.00 per recipient per year. Exhibits AA through DD when combined with E are based on the same number of recipients, but at an estimated annual cost of $295.00 per recipient instead of $330.00. The difference of $35.00 per person is based on the assumption that payments to physicians will be made on a "fee schedule" basis rather than the "prevailing fee" basis assumed in Exhibits A through D.

I. Summary of Costs for the six-month period, January 1 to June 30, 1970 at the annual rate of $330.00 per recipient.

A. Estimated Additional Cost (Table indicates additional State funds required in amount of $22,718,700.) and reduction in county costs

	Total	Federal	State	County
Money-Payment and Categorically Related (A)	$31,433,000	$18,789,300	$14,243,700	-1,600,000
ADC-Unemployed Parent (B)	2,554,000	826,000	1,821,000	-93,000
Presumptive Eligibility (C)	1,803,000	1,128,000	844,000	-169,000
Medical Assistance for the Aged (E)	-0-	-2,429,500	5,335,000	-2,905,500
Sub-Total	35,790,000	18,313,800	22,243,700	-4,767,500
Foster Care (D)	1,263,000	934,000	475,000	-146,000
Total	$37,053,000	$19,247,800	$22,718,700	-4,913,500

B. Estimated Total Basic Cost

	Total	Federal	State
Money-Payment and Categorically Related (A)	$38,500,000	$19,456,300	$19,043,700
ADC-Unemployed Parent (B)	2,926,000	826,000	2,100,000
Presumptive Eligibility (C)	2,509,000	1,156,000	1,353,000
Medical Assistance for the Aged (E)	23,243,000	9,192,000	14,051,000
Sub-Total	67,178,000	30,630,300	36,547,700
Foster Care (D)	1,848,000	934,000	914,000
Total	69,026,000	31,564,300	37,461,700

II. Summary of Costs for fiscal year 1969-70 at the annual rate of $330.00 per recipient.

A. Estimated Total Basic Cost

	Benefits	Administration	Total
Money-Payment and Categorically Related (A)	$82,500,000	$8,250,000	$90,750,000
ADC-Unemployed Parent (B)	6,270,000	627,000	6,897,000
Presumptive Eligibility (C)	5,379,000	537,900	5,916,900
Medical Assistance for the Aged (E)	46,486,000	-	46,486,000
Sub-Total	140,635,000	9,414,900	150,049,900
Foster Care (D)	3,960,000	396,000	4,356,000
Total	$144,595,000	$9,810,900	$154,405,900

B. Estimated Additional Gross Cost of Program

	Additional Gross Cost of Program for Year
Money-Payment and Categorically Related (A)	$73,790,000
ADC-Unemployed Parent (B)	6,004,000
Presumptive Eligibility (C)	4,221,900
Medical Assistance for the Aged (E)	-0-
Sub-Total	84,015,900
Foster Care (D)	2,956,000
Total	$86,971,900

III. Summary of Costs for the six-month period, January 1 to June 30, 1970, at the annual rate of $295.00 per recipient.

A. Estimated Additional Cost (Table indicates additional State funds required in amount of $20,238,500.) and reduction in county costs.

	Total	Federal	State	County
Money-Payment and Categorically Related (AA)	$27,350,500	$16,726,000	$12,224,500	-1,600,000
ADC-Unemployed Parent (BB)	2,244,300	738,300	1,599,000	-93,000
Presumptive Eligibility (CC)	1,539,500	1,006,500	702,000	-169,000
Medical Assistance for the Aged (E)	-0-	-2,429,500	5,335,000	-2,905,500
Sub-Total	31,134,300	16,041,300	19,860,500	-4,767,500
Foster Care (DD)	1,067,000	835,000	378,000	-146,000
Total	$32,201,300	$16,876,300	$20,238,500	-4,913,500

B. Estimated Total Basic Cost

	Total	Federal	State
Money-Payment and Categorically Related (AA)	$34,417,500	$17,393,000	$17,024,500
ADC-Unemployed Parent (BB)	2,616,300	738,300	1,878,000
Presumptive Eligibility (CC)	2,245,500	1,034,500	1,211,000
Medical Assistance for the Aged (E)	23,243,000	9,192,000	14,051,000
Sub-Total	62,522,300	28,357,800	34,164,500
Foster Care (DD)	1,652,000	835,000	817,000
Total	$64,174,300	$29,192,800	$34,981,500

IV. Summary of Costs for fiscal year 1969-70 at the annual rate of $295.00 per recipient.

A. Estimated Total Basic Cost

	Benefits	Administration	Total
Money-Payment and Categorically Related (AA)	$73,750,000	$7,375,000	$81,125,000
ADC-Unemployed Parent (BB)	5,606,000	560,600	6,166,600
Presumptive Eligibility (CC)	4,809,000	480,900	5,289,900
Medical Assistance for the Aged (E)	46,486,000	-	46,486,000
Sub-Total	130,651,000	8,416,500	139,067,500
Foster Care (DD)	3,540,000	354,000	3,894,000
Total	$134,191,000	$8,770,500	$142,961,500

B. Estimated Additional Gross Cost of Program

	Additional Gross Cost of Program for Year
Money-Payment and Categorically Related (AA)	$64,165,000
ADC-Unemployed Parent (BB)	5,273,600
Presumptive Eligibility (CC)	3,594,900
Medical Assistance for the Aged (E)	-0-
Sub-Total	73,033,500
Foster Care (DD)	2,494,000
Total	$75,527,500

DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF PUBLIC WELFARE
BUREAU OF BUSINESS SERVICES

EXHIBIT A
July 22, 1968

MEDICAL ASSISTANCE PROGRAM
ANALYSIS OF COSTS FOR MONEY-PAYMENT AND
"CATEGORICALLY RELATED" RECIPIENTS (WITHIN SCOPE
OF CATEGORICAL PROGRAMS AS DEFINED PRIOR TO 1/1/69)
(Excluding MAA)

	Fiscal Year 1969-70	Six-Months of 1969-70-January 1 to June 30, 1970			
		Total	Federal	State	County
Estimated Gross Cost of Benefits[a]	$82,500,000	$34,375,000[b]	$17,187,500	$17,187,500	
Administrative Expense (10%)	8,250,000	4,125,000[c]	2,268,800	1,856,200	
Estimated Total Basic Cost	90,750,000	38,500,000	19,456,300	19,043,700	
Deduct:					
Cost of Medical Care for Existing Programs (OAA,DA, ADC and AB only)	16,960,000	7,067,000[d]	667,000	4,800,000	1,600,000
Additional Cost	73,790,000	31,433,000	18,789,300	14,243,700	1,600,000

(a) For an estimated 239,000 average monthly money-payment recipients, plus 11,000 "categorically related" for a total of 250,000 recipients at an estimated cost of $330.00 per recipient.

(b) Five months at $6,875,000 (cash basis).

(c) Federal, 55%; State, 45%.

(d) Five months at $1,413,400 (cash basis).

EXHIBIT F
July 30, 1968

DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF PUBLIC WELFARE

ALLOCATION OF MEDICAL CARE EXPENDITURES FOR FISCAL YEARS 1969 TO 1971
FOR CATEGORICAL ASSISTANCE PROGRAMS ONLY INCLUDING MEDICAL ASSISTANCE
FOR THE AGED

	MEDICAL CARE EXPENDITURES			
1968-69 (Estimated)*	Total	Federal	State	County
Old Age Assistance	$ 2,700,000	$ 1,350,000	$ 1,013,000	$ 337,000
Disability Assistance	4,700,000	-0-	2,937,500	1,762,500
Assistance for Dependent Children	7,200,000	-0-	4,500,000	2,700,000
Assistance for the Blind	220,000	-0-	137,500	82,500
Sub-Total	14,320,000	1,350,000	8,588,000	4,882,000
Medical Assistance for the Aged	44,000,000	22,000,000	14,850,000	7,150,000
Totals	$58,320,000	$23,350,000	$23,438,000	$12,032,000

(Non-Federal share computed on basis of State 75%, County 25% for period 1/1 to 6/30/69.)

1969-70 (Estimated)*				
OAA	$ 3,200,000	$ 1,600,000	$ 1,200,000	$ 400,000
DA	5,200,000	-0-	3,900,000	1,300,000
ADC	8,300,000	-0-	6,225,000	2,075,000
AB	260,000	-0-	195,000	65,000
Sub-Total	16,960,000	1,600,000	11,520,000	3,840,000
MAA	46,486,000	23,243,000	17,432,000	5,811,000
Totals	$63,446,000	$24,843,000	$28,952,000	$ 9,651,000

Period 1/1 to 6/30/70 (Estimated)*				
OAA	$ 1,333,000	$ 667,000	$ 500,000	$ 166,000
DA	2,167,000	-0-	1,625,000	542,000
ADC	3,458,000	-0-	2,594,000	864,000
AB	109,000	-0-	81,000	28,000
Sub-Total	7,067,000	667,000	4,800,000	1,600,000
MAA	23,243,000	11,621,500	8,716,000	2,905,500
Totals	$30,310,000	$12,288,500	$13,516,000	$ 4,505,500

(OAA, DA, ADC and AB computed on a cash basis, i.e. for a five-month period.)

1970-71 (Estimated)*				
OAA	$ 3,700,000	$ 1,850,000	$ 1,387,500	$ 462,500
DA	5,700,000	-0-	4,275,000	1,425,000
ADC	9,400,000	-0-	7,050,000	2,350,000
AB	300,000	-0-	225,000	75,000
Sub-Total	19,100,000	1,850,000	12,937,500	4,312,500
MAA	53,470,000	26,735,000	20,051,000	6,684,000
Totals	$72,570,000	$28,585,000	$32,988,500	$10,996,500

*These estimates presume no significant changes in existing limitations on scope of medical services financed through the categorical assistance programs.

TABLE VII

STATE OF NEW JERSEY — May 1, 1968
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF PUBLIC WELFARE
BUREAU OF BUSINESS SERVICES

ALLOCATION OF MEDICAL CARE EXPENDITURES FOR FISCAL YEARS 1967 TO 1970
FOR CATEGORICAL ASSISTANCE PROGRAMS ONLY INCLUDING MEDICAL ASSISTANCE
FOR THE AGED

	MEDICAL CARE EXPENDITURES			
1966-67 (Actual Expenditures)	Total	Federal	State	County
Old Age Assistance	$ 1,665,000	$ 832,500	$ 624,400	$ 208,100
Disability Assistance	3,682,000	-0-	1,841,000	1,841,000
Assistance for Dependent Children	4,723,000	-0-	2,361,500	2,361,500
Assistance for the Blind	140,000	-0-	70,000	70,000
Sub-Total	10,210,000	832,500	4,896,900	4,480,600
Medical Assistance for the Aged	20,578,000	10,289,000	6,173,000	4,116,000
Totals	$30,788,000	$11,121,500	$11,069,900	$ 8,596,600
1967-68 (Actual 6 months, Estimated 6 months)				
OAA	$ 2,200,000	$ 1,100,000	$ 825,000	$ 275,000
DA	4,200,000	-0-	2,100,000	2,100,000
ADC	5,900,000	-0-	2,950,000	2,950,000
AB	180,000	-0-	90,000	90,000
Sub-Total	12,480,000	1,100,000	5,965,000	5,415,000
MAA	38,000,000	19,000,000	11,400,000	7,600,000
Totals	$50,480,000	$20,100,000	$17,365,000	$13,015,000
1968-69 (Estimated)*				
OAA	$ 2,700,000	$ 1,350,000	$ 1,013,000	$ 337,000
DA	4,700,000	-0-	2,350,000	2,350,000
ADC	6,100,000	-0-	3,050,000	3,050,000
AB	220,000	-0-	110,000	110,000
Sub-Total	13,720,000	1,350,000	6,523,000	5,847,000
MAA	44,000,000	22,000,000	13,200,000	8,800,000
Totals	$57,720,000	$23,350,000	$19,723,000	$14,647,000
1969-70 (Estimated)*				
OAA	$ 3,200,000	$ 1,600,000	$ 1,200,000	$ 400,000
DA	5,200,000	-0-	2,600,000	2,600,000
ADC	7,300,000	-0-	3,650,000	3,650,000
AB	260,000	-0-	130,000	130,000
Sub-Total	15,960,000	1,600,000	7,580,000	6,780,000
MAA	50,000,000	25,000,000	15,000,000	10,000,000
Totals	$65,960,000	$26,600,000	$22,580,000	$16,780,000

*These estimates presume no significant changes in existing limitations on scope of medical services financed through the categorical assistance programs.

5

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGIONAL OFFICE

SOCIAL AND REHABILITATION SERVICE

Region II
26 Federal Plaza
New York, New York 10007

August 6, 1968

Mr. Lloyd W. McCorkle
Commissioner
Dept. of Institutions and Agencies
Post Office Box 1237
Trenton, New Jersey 08625

Dear Mr. McCorkle:

New Jersey Senate Bill No. 850 (1968) proposes to establish a State program of medical assistance for the needy in accordance with Title XIX of the Social Security Act, to become effective January 1, 1970. The pattern of administration for such program would differ from that followed in New Jersey's categorical assistance programs, as it would establish a State administered program with the role of county welfare boards restricted solely to investigation and determination of eligibility. Such boards would be reimbursed by the State agency for the costs incurred in such operation.

We have the following comments with respect to the bill:

(1) Fiscal Agent

In our prior letter of May 21 commenting on State Senator Maraziti's letter concerning proposed Title XIX legislation for the State of New Jersey (copy of which we sent you), we noted that his description of the role contemplated for a fiscal agent in the program indicated a possible misunderstanding as to the permissible scope of such an agent's participation. In this connection, the bill states that the fiscal agent will "administer . . ., in full or in part, the benefits provided for under this act for and in behalf of the single State agency," and directs the Commissioner of the single State agency to negotiate a fiscal agent contract with an insurance company or with a nonprofit hospital service or medical service corporation as may be designated by the Governor, pursuant to which funds will be advanced to such agency to make payments to "providers." (Sections 3(10) and 6(i).

These provisions raise a question as to the legislative intent regarding the functions of the fiscal agent and whether those functions would impair the single State agency's ultimate authority for program administration. Handbook D-2130.5, D-5520(b), and D-5820 spell out the terms of a fiscal agent's participation in the program and make clear that those functions which are integral to fulfillment of the State agency's responsibilities for program administration may not be delegated to any other entity.

(2) Advisory Council

A similar question under the single State agency requirement is raised by the provisions of the bill governing the functions of the State Medical Assistance Advisory Council in relation to the administration of the medical assistance plan, which might be read as vesting the Advisory Council with administrative authority incompatible with the authority required to be vested in the State agency. Thus, the opening paragraph of section 6 directs the Commissioner of the State agency to implement policies "approved by the State Medical Assistance Advisory Council," and subsection (1) thereof requires him to exercise certain salient program functions "through the State Medical Assistance Advisory Council." Such references should be revised to restrict the function of the Council to serving in an advisory capacity and to make clear that the responsibility for plan administration and for the development of policies, procedures and standards is vested in the State agency.

(3) Designated State Agency

We note that the single State agency is not named by the proposed legislation but that the Governor is empowered to designate the particular State department to serve in that capacity. This means that the Department may be one other than the Department of Institutions and Agencies which is the single State agency for purposes of the categorical programs. In any event, the act should make it clear that the designated single State agency has authority to supervise county welfare boards which are empowered to make determinations of eligibility.

It is of interest to observe an implication in the bill to the effect that the State Department of Health is not intended to be named as the State agency. Such implication occurs in section 9 describing the composition of the Advisory Council to include as ex-officio members "the administrative heads of the single State agency and the State Department of Health or their successors in function."

(4) Coverage

As provided in section 3(8), coverage under the program is to be limited to the categorically needy and related groups whose coverage is mandated by the Federal statute. However, the bill fails to cover individuals who would be eligible for assistance under one of the categorical programs except for failure to meet any eligibility condition of such program which is prohibited for purposes of Title XIX eligibility, such as, citizenship, relative responsibility, consent to imposition of lien etc. (See N.J.S.A. 44:7-5(b) and 44:7-14). Its inclusion of "persons who are eligible for assistance . . . except for durational residence requirements" is too limited to meet the mandatory coverage requirement. As we advised in our above-cited letter of May 21, 1968, this section must be expanded. (See Handbook D-4030(b)).

The State may also wish to consider expanding coverage under the program to include any other individual who meets the standard of need under a categorical program but who is not receiving such assistance, as for example, a categorically related individual who although needy is not willing to apply for money payments but is seeking medical assistance. (See Handbook D-4020(2)(a)). Such coverage, if provided, would not change the character of the program as one limited to the categorically needy.

(5) Scope of Care and Services

Section 5 fails to include under the scope of medical care and services provision for "early and periodic screening and diagnosis of individuals who are eligible under the plan and are under the age of 21," as required by section 1905(a)(4)(B), effective July 1, 1969. Also, as the bill proposes to initiate the program by providing the five mandatory services under section 1902(a)(13), we wish to remind you of the need to assure that the plan provides at least the same level of medical services as was previously furnished as part of categorical assistance.

By reason of section 121(b) of Public Law 89-97, Federal matching under Title I is prohibited with respect to medical vendor cases for any period in which New Jersey will receive Federal funds under Title XIX. This means that the vendor payments must be discontinued as part of the State's Title I plan, which plan in effect would then cover money payments only. The question we raise relates to the effect of the termination of the vendor payment part of the Title I program upon the State's ability to comply with section 1902(c) of the Act which provides:

"Notwithstanding subsection (b), the Secretary shall not approve any State plan for medical assistance if he determines that the approval and operation of the plan will result in a reduction in aid or assistance (other than so much of the aid or assistance as is provided for under the plan of the State approved under this title) provided for eligible individuals under a plan of such State approved under Title I, IV, X, XIV, or XVI."

The import of the above-quoted section as reflected in its legislative history is to protect the level of aid insofar as the money payment group is concerned. In other words, the prohibition against a reduction in the level of assistance provided eligible individuals under the categories is subject solely to the exception that a State may reduce the level of such aid to the extent that medical care formerly provided as part of categorical assistance is now to be provided as Title XIX assistance. The protective purposes of section 1902(c) apply to the money payment groups and not to MAA recipients. Protection of the level of medical care means that there may be no reduction of the specific items of medical care formerly available to money payment groups.

In the event that the services mandatorily required under the bill do not encompass all the medical services now being provided to categorical recipients the mechanism employed to avoid a violation of the 1902(c) prohibition against reduction of assistance whether in maintenance needs or in the medical services could take the form of expanding the items of mandatory services under Title XIX or increasing the money payment grant to cover special items of medical needs or of providing such items as non-matchable vendor payments.

We note that New Jersey's MAA program includes home health care as an item of medical service, whereas section 5(2)(b) of the bill includes this item as one of the permissive services. The bill should take cognizance that effective June 30, 1970, section 1902(a)(13)(A) will require the State plan to provide home health services to any individual eligible for skilled nursing home services. (Section 224 of Public Law 90-248).

We also note that in listing the services which the State agency may elect to add to the plan, the bill does not take advantage of the full scope of services for which Federal financial participation is available, since it omits coverage of private duty nursing services and an omnibus clause of the type sent forth in section 1905(a)(15).

The bill does not refer to or evidence recognition of the limitation on Federal matching set forth in clauses (A) and (B) of section 1905(a) relating to inmates of public institutions other than patients in a medical institution and individuals under 65 in an institution for tuberculosis or mental diseases.

(6) Relative Responsibility; Recoveries, Etc.

As State law imposes a duty to support on specified relatives (N.J.S.A. 44:4-100, 44:4-103, 44:5-19.9 - 44:5-19.10), we recommend inclusion in the bill of a new section reading somewhat as follows:

> "Notwithstanding any other provision of law, the financial responsibility of any individual for any applicant or recipient of medical assistance shall be disregarded unless such applicant is such individual's spouse, or child who is under the age of 21 or is blind or permanently and totally disabled."

Similar clauses should be added to conform State law to the Federal requirements under section 1902(a)(18) re: liens and recoveries against the property of individuals receiving assistance (N.J.S.A. 44:5-19.1 - 44:5-19.8, 30:4-80.1 - 30:4-80.4). We would suggest that section 6(g) of the bill which refers to recovery of incorrect benefits be revised to read:

> "To recover any and all benefits incorrectly paid to a recipient from such recipient or from his estate except that no lien may be imposed against property of the recipient prior to his death except pursuant to the judgment of a court."

The bill makes no reference to a prohibition against recovery or adjustment of assistance correctly paid. Although State law authorizing recovery under the categorical programs might be interpreted as having no application to medical assistance, it would be preferable to remove any ambiguity by affirmatively providing that such provisions would have no application herein.

(7) Methods of Administration

Section 6(l) of the bill which appears to be designed to conform with section 1902(a)(30) of the Act does not fully accomplish such objective.

We therefore suggest that clauses (1) and (2) of subdivision (1) be combined to read:

> "to develop such methods and procedures relating to the utilization of and the payment for medical care and services available under the plan as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy and quality of care."

If the State adopts this recommended reference to payment in accordance with reasonable charges, the bill should also seek to avoid misunderstanding as to charges for hospital services by adding the requirement of section 1902(a)(13)(D) that payment under the plan for inpatient hospital services shall be made on the basis of reasonable cost.

(8) State Funds

Section 8, relating to financing the program, obligates the State to provide necessary funds to the extent that Federal funds are not available for the "benefits" provided under this act. The limitation to payments for medical assistance without including costs of administration is no doubt attributable to oversight. Correction is indicated by revising line 2, page 6, to read: "to pay for the expenditures incurred under this act, the State shall . . . ."

(9) Prior Vendor Payments for Medical Care

As the State intends to abolish its current programs of vendor payments for medical services upon establishment of the Title XIX program, the bill should provide for such repeal, effective as of the effective date of the new program. (N.J.S.A. 44:7-76 - 44:7-84)

(10) Miscellaneous

Other points to be taken into account when the submitted bill is redrafted include the following:

a) Review of the State's buy-in agreement with the Social Security Administration under section 1843 of the Social Security Act;

(b) Deletion of the term, "benefits," wherever it occurs to describe vendor payments for medical assistance on behalf of eligible individuals;

(c) Clarification of the definitions of applicant and recipient to relate those terms to medical assistance;

(d) A commitment to provide high quality care under the act;

(e) Inclusion of additional groups of children as categorically needy (without adding medically needy children) who do not qualify under the State's AFDC plan if based on reasonable classification. (Handbook D-4040.5)

Sincerely yours,

James C. Callison
Regional Commissioner

cc:
Mr. Engelman

VIEWS OF THE MINORITY

DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF PUBLIC WELFARE
BUREAU OF BUSINESS SERVICES

EXHIBIT B
July 22, 1968

MEDICAL ASSISTANCE PROGRAM
ANALYSIS OF COSTS FOR ADC-UNEMPLOYED PARENT PROGRAM

	Fiscal Year	Six-Months of 1969-70-January 1 to June 30, 1970			
	1969-70	Total	Federal	State	County
Estimated Gross Cost of Benefits[a]					
Unemployed Father--Fed. Definition (9,500 persons at $330.00)	$3,135,000	$1,306,000[b]	$653,000	$ 653,000	
Other Unemployed and Underemployed (9,500 persons at $330.00)	3,135,000	1,306,000[b]	-0-	1,306,000	
Total Cost of Benefits	6,270,000	2,612,000	653,000	1,959,000	
Administrative Expense (10%)	627,000	314,000[c]	173,000	141,000	
Estimated Total Basic Cost	6,897,000	2,926,000	826,000	2,100,000	
Deduct:					
Cost of Medical Care for Existing Program (State 75%, Counties 25%)	893,000[e]	372,000[d]	-0-	279,000	93,000
Additional Cost	6,004,000	2,554,000	826,000	1,821,000	-93,000

(a) For an estimated 19,000 recipients at an estimated cost of $330.00 per recipient.

(b) Five months at $261,200 (cash basis).

(c) Federal 55%, State 45%.

(d) Five months at $74,400 (cash basis).

(e) Estimated annual cost of $47.00 for each of the 19,000 recipients.

DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF PUBLIC WELFARE
BUREAU OF BUSINESS SERVICES

EXHIBIT C
July 22, 1968

MEDICAL ASSISTANCE PROGRAM
ANALYSIS OF COSTS FOR ADDITIONAL PERSONS
GRANTED ASSISTANCE UNDER ALL CATEGORICAL PROGRAMS
ON PRESUMPTIVE ELIGIBILITY BASIS

	Fiscal Year	Six-Months of 1969-70-January 1 to June 30, 1970			
	1969-70	Total	Federal	State	County
Estimated Gross Cost of Benefits[a]	$5,379,000	$2,240,000[b]	$1,008,000	$1,232,000	
Administrative Expense (10%)	537,900	269,000[c]	140,000	121,000	
Estimated Total Basic Cost	5,916,900	2,509,000	1,156,000	1,353,000	
Deduct:					
Cost of Medical Care for Existing Programs	1,695,000[e]	706,000[d]	28,000	509,000	169,000
Additional Cost	4,221,900	1,803,000	1,128,000	844,000	-169,000

(a) For an estimated 16,300 average monthly recipients at an estimated cost of $330.00 per recipient. Approximately 90% of recipients will be eligible for Federal participation.

(b) Five months at $448,000 (cash basis).

(c) Federal, 55%; State, 45%.

(d) Five months at $141,200 (cash basis).

(e) Estimated annual cost of $104.00 for each of the 16,300 recipients.

DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF PUBLIC WELFARE
BUREAU OF BUSINESS SERVICES

EXHIBIT D
July 22, 1969

MEDICAL ASSISTANCE PROGRAM
ANALYSIS OF COSTS FOR FOSTER CARE PROGRAM

	Fiscal Year 1969-70	Six-Months of 1969-70-January 1 to June 30, 1970			
		Total	Federal	State	County
Estimated Gross Cost of Benefits[a]	$3,960,000	$1,650,000[b]	$825,000	$825,000	
Administrative Expense (10%)	396,000	198,000[c]	109,000	89,000	
Estimated Total Basic Cost	4,356,000	1,848,000	934,000	914,000	
Deduct:					
Cost of Existing Program (State 75%, Counties 25%)	1,400,000	585,000[d]	-0-	439,000	146,000
Additional Cost	2,956,000	1,263,000	934,000	475,000	-146,000

(a) For an estimated 12,000 average monthly children at an estimated cost of $330.00 per child.

(b) Five months at $330,000 (cash basis).

(c) Federal, 55%; State, 45%.

(d) Five months at $117,000 (cash basis).

DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF PUBLIC WELFARE
BUREAU OF BUSINESS SERVICES

EXHIBIT E
July 22, 1968

MEDICAL ASSISTANCE PROGRAM
ANALYSIS OF COST FACTORS RELATING TO MAA
PROGRAM - NOT REFLECTED IN OTHER EXHIBITS

	Fiscal Year	Six-Months of 1969-70-January 1 to June 30, 1970			
	1969-70	Total	Federal	State	County
Costs For Individuals Now Receiving MAA					
Nursing Home Cases Eligible for OAA Program *(5,000 at $350.00 for 12 months)	$21,000,000	$10,500,000	$ 5,250,000	$ 5,250,000	
Mental and TB Cases Eligible for OAA Program **(3,650 at $360.00 for 12 months)	15,768,000	7,884,000	3,942,000	3,942,000	
Remaining MAA Cases (Not Eligible for OAA Program)					
Nursing Home Cases (1,800 at $312.00 for 12 months)	6,744,000	3,372,000	-0-	3,372,000	
Mental and TB Cases (650 at $312.00 for 12 months)	2,434,000	1,217,000	-0-	1,217,000	
Hospital Care Cases (200 at $150.00 for 12 months)	360,000	180,000	-0-	180,000	
Home Health Care Cases (300 at $50.00 for 12 months)	180,000	90,000	-0-	90,000	
Gross Cost of Benefits	46,486,000	23,243,000	9,192,000	14,051,000	
Deduct: Cost of Existing MAA Program	46,486,000	23,243,000	11,621,500	8,716,000	2,905,500
Additional Cost	-0-	-0-	-2,429,500	5,335,000	-2,905,500

Estimate of cases which will be eligible for the Old Age Assistance program.
* 5,000 (74%) of the 6,800 Nursing Home Cases.
** 3,650 (85%) of the 4,300 cases in Public Mental and TB Hospitals.

DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF PUBLIC WELFARE
BUREAU OF BUSINESS SERVICES

EXHIBIT AA
July 22, 1968

MEDICAL ASSISTANCE PROGRAM
ANALYSIS OF COSTS FOR MONEY - PAYMENT
AND "CATEGORICALLY RELATED" RECIPIENTS
(WITHIN SCOPE OF CATEGORICAL PROGRAMS AS DEFINED PRIOR TO 1/1/69)
(Excluding MAA)

	Fiscal Year	Six-Months of 1969-70-January 1 to June 30, 1970			
	1969-70	Total	Federal	State	County
Estimated Gross Cost of Benefits(a)	$73,750,000	$30,730,000(b)	$15,365,000	$15,365,000	
Administrative Expense (10%)	7,375,000	3,687,500(c)	2,028,000	1,659,500	
Estimated Total Basic Cost	81,125,000	34,417,500	17,393,000	17,024,500	
Deduct:					
Cost of Medical Care for Existing Programs (OAA, DA, ADC and AB only)	16,960,000	7,067,000(d)	667,000	4,800,000	1,609,000
Additional Cost	64,165,000	27,350,500	16,726,000	12,224,500	-1,609,000

(a) For an estimated 239,000 average monthly money-payment recipients, plus 11,000 "categorically related" for a total of 250,000 recipients at an estimated cost of $295.00 per recipient.

(b) Five months at $6,146,000 (cash basis).

(c) Federal, 55%; State, 45%.

(d) Five months at $1,413,400 (cash basis).

DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF PUBLIC WELFARE
BUREAU OF BUSINESS SERVICES

EXHIBIT BB
July 22, 1969

MEDICAL ASSISTANCE PROGRAM
ANALYSIS OF COSTS FOR ADC-UNEMPLOYED PARENT PROGRAM

	Fiscal Year 1969-70	Six-Months of 1969-70-January 1 to June 30, 1970			
		Total	Federal	State	County
Estimated Gross Costs of Benefits[a]					
Unemployed Father--Fed. Definition (9,500 persons at $295.00)	$2,803,000	$1,168,000[b]	$584,000	$ 584,000	
Other Unemployed and Underemployed (9,500 persons at $295.00)	2,803,000	1,168,000[b]	-0-	1,168,000	
Total Cost of Benefits	5,606,000	2,336,000	584,000	1,752,000	
Administrative Expense (10%)	560,600	280,300[c]	154,300	126,000	
Estimated Total Basic Cost	6,166,600	2,616,300	738,300	1,878,000	
Deduct:					
Cost of Medical Care for Existing Program (State 75%, Counties 25%)	893,000[e]	372,000[d]	-0-	279,000	**93,000**
Additional Cost	5,273,600	2,244,300	738,300	1,599,000	**-93,000**

(a) For an estimated 19,000 recipients at an estimated cost of $295.00 per recipient.

(b) Five months at $233,600 (cash basis).

(c) Federal 55%, State 45%.

(d) Five months at $74,400 (cash basis).

(e) Estimated annual cost of $47.00 for each of the 19,000 recipients.

DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF PUBLIC WELFARE
BUREAU OF BUSINESS SERVICES

EXHIBIT CC
July 22, 1969

MEDICAL ASSISTANCE PROGRAM
ANALYSIS OF COSTS FOR ADDITIONAL PERSONS
GRANTED ASSISTANCE UNDER ALL CATEGORICAL PROGRAMS
ON PRESUMPTIVE ELIGIBILITY BASIS

	Fiscal Year	Six-Months of 1969-70-January 1 to June 30, 1970			
	1969-70	Total	Federal	State	County
Estimated Gross Cost of Benefits(a)	$4,809,000	$2,005,000(b)	$ 902,000	$1,103,000	
Administrative Expense (10%)	480,900	240,500(c)	132,500	108,000	
Estimated Total Basic Cost	5,289,900	2,245,500	1,034,500	1,211,000	
Deduct:					
Cost of Medical Care for Existing Programs	1,695,000(e)	706,000(d)	28,000	509,000	169,000
Additional Cost	3,594,900	1,539,500	1,006,500	702,000	-169,000

(a) For an estimated 16,300 average monthly recipients at a stipulated cost estimate of $295.00 per recipient.

(b) Five months at $401,000 (cash basis).

(c) Federal, 55%; State, 45%.

(d) Five months at $141,200 (cash basis).

(e) Estimated annual cost of $104.00 for each of the 16,300 recipients.

DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF PUBLIC WELFARE
BUREAU OF BUSINESS SERVICES

EXHIBIT DD
July 22, 1969

MEDICAL ASSISTANCE PROGRAM
ANALYSIS OF COSTS FOR FOSTER CARE PROGRAM

	Fiscal Year	Six-Months of 1969-70-January 1 to June 30, 1970			
	1969-70	Total	Federal	State	County
Estimated Gross Cost of Benefits(a)	$3,540,000	$1,475,000(b)	$737,500	$737,500	
Administrative Expense (10%)	354,000	177,000(c)	97,500	79,500	
Estimated Total Basic Cost	3,894,000	1,652,000	835,000	817,000	
Deduct:					
Cost of Existing Program (State 75%, Counties 25%)	1,400,000	585,000(d)	-0-	439,000	146,000
Additional Cost	2,494,000	1,067,000	835,000	378,000	-146,000

(a) For an estimated 12,000 average monthly children at a stipulated cost estimate of $295.00 per child.

(b) Five months at $295,000 (cash basis).

(c) Federal, 55%; State, 45%.

(d) Five months at $117,000 (cash basis).

TABLE VI

AS AMENDED 8-10-68

State of New Jersey

DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF PUBLIC WELFARE

DIVISIONAL OFFICES
129 EAST HANOVER STREET
TRENTON, NEW JERSEY

TELEPHONE
AREA CODE 609

ADDRESS REPLY TO:
STATE OF NEW JERSEY
DIVISION OF PUBLIC WELFARE
P. O. BOX 1627
TRENTON, NEW JERSEY 08625

July 30, 1968

Assemblyman Richard J. Vander Plaat, Chairman
Committee on Institutions and Welfare
State House
Trenton, New Jersey

Dear Sir:

This transmittal supplements information dated July 22, 1968 which was furnished to your Committee at the meeting of July 24, 1968 with Mr. Wechsler, Mr. Petito, et al.

The attached exhibits, A through E, represent estimates of costs for fiscal year 1970-71 for a Medical Assistance Program which includes the indigent persons listed below and all persons presently eligible for the Medical Assistance for the Aged program. The estimates exclude any concept of "medically indigent only".

The listing also shows a comparison of person estimates prepared by the Department of Institutions and Agencies and by Blue Cross for fiscal year 1969-70.

	1969-70		1970-71
	Blue Cross	Department	Department
Old Age Assistance	15,000	15,000	15,000
Disability Assistance	11,000	11,000	11,500
Assistance for Dependent Children	200,000	212,000	242,000
Assistance for the Blind	1,000	1,000	1,000
Categorically Related	5,000	11,000	12,000
Sub-Total	232,000	250,000	281,500
ADC-Unemployed Parent		19,000	23,000
Presumptive Eligibility		16,300	13,000
Medical Assistance for the Aged		11,600	12,200
Sub-Total		296,900	334,700
Foster Care		12,000	13,000
Total		308,900	347,700

Exhibits A through E are based on 347,700 recipients per year at an estimated annual cost (as per your request) of $295.00 per recipient instead of the $330.00 figure used in certain other estimates. The difference of $35. per person is based on the assumption that payments to physicians will be made on a "fee schedule" basis rather than the "prevailing fee" basis.

I. Summary of costs for fiscal year 1970-71 at the annual rate of $295.00 per recipient.

A. Estimated Additional Cost to Federal and State Governments and reduction in county costs

	Total	Federal	State	County
Money-Payment and Categorically Related (A)	$72,247,300	$44,238,300	$32,321,000	-4,302,500
ADC-Unemployed Parent (B)	6,267,500	2,069,500	4,497,000	-299,000
Presumptive Eligibility (C)	3,861,000	2,603,000	1,733,000	-475,000
Medical Assistance for the Aged (E)	-0-	-5,669,000	12,353,000	-6,684,000
Sub-Total	82,375,800	43,242,300	50,904,000	-11,770,500
Foster Care (D)	2,618,500	2,128,500	890,000	-400,000
Additional Cost	84,994,300	45,370,800	51,794,000	-12,170,500

B. Estimated Federal and State share of Total Basic Cost (Cost prior to deduction of the cost of the existing programs)

	Total	Federal	State
Money-Payment and Categorically Related (A)	$91,347,300	$46,088,800	$45,258,500
ADC-Unemployed Parent (B)	7,463,500	2,069,500	5,394,000
Presumptive Eligibility (C)	5,841,000	2,682,000	3,159,000
Medical Assistance for the Aged (E)	53,470,000	21,066,000	32,404,000
Sub-Total	158,121,800	71,906,300	86,215,500
Foster Care (D)	4,218,500	2,128,500	2,090,000
Total	162,340,300	74,034,800	88,305,500

C. Analysis of Estimated Basic Cost by Benefits and Administration (Cost prior to deduction of the cost of the existing programs)

	Total	Benefits	Administration
Money-Payment and Categorically Related (A)	$91,347,300	$83,043,000	$8,304,300
ADC-Unemployed Parent (B)	7,463,500	6,785,000	678,500
Presumptive Eligibility (C)	5,841,000	5,310,000	531,000
Medical Assistance for the Aged (E)	53,470,000	53,470,000	-0-
Sub-Total	158,121,800	148,608,000	9,513,800
Foster Care (D)	4,218,500	3,835,000	383,500
Total	162,340,300	152,443,000	9,897,300

II. Medical Care Expenditures for Existing Programs

Exhibit F reflects the allocation of estimated medical care expenditures for fiscal years 1969-1971 for the existing categorical assistance programs including Medical Assistance for the Aged. In other words, this reflects the medical care costs, and the distribution thereof, that must be anticipated without regard to a Title XIX program.

Following is a listing of the estimated reductions in county costs for the periods indicated that would result from the State's absorption of the county share.

1968-69 fiscal year	$12,032,000
1969-70 fiscal year	$ 9,651,000
1/1 to 6/30/70 (6 months)	$ 4,505,500
1970-71 fiscal year	$10,996,500

Does not include ADC-U, pres. eligibility, foster care

The reductions indicated do not mean that the counties will be able to reduce their current appropriations by the amounts indicated. Since the projected estimates for the periods indicated incorporate increases in costs of medical care that are estimated to occur in any event, the figures simply indicate the amount by which the funds to be contributed by the counties for the periods indicated would be less than would otherwise have been required.

We are developing new estimates of the costs that are likely to be incurred by a Medical Assistance Program in New Jersey for fiscal year 1975-76 and will make such estimates available to your Committee as soon as they are available.

Sincerely yours,

Irving J. Engelman, Director
Division of Public Welfare

IJE:PPp

DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF PUBLIC WELFARE

EXHIBIT A
July 30, 1968

MEDICAL ASSISTANCE PROGRAM
ANALYSIS OF COSTS FOR MONEY-PAYMENT
AND "CATEGORICALLY RELATED" RECIPIENTS
(WITHIN SCOPE OF CATEGORICAL PROGRAMS AS DEFINED PRIOR TO 1/1/69)
(Excluding MAA)

FISCAL YEAR 1970-71

	Total	Federal	State	County
Estimated Gross Cost of Benefits[a]	$83,043,000	$41,521,500	$41,521,500	
Administrative Expense (10%)	8,304,300[b]	4,567,300	3,737,000	
Estimated Total Basic Cost	91,347,300	46,088,800	45,258,500	
Deduct:				
Cost of Medical Care for Existing Programs (OAA, DA, ADC and AB only)	19,100,000	1,850,000	12,937,500	4,312,500
Additional Cost	72,247,300	44,238,800	32,321,000	-4,312,500

(a) For an estimated 269,500 average monthly money-payment recipients, plus 12,000 "categorically related" for a total of 281,500 recipients at an estimated cost of $295.00 per recipient.

(b) Federal, 55%; State, 45%.

DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF PUBLIC WELFARE

EXHIBIT B
July 30, 1968

MEDICAL ASSISTANCE PROGRAM
ANALYSIS OF COSTS FOR ADC-UNEMPLOYED PARENT PROGRAM

FISCAL YEAR 1970-71

	Total	Federal	State	County
Estimated Gross Costs of Benefits[a]				
Unemployed Father--Fed. Definition (11,500 persons at $295.00)	$3,392,500	$1,696,250	$1,696,250	
Other Unemployed and Underemployed (11,500 persons at $295.00)	3,392,500	-0-	3,392,500	
Total Cost of Benefits	6,785,000	1,696,250	5,088,750	
Administrative Expense (10%)	678,500[b]	373,250	305,250	
Estimated Total Basic Cost	7,463,500	2,069,500	5,394,000	
Deduct:				
Cost of Medical Care for Existing Program (State 75%, Counties 25%)	1,196,000[c]	-0-	897,000	299,000
Additional Cost	6,267,500	2,069,500	4,497,000	-299,000

(a) For an estimated 23,000 recipients at an estimated cost of $295.00 per recipient.

(b) Federal 55%, State 45%.

(c) Estimated annual cost of $52.00 for each of the 23,000 recipients.

DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF PUBLIC WELFARE

EXHIBIT C
July 30, 1970

MEDICAL ASSISTANCE PROGRAM
ANALYSIS OF COSTS FOR ADDITIONAL PERSONS
GRANTED ASSISTANCE UNDER ALL CATEGORICAL PROGRAMS
ON PRESUMPTIVE ELIGIBILITY BASIS

FISCAL YEAR 1970-71

	Total	Federal	State	County
Estimated Gross Cost of Benefits(a)	$5,310,000	$2,390,000	$2,920,000	
Administrative Expense (10%)	531,000(b)	292,000	239,000	
Estimated Total Basic Cost	5,841,000	2,682,000	3,159,000	
Deduct:				
Cost of Medical Care for Existing Programs	1,980,000(c)	79,000	1,426,000	475,000
Additional Cost	3,861,000	2,603,000	1,733,000	-475,000

(a) For an estimated 18,000 average monthly recipients at a stipulated cost estimate of $295.00 per recipient.

(b) Federal, 55%; State, 45%.

(c) Estimated annual cost of $110.00 for each of the 18,000 recipients.

DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF PUBLIC WELFARE

EXHIBIT D
July 30, 1968

MEDICAL ASSISTANCE PROGRAM
ANALYSIS OF COSTS FOR FOSTER CARE PROGRAM

FISCAL YEAR 1970-71

	Total	Federal	State	County
Estimated Gross Cost of Benefits(a)	$3,835,000	$1,917,500	$1,917,500	
Administrative Expense (10%)	383,500(b)	211,000	172,500	
Estimated Total Basic Cost	4,218,500	2,128,500	2,090,000	
Deduct:				
Cost of Existing Program (State 75%, Counties 25%)	1,600,000	-0-	1,200,000	400,000
Additional Cost	2,618,500	2,128,500	890,000	-400,000

(a) For an estimated 13,000 average monthly children at a stipulated cost estimate of $295.00 per child.

(b) Federal, 55%; State, 45%.

DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF PUBLIC WELFARE

EXHIBIT E
July 30, 1968

MEDICAL ASSISTANCE PROGRAM
ANALYSIS OF COST FACTORS RELATING TO MAA
PROGRAM - NOT REFLECTED IN OTHER EXHIBITS

FISCAL YEAR 1970-71

	Total	Federal	State	County
Costs For Individuals Now Receiving MAA				
Nursing Home Cases Eligible for OAA Program *(5,300 at $390.00 for 12 months)	$24,804,000	$12,402,000	$12,402,000	
Mental and TB Cases Eligible for OAA Program **(3,800 at $380.00 for 12 months)	17,328,000	8,664,000	8,664,000	
Remaining MAA Cases (Not Eligible for OAA Program)				
Nursing Home Cases (1,900 at $352.00 for 12 months)	8,026,000	-0-	8,026,000	
Mental and TB Cases (700 at $330.00 for 12 months)	2,772,000	-0-	2,772,000	
Hospital Care Cases (200 at $150.00 for 12 months)	360,000	-0-	360,000	
Home Health Care Cases (300 at $50.00 for 12 months)	180,000	-0-	180,000	
Gross Cost of Benefits	53,470,000	21,066,000	32,404,000	
Deduct: Cost of Existing MAA Program	53,470,000	26,735,000	20,051,000	6,684,00
Additional Cost	-0-	-5,669,000	12,353,000	-6,684,00

Estimate of cases which will be eligible for the Old Age Assistance program.

* 5,300 (74%) of the 7,200 Nursing Home Cases.

** 3,800 (85%) of the 4,500 cases in Public Mental and TB Hospitals.

MINORITY REPORT ON MEDICAID

While recognizing that the report of the Assembly Committee to the Legislature recommending the implementation of Medicaid in New Jersey is basically factually accurate, the undersigned members of the Joint Committee cannot agree with the conclusion reached by the majority. In order for the people of the State of New Jersey and our fellow legislators to decide intelligently whether Medicaid should be adopted, we are submitting herewith our report recommending that Medicaid not be adopted in New Jersey.

At the outset we wish to establish clearly our conviction that there exists a great need for improvement in the medical services available to our citizens. No one can argue that many persons are not receiving the care and services available to the more affluent members of our society. But we do not believe that Medicaid is the vehicle which should be used by New Jersey to provide these services to the needy.

The Philosophical Problem

Before discussing the practical problems associated with Medicaid we feel that the underlying philosophical proposition should be considered. The avowed purpose of Medicaid is to provide health care for the needy which will not merely be necessary and adequate but which will be "high quality health care ... on an equal basis with all other citizens" (Statement of Dr. Louis K. Collins, President of the Medical Society of New Jersey, at public hearing before Joint Committees on April 19, 1968, at page 3.). This will require, in 1975, the provision of services to approximately 20% of our citizens (Majority report page 28, high cohort), using the standards now applicable in determining eligibility for general welfare assistance. These standards, as a practical matter, cannot be lowered without doing a great disservice to our people, and therefore must be used. Consequently, we must therefore ask ourselves the following: Are eighty per cent of our citizens willing to provide medical services to the other twenty per cent, which services are not only adequate, but also "equal to" those which the majority of the other eighty per cent can provide for themselves? By way of simple illustration, should the state establish a program permitting a recipient to have his way paid to a doctor of his own choice and pay that

doctor a reasonable fee for his services, or should a recipient have his way paid to a clinic or other state provided facility, and there be given adequate medical treatment, although not by a person of his own choosing?

If we accept Medicaid we should do so cognizant of the philosophy we are embracing. We question whether New Jersey can and should undertake a commitment to a proposition with such far reaching consequences. For what comes after health care services? Do we then guarantee equal quality recreation and cultural services? Is every boy, in order to be well rounded and well adjusted, entitled to admission to a big league baseball game each year so that he can feel he is part of "the great American pastime", and a participant in it? Do we then move on to providing everyone with new clothes from the best of stores rather than utilizing perfectly good second hand clothes and discount store clothes, because it will make the recipient feel he is a "second class" citizen? Other examples could be given, but suffice it to say, that in adopting Medicaid, we are adopting a far reaching philosophical proposition never yet accepted.

The Effect of Medicaid

What Medicaid Does Not Do

Despite the many claims of its proponents about making services available, Medicaid does not really meet the needs of our people. The need is not for the money to buy services, but for the services themselves. Medicaid will not produce more doctors, or have them establish a practice in the ghettos or with the rural poor. No new hospital beds will be provided, nor will additional nurses be graduated to staff them. Not a single one of the services to be available under the Medicaid program will be made more available by an increase in the number of persons and facilities in New Jersey. The need is to have a doctor or hospital or nurse physically ready and available, not to pay the existing doctors and hospitals and nurses for the services which they already render.

What Medicaid Does

Very simply put, Medicaid redistributes the cost of providing medical services to the needy. Today, doctors, as part of their professional standards, treat many needy

patients at greatly reduced rates, or without any charge at all. Druggists, dentists, physical therapists, optometrists and others do the same. Now they will all be paid. Hospitals, which in New Jersey today underwrite the cost of indigent care in an annual amount of approximately sixteen million dollars by fund drives, tight fiscal policies, higher rates to private patients, and other devices, now will be paid in full. The counties contribute approximately ten million dollars a year to the hospitals; now they will contribute nothing. An undeterminable amount of the general welfare monies spent by the municipalities for medical services will now be provided by Medicaid. We can only conclude, after a close study of Medical that its principal impact will be financial. Medicaid services heretofore provided and underwritten from many sources will be paid for from one source - the state - and vendors will all be paid in full for their services.

This conclusion is buttressed by the testimony presented at the three days of hearings held by the Joint Committee. Everyone who testified supported Medicaid. And nearly everyone who testified had a direct, vested economic benefit to be gained, for they as vendors would receive state

guaranteed payments in full for their services. Not a single representative of the group ostensibly to be benefited by Medicaid was heard from. No ghetto dweller, no needy person, nor any one of the many persons working with them said: "Adopt Medicaid, so I can go to my own doctor and have a semi-private hospital bed, like everyone else".

Additional Implications of Medicaid

If we adopt Medicaid, we adopt a program over which we have no control. Control is vested in Congress, and we must comply with the requirements of the enabling federal legislation, as it exists, and as it may be changed in the future. This means, for example, that eligibility will be federally determined, except to the extent which we can contol it by defining the "medically indigent". Our one year residence requirement is eliminated (Majority Report, pg. 23), and we can no longer require adult children to be responsible for the medical services provided their aged parents, no matter how wealthy they are (Majority Report, pg. 23). We no longer will be molders of our own destiny, best able to perceive and meet the needs of our people. This will be done for us by the federal government, establishing

single standards applicable to the entire country without regard to the varying needs of the different states.

Furthermore, we are embarking on a program which assumes roughly equal participation by the federal government with the State of New Jersey. But what guarantee is there that the day will not come when the federal funds will be reduced, or eliminated altogether, leaving us with a program designed and controlled by others, but paid for by ourselves? Experience shows that this is not a remote possibility but a very real one. New York embarked on an overly ambitious Medicaid program, so much so that not only did it have to cut back on its own eligibility standards, but the federal government reduced its share in the first year, thereby imposing a still greater burden on the State of New York. Meanwhile, in Washington, emergency appropriations have been required this year to finance the Medicaid program, as costs have greatly exceeded budget estimates and the program is only beginning. As pressures build up to cut the federal budget, one of the first areas to feel the effect will be Medicaid, for here is found an on-going program whose financing can easily be passed on to the states. The possibility of the existing federal commitment being only "seed money" is very real, and cannot be disregarded. Already this year we have appropriated 3 million dollars to

underwrite the school lunch program so that it could continue when federal funds were withdrawn. The history of federal matching funds in the areas of road construction, clean air and water projects, transportation and other areas is a clear warning to us that the day may come, and very soon, when most if not all of the cost of the Medicaid program will be born by the State of New Jersey.

The Cost

Before scrutinizing the cost of Medicaid, the entire program must be placed in the proper fiscal framework. For New Jersey, Medicaid cost will be divided approximately equally between state and federal funds. But, if New Jersey does not adopt Medicaid, existing federal funds for several of our programs will be discontinued, resulting in a loss in Fiscal Year 1969-1970 of approximately 13.3 million dollars in federal aid. We point this out clearly at the outset so that the federal blackmail will be readily apparent. Either New Jersey goes along, or Washington will take away its subsidies. We believe New Jersey would be better off without the federal funds than with Medicaid.

In discussing cost, great care must be taken, for several approaches present themselves:

1. What will be the total cost in the first full fiscal year of the program, i.e., fiscal 1970-1971?

2. What will be the total cost in the first fiscal year of the program i.e., fiscal 1969-70?

3. How much state money must be appropriated in addition to that which will be spent on medical care in any event, both in fiscal 1970-71 and fiscal 1969-70?

4. What will be the cost of the program in 1975, its first year of full operation?

Prior to answering these questions two things must be pointed out. First, no one has dared to predict with any confidence what Medicaid will cost. This is easy to understand inasmuch as the cost of almost every other Medicaid program adopted throughout the country has been underestimated. Our committee found that the principal sources for estimates used by the committee, the Department of Institutions and Agencies, Blue Cross-Blue Shield, and Prudential, varied as much as 43 per cent in their estimates. Secondly, care sould be taken in assessing costs to allow for a time-lag in implementing the program. For example, the 1969-70 fiscal year cost will only be for four to five months inasmuch as thirty to sixty days will be required for the provision of the services, billing and paying.

Summarily stated, the best estimates provided lead us to conclude that the cost of Medicaid, at an estimated per unit cost of $295.00, will be no less that the following:

1. For the first full fiscal year of 1970-71, 162,340,300 million dollars, of which New Jersey must provide $88,305,500.

2. In fiscal 1969-70, or for approximately four to five months of actual operation, a total of 64,174,300 million dollars of which New Jersey must provide $34,981,500.

3. It is estimated that of the 34,981,500 million which will be required from New Jersey in fiscal 1969-70, $14,743,000 would have been required anyway, resulting in $20,238,500 in new money to be appropriated.

4. For the first twelve months of full operation, $51,794,000 in new state money will be required.

5. Only Prudential, whose estimates for the cost of an initial program were considerably lower than the Department's, has dared project the 1975 estimates; this was $500 million. As of this writing the Department has not provided this committee with its estimates for the 1975 cost of the program, despite requests. We feel, based on our analysis and comparison of the other estimates provided, that $700 million is a more

realistic figure for 1975, inasmuch as the number of persons covered by Medicaid will be increased from 308,900 to approximately 20 per cent of the population or 1.6 million persons assuming a population of 8 million.

Our consideration of cost thus resolves itself into one crucial question: Will Medicaid be worth 350 million dollars of the State money to the people of New Jersey in 1975, or can the money be better spent in other ways to provide medical services for the poor?

The Alternatives

Obviously we do not believe that the expenditure of 350 million dollars on Medicaid will be money well spent, but at this juncture, we can do no more than point the way we should go. It has not been possible for us to develop in the few months we have had to consider this problem a concrete proposal; that must come later. We can with confidence, nonetheless, suggest the following avenues of approach.

The existing programs should be continued, but administration of them vested in one fiscal intermediary operating with and through a new Division of Medical Services in the Department of Institutions and Agencies, assisted

by a State Medical Advisory Council. With our medical services administration thus constituted, programs designed to directly meet the needs of the medically indigent can be formulated. These might include the crucial area of pre-natal and infant care; greater emphasis on preventive medicine, especially for children; relocation of clinics and medical care facilities in city areas, and the bringing of the medical services to the rural poor; greater emphasis on providing medication, drugs and therapy outside of hospitals; provision of birth control information and devices; and similar ways. The emphasis of such programs must be to bring the provider and recipient physically together in a practical way if the needs of the poor are to be met.

By comparison with the well outlined and documented Medicaid Program which has been proposed in the Assembly Bill, these alternatives may appear inadequate, but we believe that they can be developed into a more meaningful service for the people of New Jersey.

Conclusion

It follows from our analysis of Medicaid as little more than a redistribution of the cost of existing services,

combined with a built in commitment to expansion over which we have no control, that we recommend that Medicaid not be adopted. If this is done, New Jersey will then be free to develop a program designed to meet the needs of its citizens in an imaginative, realistic, and more economical manner.