PUBLIC HEARING

before

SENATE COMMITTEE ON AGING

Senate Bill 2132

(Home Health and Community Care Partnership Act)

August 4, 1986
Council Chambers
Long Branch Municipal Building
Long Branch, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Senator Frank Pallone, Jr., Chairman

ALSO PRESENT:

Senator Richard Van Wagner
District 13

Anita M. Saynisch
Office of Legislative Services
Aide, Senate Committee on Aging

Eleanor H. Seel
Office of Legislative Services
Section Chief, Senate Committee on Aging

* * * * * * * *

Hearing Recorded and Transcribed by
Office of Legislative Services
Public Information Office
Hearing Unit
State House Annex
CN 068
Trenton, New Jersey 08625

FRANK PALLONE, JR.
Chairman
CATHERINE A. COSTA
Vice-Chairman
CHRISTOPHER J. JACKMAN
LEANNA BROWN
PETER P. GARIBALDI

New Jersey State Legislature
SENATE COMMITTEE ON AGING
STATE HOUSE ANNEX, CN-068
TRENTON, NEW JERSEY 08625
TELEPHONE (609) 292-1646

July 17, 1986

NOTICE OF A PUBLIC HEARING

THE SENATE COMMITTEE ON AGING ANNOUNCES A PUBLIC HEARING ON SENATE BILL NO. 2132 OF 1986, THE "HOME HEALTH AND COMMUNITY CARE PARTNERSHIP ACT"

Monday, August 4, 1986
Beginning at 10:30 A.M.
Council Chamber
Long Branch Municipal Building
3rd Floor, 344 Broadway
Long Branch, New Jersey

The Senate Committee on Aging will hold a public hearing on Monday, August 4, 1986, beginning at 10:30 A.M. in the Council Chamber of the Long Branch Municipal Building in Long Branch, New Jersey to hear testimony on Senate Bill No. 2132 of 1986, sponsored by Senator Richard Van Wagner. Senate Bill No. 2132 of 1986 establishes the Home Health and Community Care Partnership Program in the Department of Health.

Address any questions and requests to testify to Anita Saynisch (609) 292-1646, State House Annex, Trenton, New Jersey 08625. Persons wishing to testify are asked to submit nine copies of their testimony on the day of the hearing. The chairman may find it necessary to limit the number of witnesses or the time available for each witness.

ASSEMBLY COMMITTEE SUBSTITUTE FOR

SENATE No. 2132 (OCR) and ASSEMBLY No. 3177

STATE OF NEW JERSEY

ADOPTED JANUARY 13, 1987

AN ACT concerning community care for the elderly and disabled and making an appropriation therefor.

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

1. This act shall be known and may be cited as the "Home Care Expansion Act."

2. The Legislature finds and declares that:

a. The need to offer care services to the growing number of frail elderly and disabled persons in New Jersey and the benefits derived from the provision of these services are well documented;

b. While State government has responded to the home care needs of the State's elderly and disabled population through the Medicaid Community Care Program for the Elderly and Disabled (CCPED), there remains a substantial number of people whose home care needs have not been met;

c. Many of these frail elderly and disabled people in the "no-care" zone are equipped to impoverish themselves to receive services under Medicaid;

d. The limitations on resources that a person may have to participate in the Medicaid program or the Community Care Program for the Elderly and Disabled are so restrictive as to make many of those in need of home care ineligible for needed services;

e. Many people who need care to remain in their homes do not have the funds to pay privately for the services; and,

f. It is therefore necessary to establish a program to extend such services to a greater number of the State's elderly and disabled population.

3. As used in this act:

a. "Commissioner" means the Commissioner of the Department of Human Services.

b. "Program" means the Home Care Expansion Program.

4. a. The commissioner shall establish and administer through the Division of Medical Assistance and Health Services in the Department of Human Services a program which shall be known as the Home Care Expansion Program, and which shall be funded with Casino Revenue Fund monies. This program shall incorporate, whenever possible, the features of CCPED, including eligibility criteria, with the exception of Medicaid resource and income limitations.

b. In order to ensure maximum efficiency in the use of State funds and prevent duplication of services, the Home Care Expansion Program shall utilize mechanisms currently in place in the CCPED program.

5. a. Individuals served by the Home Care Expansion Program shall receive a comprehensive assessment of the need for long-term home care services. A case manager shall develop a plan of care. In addition, the case manager shall provide ongoing monitoring of the individual's situation, services and cost of care.

b. The program shall consist of the following services: home health care, medical day care, non-emergency medical transportation, case management, social adult day care, homemaker care and respite care. The commissioner may expand the scope of services by regulation.

c. The commissioner shall determine that the services to be provided are medically necessary and will assist in avoiding institutionalization.

d. The cost of care for each individual shall be limted to an annual amount that is based on a percentage of the cost of nursing home care. The payment for services received by an eligible person under this act shall not exceed a percentage, as established by the commissioner, of the payment for the comparable level of care that the person would receive in a skilled nursing home or intermediate care facility under the Medicaid program pursuant to P. L. 1968, c. 413 (C. 30:4D-1 et seq.).

e. Eligible persons shall share in the cost of services, depending on the amount of their monthly income, in accordance with standards and criteria prescribed by the commissioner.

6. Any person who is a resident of this State, with resources within limits set by the commissioner, and is 65 years of age or older and is eligible for Medicare benefits or has other medical insurance which includes physician coverage and hospitalization, and whose annual income is less than $18,000.00 or an amount to be established by the commissioner by regulation, whichever is

higher, is eligible for assistance under the program. Any person under the age of 65 who is determined to be disabled by the Social Security Administration (SSA) or by the New Jersey Division of Public Welfare, Bureau of Medical Affairs in the Department of Human Services, using SSA criteria, and is eligible for Medicare benefits, or has other medical coverage which includes physician and hospital coverage and who meets the income eligibility requirements of this section, is eligible for assistance under the program.

7. The commissioner shall establish criteria for determining medical and financial eligibility, including provisions for submission of proof of income, resources and health insurance, and a system of providing services to eligible persons.

8. The commissioner is entitled to call upon the assistance, or contract for the services of any State, federal, or local agency as may be necessary to implement the provisions of this act.

9. The commissioner shall submit a report on the program to the Governor and the Legislature, including the Senate Standing Reference Committee on Institutions, Health and Welfare and the General Assembly Standing Reference Committee on Health and Human Resources within six months after the first year of operation of the program. The report shall include, but not be limited to, a detailed summary of the activities of the program, including the services provided, costs incurred, and the number of persons served, and a study of its overall impact and specific impacts in urban, suburban, and rural counties.

10. The commissioner shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P. L. 1968, c. 410 (C. 52:14B–1 et seq.) necessary to carry out the purposes of this act.

11. There is appropriated to the Department of Human Services $15,500,000.00 from the Casino Revenue Fund established pursuant to P. L. 1977, c. 110 (C. 5:12–145) to carry out the purposes of this act.

12. This act shall take effect on the first day of the ninth month following enactment.

"Home Care Expansion Act" and appropriates $15,500,000 from Casino Revenue Fund.

TABLE OF CONTENTS

TABLE OF CONTENTS (Continued)

* * * * * * * * *

ig: 1-130

SENATOR FRANK PALLONE, JR. (Chairman): Good morning. We are going to start the public hearing. I want to introduce myself. I'm Senator Pallone, and I'm Chairman of the Senate Committee on Aging. I'd like to welcome all of you to the first of several public hearings which the Committee plans to hold on Senate Bill S-2132, which is the Home Health and Community Care Partnership Act, sponsored by Senator Van Wagner. One of the reasons that I've delayed beginning the hearing is because Senator Van Wagner isn't here. But he is coming, and I want to get started. When he does come, we'll simply stop and have him present his testimony. Before-- Oh, he's here. Okay, terrific. (Senator Pallone addresses Senator Van Wagner) No, you're coming up here to sit with us. Climb up here.

Okay, let me start off first of all by introducing those of us who are up here at the podium. The other Senators will not be here today -- the other members of the Committee -- because, as some of you may know, we have the National Conference for State Legislators in New Orleans this week. I was hoping--

UNIDENTIFIED SPEAKER FROM AUDIENCE: Speak into the microphone, Senator, please.

SENATOR PALLONE: I'm sorry, you can't hear me? I'll try to bring it a little closer. Thank you for reminding me. I wasn't sure if you were able to hear me or not. Is that better? Can you hear me now? Okay, I'll get as close as I can here. How's that? Okay? You can't hear?

UNIDENTIFIED SPEAKER FROM AUDIENCE: Don't worry, we can hear now. I think that mike is hooked up to the recording machine, rather than for amplification.

SENATOR PALLONE: This one is the one. Okay, I guess I'm going to have to hold it pretty close then. I'll just have to try to talk into it. Okay, thank you for telling me, because sometimes we go on for half an hour before somebody says they can't hear.

Okay, as I said, the other Senators will not be here today. This is the week that we're having the National Conference of State Legislators down in New Orleans, and I think that many of them are at that conference. I do want to introduce the other people who are up here though, with our Office of Legislative Services and the Minority and Majority staff. First of all, on my right on the end is Rosemary Kramick, who is with the Senate Republican staff. To my immediate right is Barbara Cantrell, who is with the Senate Democratic staff, and to my left is Anita Saynisch, who is the Committee Aide from the Office of Legislative Services. Also, to her left, who just stepped out -- she is coming back to the room -- is Eleanor Seel, who is the director of the OLS division that deals with aging and other human services issues.

Before I introduce Senator Van Wagner, who is going to lead off the testimony, I wanted to say a few words about the procedure this Committee will follow regarding Senator Van Wagner's bill. We do have a tape presentation of about 15 minutes. It's a videotape presentation that will follow his testimony, by the Home Health Agency Assembly of New Jersey. Then we will go right into the testimony with the various speakers. I'm going to try to skip around so that we get some people from the different points of view that are expressed on this bill, and also have some combination of speakers who are just private citizens versus representatives of State agencies or other public health agencies.

Because of the interest in this legislation from senior citizens, health care providers and also county officials, this Committee is going to hold several hearings on this bill in every region of the State. Now this is the first hearing. However, we're already in the process of scheduling the next public hearing, which will be held in Hudson County, probably at the end of this month or in early September.

Earlier this year, the Committee held a public hearing in Long Branch, in this room, to review how the DRG -- Diagnostic-Related Group system -- is working in the State to reduce health cost, and whether seniors are being released from our State's hospitals sicker and quicker, which has been a concern since the DRG system went into place. Now I don't think there is anyone that questions the positive role played by DRGs in restraining health costs. But it's also clear that many experts think -- and this came out at the hearing that was held here -- that the system does encourage hospitals with incentives to discharge patients sicker and quicker. This, in turn, has contributed to the fact that many seniors on reduced incomes are now paying significantly more for services that were once covered while they were in the hospital. For example, drugs which people used to get free of charge in the hospital they may now have to buy themselves.

Seniors returning to their own homes frequently are surprised to find out that many of the services that they thought were covered by Medicare are not indeed covered. This came out in a very large fashion I think in the hearing that we did have here several months ago. That's one of the reasons why we're so concerned about this bill that Senator Van Wagner has proposed.

Recently, the U.S. Senate Special Committee on Aging heard testimony that cutbacks in Medicare reduced the number of home health visits paid for by Medicare. It was also shown that Medicare denials for services have nearly tripled since 1983. The significant increase in the number of denials for reimbursement under Medicare is disserving, and is a trend that simply has to be reversed.

I'd also like to mention that some members of the business community -- I'm sure you've noticed -- are now setting up elder care benefit packages for their employees. It's just something that I have a great deal of interest in.

These new developments reflect the changes in the work force, and the need for greater partnership efforts between the private and the public sector, which is one of the things that this bill seeks to accomplish.

A recently completed government study conducted by the National Center for Health Services Research found that 2.2 million care-givers are responsible for 1.2 million moderately to severely impaired people. Of these 2.2 million, more than one-third were employed with severe job conflicts. As one of the researchers of this study notes, work doesn't really deprive people from providing care. It just doubles up on the responsibilities. I'm sure many of you know either personally -- friends or relatives -- care-givers who have to go work, and at the same time have to go home and provide for other elderly members of their family on a daily, weekly, or monthly basis.

Given the increased longevity patterns, a lot more divorce, people getting married later, or choosing not to have children or having them later, plus more women in the labor force, there will soon be even more of a drain on care-givers than there is now. At the national level, Congress recently amended the Family and Medical Leave Act of 1986 to allow adult children of dependent parents with serious medical conditions to take up to 18 weeks of unpaid leave over a two-year period. This bill is not yet law, and there is considerable opposition to parts of the bill, as well as support as evidenced by the bill's 125 cosponsors.

I think you can see from my remarks that seeking ways to provide home health care for our frail elderly is a timely topic. It is an issue that will not go away; it is an issue that is very much of concern to members of this Committee, and I want to commend Senator Van Wagner for introducing this bill for discussion. At this time I want to introduce Senator Van Wagner. I'm sure most of you in this room know him. He's been a member of the New Jersey Legislature since 1973. He's

Chairman of the Senate County and Municipal Government Committee. He's been involved with issues of health care, and issues that affect senior citizens. He has been one of the main people in the State Legislature involved in those issues over the last decade. Senator Van Wagner. (applause) I think this one there, Rich. The small one is the one to speak into, and the other is for the recording.

S E N A T O R R I C H A R D V A N W A G N E R: I'll try to remember my training, Mr. Chairman, in terms of which mike to speak into. First, I'd like to thank you, Senator Pallone, for calling this public hearing so that we might begin discussion of S-2132, the Home Health and Community Care Act.

As you pointed out in your opening statement, certainly the issue of alternative health care for the growing frail and elderly population of New Jersey is one that should be a major priority in this session of the Legislature. As a matter of fact, if I might add parenthetically, it was my contention when I introduced another version of this bill in 1984 -- S-13 -- it was my feeling that it should be a major priority not only of the State Legislature, but a major priority of everyone in this country, that we begin to look very carefully at the process by which we provide health care, and look very carefully at alternatives to providing that health care, which in my view are more sensitive, in many cases more helpful, and in the long run I believe, for all of society, less costly.

By providing-- This bill is designed to begin a dialogue. It seeks to provide a core of health care and social services. It does so by identifying potential health problems before they reach the stage for hospitalization, and by developing comprehensive preventive health maintenance programs. In this fashion, I believe we can dramatically reduce the amount of time spent in the hospitals and nursing homes for thousands of our older citizens.

I want to again add also that I've had a great amount of correspondence on this particular bill. I deeply appreciate the concern expressed by all those agencies, departments of government, county offices on aging, and other groups who have expressed an interest in this legislation. I also wanted to assure them as sponsor of this bill, that by all means I would anticipate that their input and their constructive analysis will lead us to the kind of bill that everyone can support, and the kind of bill that can be implemented.

It is rather well established that patients recover from illnesses faster and improve to a greater degree when able to do so amid familiar surroundings and among their loved ones. I view this hearing as the beginning of a constructive dialogue, the sharing of different viewpoints and practical experiences which is essential to the legislative process. Hopefully the culmination of this process will produce a program will be able to achieve the admittedly ambitious goals of S-2132.

I would also like to add -- if I might -- some comments, Mr. Chairman. I am not without experience in dealing with the care of an elderly person. My wife and I do so within the confines of our own home. Fortunately, the person we care for does not have any great physical disability, although she certainly is frail and elderly, but mobile and able to do many things on her own. There are also many things that she is not able to do on her own, which are in many cases, what people would define as basic homemaking skills. She needs specific kinds of supervision in taking medication. In general, she requires a certain amount of overview and oversight by the family.

I can tell you from our own experience as a family, and my belief -- and this happens to be my wife's mother -- that in my view, it has not only been helpful to her in the sense that we have been able to provide her with the care and

understanding that she requires, but it's also been helpful to us, I believe. It's been helpful to me and my wife. There are times when it becomes frustrating. I would acknowledge that. There are times in life when everything becomes frustrating. But it has also enhanced the view of my children in terms of what a commitment to a family really is.

In a sense, if I had a broader goal in developing a home health care model in this state, it is the sense of reestablishing in the view of people that it is not necessary when a person becomes older, more frail, or even handicapped, that they be institutionalized, that the overriding burden for caring for that person is so great that it can only be done in an institutional setting. I would hope that as part of our model that we develop, that we would do something -- for example that was suggested to me by a high-ranking health official in this State -- that we begin a process of Medicaid intake screening so that when a person becomes eligible for Medicaid, a full medical and social assessment is done of that person's needs and a determination is made of what kind of services that person might receive, not only to help that person -- because in many cases when a person first becomes eligible for Medicaid, they may not in fact need any kind of health care or maintenance program.

However, if a program is developed and recommendations are made to that person at that point-- And I would hope that ultimately, throughout all of society, we could offer home health care as an overall alternative in the medical sense. If that person has an understanding of the kinds of preventive techniques in nutritional areas, or whatever other areas of their life that can be utilized to avoid any long-term illness, or catastrophic illness, that we collectively as a society will have profited by that.

So I think that in any event, and in any way this Committee seeks to amend this legislation -- and I know that

there will be a great deal of amendatory language added to the bill based on testimony that will be heard today, that one of the first concerns and one of the first steps in the process of establishing a home health care program in this State, would be to do an assessment -- a full-scale Medicaid assessment. I think that could be conducted within the departments that we have available in the State of New Jersey.

Lastly, before I end my statement, let me say that I believe in my own view -- and I think in the view of others -- that the stronger steps that we take toward establishing home health care in this State and hopefully at some point in time, nationally-- I know there have been expressions of support for national legislation. There has been some legislation introduced in Congress already. But the sooner and faster that we move in establishing a workable and practical home health care model, one that will serve the people and the population that need to be served, the sooner we will be able to begin to get a handle and a better idea on just how far health care costs are going to rise in the future, and just what steps we can take to contain those costs.

I noted in your opening statements you talked about areas of cost containment, areas where individuals have unfortunately been foreclosed from receiving Medicare benefits. I think that if we begin to develop a comprehensive home health care model with underlined emphasis on health care assessment and health care services of a preventative variety, we will ourselves begin to address the very problem that you mentioned in your opening statement, and that is the problem of cost containment and the problem of ever increasing cost, particularly for those who are unfortunate to be afflicted with a catastrophic, long-term illness.

So again I thank you for holding this hearing. I appreciate your invitation to sit with the Committee. I accept that invitation and I will look forward to listening to the

testimony of those that are here today to express their feelings on this bill, and on the concept of home health care. Let me say also at the end of this hearing process, by way of suggestion only, and something that we in the County and Municipal Government Committee have used to our advantage at times-- It might well be that during the process -- and perhaps at the end of the process -- that a working group of people, of citizens, representing the various facets of health care and care for the elderly that are here today might be put together in order for us to reach a consensus on the drafting of the ultimate bill that will come forth from this Committee. I think this working group, in its ability to exchange ideas and its ability to look at some of testimony and hear some of the testimony that takes place in the public hearing process will in fact speed the ultimate passage of this bill, and hopefully the signing of the bill into law by the Governor.

Again, thank you. I will, with your permission, join the Committee.

SENATOR PALLONE: Thank you Senator, very much. Would you please come up and join us? That idea you mentioned about having the working group is certainly an excellent one, and I think goes to emphasize what I've been trying to tell many of the people who have called my office, which is as far as we're concerned, we're working on this program at this point. We have a bill in front of us as a model, but by no means are we saying that this is the bill that necessarily has to be released, or this is the form of the bill. As Senator Van Wagner pointed out, he would like to have comments from all the different parties who are concerned about it to make amendments or whatever is necessary before we finally do release a bill. I'm glad he mentioned that today.

Next we're going to have the tape presentation by Mr. John Paul Marosy, who is the Executive Director of the Home Health Agency Assembly of New Jersey. The people who are going

to be assisting -- or I guess, are going to be presenting the tape are Joe Riordan and Dr. Ann Young. Is everyone able to see that screen? I have to tell you this is the first time that I've done something like this, so feel free to give us some comments afterwards about it. We thought we would make this kind of a presentation. You can't see it? I don't know if we can raise it. I don't think we can. That console is pretty heavy and we don't really have anything to put it on. If any of you want to come closer or reposition yourselves to watch it, don't hesitate.

Mr. Marosy, could you give us a little background on how we got this tape, and what we're trying to do here?

J O H N P A U L M A R O S Y: Sure Senator. While they're preparing-- You need to rewind it. While they're preparing the tape, Senator, I'll just point out that this particular videotape was prepared with support from a foundation in Washington D.C. called the Villers Foundation, which is dedicated to empowering the elderly, and gave us the funds in order to educate people about the kinds of gaps in coverage of home health care that exist in the United States today. Actually this is its premiere public viewing -- hopefully, the machine will be working -- after which the tape is going to be shown at various conferences around the country to stimulate discussion around the very issues that we're here to talk about today. (At this point the video on home health care is presented.)

SENATOR PALLONE: Well, I want to thank you for that presentation. I thought it was excellent.

MR. MAROSY: You're welcome, Senator.

SENATOR PALLONE: Maybe we can get some comments from the other members of the public as we go on. Do you have a statement that you're going to give us?

MR. MAROSY: Yes, Senator. Which microphone am I supposed to be on?

SENATOR PALLONE: Well, this is the one for amplification. Maybe you can just bring that New Jersey Network one over. That's good.

MR. MAROSY: Chairman Pallone and Senator Van Wagner, members of the Committee staff, ladies and gentlemen, I'm John Paul Marosy, Executive Director of the Home Health Agency Assembly of New Jersey. On behalf of the 64 home health care providers who are our members, I want to thank you for giving us this opportunity about the Home Health and Community Care Partnership Act with you today.

SENATOR PALLONE: It's starting again.

MR. MAROSY: I guess the tape wants a share in this too.

SENATOR PALLONE: Quite a machine there.

MR. MAROSY: The Home Health Agency Assembly--

SENATOR PALLONE: Is it off now?

MR. MAROSY: Pull the plug. Okay, you got it Joe. As I was saying, the Home Health Agency Assembly of New Jersey is a nonprofit organization. We're based in Princeton, and we're dedicated to constantly improving the quality and availability of home health care in the State of New Jersey. We're proud of the fact that no matter where you live in the State of New Jersey, you can obtain quality home health care. That's not the case in every state in the country. In recent years we've trained our employees as experts in the care of the elderly in their homes. With a special Federal grant, right now we're training over 300 community health nurses in gerontological knowledge and skills, so that they can serve the elderly even better.

I'm going to keep my remarks brief because I know that you will want to ask some questions. The Home Health Agency Assembly of New Jersey strongly supports the passage of Senate Bill 2132. We feel that the care of the frail older person is a shared responsibility. Therefore, the idea of a partnership

between the public and private sectors, and between family volunteers and the professionals in the home health care field makes sense.

The State of New Jersey is at the forefront of the trend toward the aging of America. We've never before seen so many people surviving to the age of 85 and over. That's right, 85 and over. It's the fastest growing population group in the State today. We're facing new challenges that require us to stretch our imaginations. We feel that bill helps us to do that.

Right now, as we meet here today, the visiting nurses, therapists, social workers, and home health aides are visiting over 130,000 clients throughout the state. They're helping families, elderly who live alone to cope with pain and with physical and mental limitations. They're helping people remain independent. However, there are many people in New Jersey who need home care help to maintain their independence, but they can't get the help they need. Many simply don't know where to turn to get a complete assessment of their situation.

Every day our visiting nurses must say no to many who really need care. They must say no because they've got no way to pay for the care that they need. Yet, because they have some assets and a modest income, they're not eligible for help under the Medicaid programs. Medicare won't pay for the long-term home care they need, as we've just seen in this tape. As a matter of fact, Medicare is cutting back on the services that it will pay for, and Senator Bradley documented this last April at a hearing in Newark.

So what happens to these people? They fall into a no-care zone. Their chronic illnesses run their course, and often they wind up in a hospital or a nursing home where they're cared for at greater government expense. Simple monitoring of their health condition, combined with a little home care assistance, would help avoid these costly hospital and nursing home placements.

Senate Bill 2132 fills this gap in the service system for the frail elderly. Mr. and Mrs. Lawrence -- not their real name -- are two people who recently fell into the no-care zone. When he retired from his successful retail business 10 years ago, Mr. Lawrence thought that he and his wife would lead the life of Riley. They sold their big old home where they raised their two children. They moved out of their urban neighborhood, and moved to one of the small pretty towns in the more rural area of New Jersey. For eight years they lived quite happily. When Mr. Lawrence wasn't fishing at a nearby lake, he helped his wife tend the garden behind the house.

The picture began to change about five years ago. Mr. Lawrence's eyesight gradually began to fail. He lost his sight two years ago. At the same time he began to have trouble with his legs -- Parkinson's disease -- and he found it slow going even in the house. Two years ago, Mrs. Lawrence had to have an operation of the colon. On the day that I visited with them, Mrs. Lawrence was in bed. While the nurse who came with me tended to the dressing change for his wife's surgical wound, I sat at the kitchen table and spoke to Mr. Lawrence. We talked about the fish he caught. He told me how he strung some fishing line from a nail in the front door out the mailbox so he could get his mail every day. He used it to guide himself to walk out to the road. He stepped up from the table, and slowly shuffled to the back door to show me how he strung some other fishing line out to the garden so that he could feel his way to water the flowers that his wife so dearly loved.

I asked him what he ate. He told me how hard it was to get through the week. He had never learned to cook in the 52 years of married life. Usually, he and she ate a home-delivered meal, which as it turned out, was delivered while I spoke to them. He explained that since neither of them were big eaters, he usually stored away half the meal, and

reheated the leftovers at dinnertime. He said I was the first person to sit down and talk with them about his situation in a long time. He thanked me for listening, and I thanked him and told him that I will tell his story to others so that someday, old people like him and his wife could get the help that they need.

On the way back to the office, the nurse told me that she would no longer be seeing the Lawrences for more than another two weeks or so, when Mrs. Lawrence's surgical wound would be healed. They had a modest pension, so they were not eligible for any Medicaid services. I asked her how they would cope. She said she really didn't know. She said she had about a dozen similar cases in the past two months.

Senator, we've studied the problem. Our research staff has poured over the statistics and reviewed the programs in other states. There are at least 16,000 older New Jerseyans who need the help that this bill can offer. These people just need a little bit of help -- a regular nursing visit, some help with meal preparation, perhaps assistance with bathing or with housecleaning. Some just need the warmth of an occasional visit from a companion.

The Home Health and Community Care Partnership Act will assure that every frail older New Jerseyan can receive an assessment of his or her needs in his or her own home by a qualified nurse-social worker team from a certified home health agency. If they need help and don't meet the requirements of the Medicaid programs, they can have a volunteer companion come into their house. They'll pay what they can according to a sliding fee scale. The rest will be paid for by State funds allocated to the Home Health Care Partnership Center.

These frail older people need strong consumer protection. The bill provides for this by requiring that the care be coordinated by the certified home health agency which is the only type of home care agency which must meet the strict

licensing requirements of the New Jersey Department of Health. Partnerships on many levels are needed to prevent repeated unnecessary hospitalizations, premature use of institutions and isolation from familiar communities.

The most important partnership of all is the partnership of providers. There are three critical areas of provider service. The first is the provision of skilled nursing services. This service is available through the certified home health agencies. The second is the provision of homemaker-home health aides service. These services are available primarily though a network of homemaker agencies located throughout the State. The third is provision of home support services, such as home delivered meals, volunteer services, and community awareness and education. These services are available through your county offices on aging.

The partnership of these three providers -- that is the Medicare certified agencies, the homemaker agencies and the offices on aging is what guarantees the comprehensive home health and community care can and will be delivered to our elderly citizens through Senate Bill 2132. Local businesses, foundations, churches and civic groups, and senior citizens' organizations can focus their contributions through the partnership center. They can give their share of help with confidence, because they will know that a professional assessment of each patient's needs will target help to those who need it most and will do that at an average cost of $3200 per year per person -- about $10 a day.

Our communities have what it takes to help people in a no-care zone. We can and should take this step to help prevent elderly citizens from becoming pauperized by the cost of long-term care. We urge you to pass this legislation, which will provide the incentives needed to make this partnership a reality. Thank you, Senator.

SENATOR PALLONE: Thank you, Mr. Marosy. Senator Van Wagner.

SENATOR VAN WAGNER: Yes. Mr. Marosy, or I'll call you John Paul.

MR. MAROSY: Good morning, Senator.

SENATOR VAN WAGNER: As you know, I have received a great deal of correspondence on this specific bill. So, I'm going to direct my questions directly at those areas of concern that have been expressed. We can get right to it. There's no sense in beating around the bush. There has been concern-- In fact, in reviewing it myself, I guess I have a partial concern about the question and issue of duplication of services. I'd like to deal with that since the Department of Human Services, as you know, has indicated basically that there would be a duplication in some instances of service provided under this bill. I wonder if you would address that issue?

MR. MAROSY: Well, I would say, Senator, that one of the features of that bill is that it is intended to avoid duplication of services. I think that's one of the strong points of the bill. This bill, and the funding that would be attached to it would be intended to serve a specific population of people who are not currently served by any existing Medicaid or Medicare funding program. The reason I feel the bill will avoid duplication is that the nurses that are currently dealing with these patients already are using the various programs -- Medicare, Medicaid, other services that are available at the local level -- to serve people's needs as those needs become apparent. Because the responsibility for the assessment in the care planning would be in a certified home health agency, the capability would be there to tap the most appropriate funding source as the person's needs change.

I guess a word of explanation is needed there. If you look at how home health care is paid for in America today, and in New Jersey, you'll see that approximately 85 to 90% of the care is paid for by Medicare. That's because 90% of all the older people in America participate in the Medicare program.

And what often happens is a person's funding for services runs out under Medicare. If they go home from the hospital after an operation -- as Mrs. Lawrence did, and her wound heals -- Medicare says there's no longer a need for a skilled care service. Therefore, Medicare will no longer pay for care. That doesn't mean that she's in condition to get up and around and take care of herself completely, but it does mean Medicare won't pay.

That's where, in this bill, we feel since the partnership funds would be available to a certified home health agency dealing with the Medicare funds, when Medicare runs out, the partnership funds could be put in for whatever duration is necessary to get the person up and functioning independently.

SENATOR VAN WAGNER: What about the-- I'm addressing criticisms of the bill -- you know, not the concept -- everyone has been supportive of that, but criticisms of the bill in its present fashion. I've had a number of criticisms, indicating that the bill restricts the service providers, that there is not an expansion of service providers, that there are other service providers that can provide the services outlined under the bill. I wonder if you would address that.

MR. MAROSY: I've heard that criticism also, Senator. The response to that is simply that although the assessment would have to be done by the Medicare certified agency, as we envision it, probably 50% of all the funds would be distributed to other types of providers. At the current time, probably half of all services delivered through Medicare certified agencies are subcontracted to other types of providers. That would be the case with this bill as well.

SENATOR VAN WAGNER: Okay, I have-- Mr. Chairman, there's a number of other questions. I present this to Mr. Marosy because we have both become aware of it, and obviously we're going to try to address some of those concerns. But I

have found that running throughout-- The other area was administrative costs. There has been criticism there as to the 25% administrative cost level. Recommendations have been made that this be capped, I believe, at 18% or 12% in some cases.

MR. MAROSY: I don't know where the 25% figure came from. As you know, there is no fiscal note attached to this bill at this time. So a lot of people are generating a lot of numbers.

SENATOR VAN WAGNER: I couldn't find the 25% in the bill. I don't know where that was derived from. I'm assuming that there was some cost calculation made.

MR. MAROSY: We have reviewed the figures to the best of our knowledge, and it appears the program can be operated at an administrative cost of 15 to 18%. I don't think that would be a problem.

SENATOR VAN WAGNER: Okay, I have no further questions.

SENATOR PALLONE: Thank you. I just want to ask some basic questions, because I'm not-- Excuse me?

UNIDENTIFIED SPEAKER FROM AUDIENCE: You know we are so anxious to hear everything that you all have to say, that we would appreciate it very much if you would make a real effort either to speak right into the microphone that is assigned for you. We'd really love to hear something.

SENATOR VAN WAGNER: Did you hear me before?

UNIDENTIFIED SPEAKER FROM AUDIENCE: Your mouth is too far from the mike.

SENATOR VAN WAGNER: Were you able to hear me before?

UNIDENTIFIED SPEAKER FROM AUDIENCE: No.

SENATOR VAN WAGNER: Now you can hear me?

UNIDENTIFIED SPEAKER FROM AUDIENCE: We cannot hear your questioning.

SENATOR VAN WAGNER: So, what you're saying is I have to sit up right close to this for you to hear.

UNIDENTIFIED SPEAKER FROM AUDIENCE: Hold the mike.

UNIDENTIFIED SPEAKER FROM AUDIENCE: You're close enough so you don't break your neck.

SENATOR PALLONE: We don't want that. (Laughter) Okay, we hear you loud and clear. How's that?

UNIDENTIFIED SPEAKER FROM AUDIENCE: Much better.

SENATOR PALLONE: Okay, Mr. Marosy.

SENATOR VAN WAGNER: That was the nicest thing anybody said to me today. (Laughter)

SENATOR PALLONE: Let me just see if I-- I just wanted to ask some basic questions. The example that you gave I thought was very informative because you put it in perspective exactly what we were talking about. The problem with Medicare, of course, is they're only paying that home health care that results from, say an operation or recent hospital care pretty much.

MR. MAROSY: Skilled care or need must be there.

SENATOR PALLONE: Okay, but not on a long-term basis for the very services you mentioned. You mentioned that there would be three-- Well, first of all, mention was made of Medicaid as opposed to Medicare. I'm not sure I understand how that all fits into all of this. Most of the people that we're talking about will not be eligible for Medicaid because they have some sort of pension or they have some sort of income that would make them ineligible.

MR. MAROSY: Or assets.

SENATOR PALLONE: Or assets-- But if they are eligible for Medicaid, then the problem doesn't exist with regard to Home Health Care reimbursement.

MR. MAROSY: Well, individuals who are eligible for Medicaid can receive a fairly wide range of home health care services.

SENATOR PALLONE: Okay, so most of the activities, most of the things mentioned would be covered by Medicaid, as opposed to Medicare.

MR. MAROSY: Most of them, yes.

SENATOR PALLONE: But what percentage-wise of the elderly would not-- I don't know if you can give me a percentage, I'm just wondering what percentage of those say, over 65 would get that Medicaid coverage?

MR. MAROSY: Well, there are about 130,000 people served by the Medicare certified agencies last year. About 10% of their patients were Medicaid funded. So, do the division.

SENATOR PALLONE: Okay.

MR. MAROSY: About 1300 people or so.

SENATOR PALLONE: All right, in terms of the types of coverage you mentioned first, that the provision for skilled nursing service and then the homemaker-home health aide and third is the other types of supportive services. I'm just trying to get a handle on it. In terms of the amount of money that's in this bill, how frequent or what type of services would that average person be getting for this $3200 a year that you're averaging out?

MR. MAROSY: Well, the number one thing the bill does, Senator, is sees to it that if you have an elderly relative that you feel is frail and at home-- Number one, when this becomes law, the media will make these partnership centers very highly visible to the community so that the family will know where to call, which number to call. That would be an achievement in itself.

Number two, as long as through the telephone intake -- the information is taken on the phone from the son or daughter about the elderly person -- if it appears that the person is frail, they're going to get a complete assessment.

SENATOR PALLONE: So that's the first thing that's done, which may not be done right now, is this assessment that Senator Van Wagner mentioned.

MR. MAROSY: It will be done in a standard way, and it will be done by a nurse-social worker team, and it will be done statewide in the same manner.

SENATOR PALLONE: And generally, right now, the average frail elderly person isn't getting that assessment.

MR. MAROSY: They may, or they may not.

SENATOR PALLONE: And if they do get it, they have to pay for it themselves.

MR. MAROSY: Yes.

SENATOR PALLONE: Whereas now, they would pay on a sliding scale basis.

MR. MAROSY: The assessment would be available without charge, regardless of their income.

SENATOR PALLONE: Okay. Now what is the typical person going to get? Let's assume that it's found that they do need some meals on a regular basis, that they need someone to help them come in and them clean the apartment, they might need some skilled nursing care. How often are they doing to get those services? Is it unlimited?

MR. MAROSY: There would be no specific cap on the amount of services the individual could receive.

SENATOR PALLONE: So theoretically, if it is found necessary to the assessment that I could get my meals once a week for five days, I could have someone come in and clean the place, the house or apartment a couple times a week, and -- you know -- the full panoply.

MR. MAROSY: That's right. There is an interesting dimension to this which your questioning kind of leads me to, which is what is the unlimited cost of serving each person, unlimited set of services? And the answer to that would be no. The way the bill is structured, a limited allocation would be given to each section of the State -- whether listed by the county or by region -- so that the local program people and the advisory council that's required in the bill-- You have to think about how they're going to spend that limited allocation to help a limited number of people in a given year, to make some choices about just what kind of characteristics, how far can they stretch the money?

SENATOR PALLONE: Well, in turn, you gave me a figure of about $3200 per year per person, and of course there's an appropriation of, I guess, $10 million to $11 million. How was that derived at?

MR. MAROSY: Well, basically, certain assumptions were made about-- We took the population and said about one-third of the people are going to have relatively light support of service needs. Maybe the nurse would come in to visit once or twice a month to monitor their condition, and to get a couple of hours-- Maybe they would get bathing once or twice a week. Then there would be a more moderate category. A third of the patients would need several times a week, maybe a weekly visit by a nurse to do monitoring. And then there would be a heavier caseload -- perhaps people who have multiple chronic illnesses who can't do much for themselves.

So we've broken it down to a light, a medium, and a heavy, and that's how we came up with the average of $3200 per year.

SENATOR PALLONE: And then you multiplied that times the number of people you assumed would have to be taken care of. And we're talking about the $10 million or $11 million that would have to be available on an annual basis clearly -- as an annual budget appropriation.

MR. MAROSY: Well, the program wouldn't spend $11 million in the first year. The $11 million would be after growth of the program to serve approximately 3500 people. If you took in 3500 people immediately, you'd be out $11 million.

SENATOR PALLONE: But in other words, and I can assume pretty much based on your analysis that with the amount of money that's suggested here that you feel that senior citizens who are not having these home health care services would be getting basically what they need in the State with this program.

MR. MAROSY: There's no question about it, Senator. We've studied programs in other states. We've looked at how we

do it, and nobody has taken quite this approach of putting the public and private monies together, and bringing the volunteers in. We think it's a unique approach that can really work.

SENATOR PALLONE: I just wanted to be sure that I understood that it's envisioned as something that would take care of all the needs pretty much that we were talking about. That's basically the way you assume it would be.

MR. MAROSY: It's directly targeted to meet those needs.

SENATOR PALLONE: All right what about the-- I guess I better hold this again. What about the question of the source of funds? I see that the bill as written has the money covered from general revenue. On the other hand, I know that home health care, as well as senior rental assistance have been targeted by the legislative commission that I was on -- dealing with casino revenue funds -- and by many of the senior citizen organization statewide and countywide, that suggest that this be one of the two priorities that come out of casino revenue funds. I'm just wondering if you thought about that at all.

MR. MAROSY: Well, we're well aware of the fact that the Special Advisory Committee on Casino Revenue Funds recommended home health care as number one and number two needs in the State for the use of those monies. On the other hand, we're the experts on delivering the care to people in their homes, and meeting their needs. We feel that members of the Committee -- with all due respect -- are in a much better position to determine what the appropriate source of money would be. We know how to deliver the care. Hopefully, you can help us figure out how to pay for it.

SENATOR PALLONE: Okay, thank you. Any further questions? (negative response) Well, thank you very much for your presentation and the video. I appreciate it.

MR. MAROSY: Thank you Senator.

SENATOR PALLONE: Our next speaker is Mr. Kenneth Dolan, Executive Director of the Home Care Council of New Jersey.

K E N N E T H D O L A N: Good morning. My name is Kenneth Dolan. I'm Executive Director of the Home Care Council of New Jersey, a state association exclusively representing nonprofit home care providers. I'm here today to speak on behalf of the council's member agencies, the 21 nonprofit homemaker-home health aide agencies across the State that provide valuable, in-home and supportive services to thousands of New Jersey's sick frail elderly and disabled. Last year, our member agencies provided more than 3.3 million hours of services to more than 25,000 clients.

Before I begin my testimony I would like to thank Senator Pallone and members of the Senate Committee on Aging for providing this opportunity to those of us who are most involved in the provision of long-term home care services, to express our opinions regarding S-2132, the Home Health and Community Care Partnership Act. It is a documented fact that the need for long-term care services is determined not so much by medical diagnosis, the presence of specific disease, or even by general health conditions, but by the dependencies and need for assistance which these conditions can create.

A recent Federal report on the types of services needed by adults to remain living in their own communities indicates that as people advance from young-old -- 65 to 74 -- old-old -- those 75 and older -- the dramatic increase in need for assistance occurs in basic physical activities such as walking and going outside, and in home management activities such as shopping, cleaning and, cooking. One long-term care researcher succinctly summed up this and other research studies with the statement, "Most long-term care services simply constitute replacements for things individuals have done for themselves since childhood."

Given the rapid growth in New Jersey's elderly population, the Council applauds S-2132's legislative intent of expanding the availability of community based, long-term support services. However, as currently written, there are several key programatic problems with S-2132 which would make it difficult to achieve this legislative intent.

The first involves State administration. Currently, the majority of community based, long-term care services are funded by and administered through the Department of Human Services, and to a lesser extent, the State Division on Aging through the statewide network of area agencies on aging. S-2132 specifies that the program will be administered by the State Department of Health. Traditionally, the Health Department's primary involvement with long-term care services, both institutional and community based, has been in the important areas of licensing, regulation, standards setting, education, and training of service providers.

During this period of major Federal government budget cutbacks, it would be fiscally imprudent to spend precious service dollars to develop a new duplicative long-term care service capacity within the Department of Health. To do so would only further fragment the State's long-term care delivery system.

The second area of concern -- program services: S-2132 specifies that the services to be funded under the program will include pre-admission assessment, plan of care development, periodic health status assessment, homemaker-home health aide services, and volunteer service coordination. All other needed services are to be arranged for, but not funded directly through the program. There are many other services needed by frail elderly to enable them to stay in their own homes, including, but not limited, to adult day care, Meals on Wheels, chore and escort service. For the program to be effective, the range of services eligible for direct funding must be expanded.

The third area of concern is the target population. S-2132 was specifically developed to care for frail elderly who fall into the infamous no-care zone. These are the people who need support services in order to stay in their own home, but are not eligible for Medicare, and are above the income eligibility limits of the regular Medicaid program. Because there are no income eligibility criteria specified for the proposed sliding fee schedule in the program, it is not clear in the legislation whether the program's target population will be the same as that served under the new Medically Needy Program.

According to a Department of Human Services analysis of S-2132, that I quote: "Roughly three-quarters of the partnership's proposed target population might meet the income eligibility criteria for either the new Medically Needy Program, or the existing community care program for the elderly and disabled." To avoid costly duplication with existing State long-term care programs, it is important that S-2132 specifically identify the target population to be served.

Fourth area of concern -- role of partnership centers. S-2132 specifies that the program's services will be provided locally through designated partnership centers. The legislation proposes to give these centers significant power and authority in a wide range of activities, including community education, outreach, client screening and selection, identification and arrangement of direct services, service monitoring, coordination of volunteer services, and fundraising.

Vesting so much authority and power in one agency can only serve to disrupt our established county level service coordination delivery systems. S-2132 should be modified so that the partnership concept could be used to build upon and improve the existing service coordination provider network. The role of the designated partnership center should be more circumscribed, with more power and authority vested with the partnership advisory council and county governmental

units such as offices on aging, and departments of social service.

Over the next 10 to 15 years, as we in New Jersey face the tremendous challenges presented by the geriatric imperative, it is important that we rethink our traditional approaches to funding and providing long-term home and community based care. New coalitions and cooperative arrangements between private sector providers, funders of service, consumers, government, and the business community would be required if we were to ever hope to develop a comprehensive, cost-effective long-term care system.

I hope my comments and observations will be helpful to the Committee as it proceeds with the difficult task of amending S-2132, so that it can represent the important first step in redesigning our State's long-term care delivery system. Thank you.

SENATOR PALLONE: Thank you, Mr. Dolan. Senator Van Wagner?

SENATOR VAN WAGNER: Can you hear me all right? (affirmative response) Okay, good. Earlier I had asked the question on some of the issues you just raised concerning possible duplication. Would it then be your-- From how I see this paper that you presented, that if in fact there was included in the planning an assessment, a requirement of coordination between county offices on aging, etc., this would perhaps eliminate that duplication?

MR. DOLAN: It would certainly be a step in the right direction. I also have a concern about the fact that where the program -- like I said, the administrative aegis of the program -- State level-- I mentioned in the testimony too, while the Department of Health does what they do very well, and that's in regulation and licensing -- those areas -- and education, they really do not have a large amount of experience with administering a long-term program on such a broad -- such a

large program like this. I'm concerned that we would be creating another system parallel to what's being done in Human Services. We have the community care program for the elderly and disabled; we have the new Medically Needy Program--

SENATOR VAN WAGNER: I'm aware of that.

MR. DOLAN: Right. Now we're talking about creating another parallel program in another department. I think that would serve-- I don't think that would serve to help bring services together.

SENATOR VAN WAGNER: Well, let me then somewhat re-amend my question and say that if in fact the inclusion of the basic statewide area or network of area agencies on aging were incorporated as part of the assessment process, and included in the expansion of service providers, and in fact, an agreement were reached on -- let's say on language that would-- I've already heard from the Acting Commissioner of Health. She has indicated similarly to you that they would have a difficult time setting up an administrative model at this point, since it is already conducted through the Department of Human Services. But if in fact the Department of Human Services -- let's say for the sake of another term -- were used as the lead agency with the requirement for coordination with the Department of Health and Community Affairs, then that would basically satisfy any concerns you have other than specific areas in the body of the bill itself?

MR. DOLAN: Yes, absolutely. And the other area would be expansion of the services funded under the bill.

SENATOR VAN WAGNER: Thank you very much.

SENATOR PALLONE: I'm going to ask you a few questions, because I'm not sure you understand all the objections. You said that a lot of the services are currently provided, or that some of the target population is already helped, sufficiently perhaps, by the Medically Needy Program, or the community care program for the elderly and disabled.

Could you just clarify, for example, the Medically Needy Program? You talked previously about Medicaid. A person now falls into the Medically Needy category because their income is a little more than what they would receive than if they were on Medicaid. Would they then get the full services that Medicare provides--

MR. DOLAN: Medicaid.

SENATOR PALLONE: --that Medicaid provides for home health care?

MR. DOLAN: Yes. My understanding of the Medically Needy Program is that it addresses that very issue. It was those people falling above the strict Medicaid income eligibility limits. I'm not suggesting that all the people that were to be served under this program are going to be served under the medically needy. What I am saying is that the medically needy has just been implemented as of July 1st. I am a little concerned that given the fact of the newness of that program and the fact that this program didn't specify what the target population was -- because it said there will be a sliding fee schedule established, but it didn't give the income. So we're talking about an amorphous population. We don't know what that group is.

SENATOR PALLONE: Well, what I'm saying is that I was given the figure by the previous speaker that perhaps 10% of the frail elderly who are in need of home health care are serviced through Medicaid. Okay, how many more are going to be serviced? Their home health care needs are basically going to be met by this Medically Needy Program, would you say?

MR. DOLAN: Well, I can't answer that. I'm not-- I think the Department of Human Services should address that. I really don't know.

SENATOR PALLONE: Okay, but obviously a significant amount in your opinion.

MR. DOLAN: That's what I've been told. And also,

they can expand the community care program for the elderly and disabled, which is--

SENATOR PALLONE: Okay, that's second question -- the community care program. How does that handle the home health care needs of the same target group?

MR. DOLAN: Well, that program is comprehensive in that it provides a broad range of services. Again, it is addressed to the people that fall in that no-care zone in many ways. Those are people-- Those are only people who have been determined to need nursing home care. So they get all the supportive services in the home as an alternative to nursing home care.

SENATOR PALLONE: Is that based on the financial need also?

MR. DOLAN: It ranges up to very high level -- $900. It covers-- It doesn't limit itself to $400 a month. It goes up to the nursing home eligibility level, which is very much tied-- It's like 900 and some dollars right now.

SENATOR PALLONE: Did you want to comment?

SENATOR VAN WAGNER: Is that in every county?

MR. DOLAN: Yes, community care programs-- And that program, I know can be expanded.

SENATOR VAN WAGNER: You're talking about the community care waiver project.

MR. DOLAN: Right. In fact, I think they just went in for waiver for another five years. So they will have the program for at least five years. I mean, it will be continued.

SENATOR PALLONE: I just want to-- Just if you could give me a little better handle on exactly who is covered by the program? Obviously, we know that there are a lot of people that aren't covered. I'm just wondering.

MR. DOLAN: Okay. My understanding of that program-- The prime eligibility of that program -- for getting into it -- is that you have been judged by the assessment team from the

local Medicaid office as being in need of nursing home care.

SENATOR PALLONE: Medicaid office?

MR. DOLAN: Yes, the Medicaid office. The income eligibility under that program is much more liberal in that it's up to the nursing home level of eligibility, which I'm not sure it changes as cost of living goes up. I think it's in the $900 range. If your income is $900 or less, you can qualify for that program.

SENATOR PALLONE: Per month?

MR. DOLAN: Yes, per month.

SENATOR PALLONE: And then what type of services do you get provided -- all the things that we're talking about?

MR. DOLAN: Transportation, day care-- You can get homemaker service, home health aide services, skilled nursing. It's quite an extensive program.

SENATOR PALLONE: Okay and what percentage-- Again, how many people are we talking about that are covered by that?

MR. DOLAN: I think right now it's-- I'm not sure. I'm not a Department of Human Service rep. I think it's something like 1400 people under the program. I think that people here can give you more information.

SENATOR PALLONE: I would like that, you know, when we have the human service program. Because, you know, we have to have a handle on exactly who we're talking about. Okay, what about the other-- You mentioned program services, that in S-2132 we're talking about certain services, but that adult day care, Meals on Wheels, chore and escort services are not necessarily provided for?

MR. DOLAN: Yes. In my reading of the bill, it says that those services will be arranged for under the partnership -- by the partnership centers, but will not be directly funded, from my reading of the bill. Services that are directly funded would be the pre-admission assessment, the ongoing nursing monitoring, and the homemaker-home health aide services, and volunteer coordination.

SENATOR PALLONE: So therefore, they're not going to be paid for by this appropriation?

MR. DOLAN: They're not going to be directly paid for, but arranged for. Unfortunately, there is a problem in funding for those services now. So I mean if a person needs Meals on Wheels, but the local county office on aging doesn't have the funds, then you can't arrange for something you don't have the money for. That's why I think by limiting it. Now, we represent the homemaker-home health aide providers. So I'm speaking-- I'm saying it's not just limited to those direct services, but to adult day care, Meals on Wheels, and other supportive services.

SENATOR PALLONE: So you feel that the money that we're talking about, the $10 million or $11 million, is not going to include those services?

MR. DOLAN: My reading of the bill is that it would be a very limited amount. It said mainly-- I understand the language said there it will be arranged for, but not directly funded. It identified it.

SENATOR PALLONE: I'm sure we're going to go on again on this whole question, but I'm not sure I understand why the partnership centers are circumscribing or, I guess, avoiding the role of -- say, the traditional role that the Department of Human Services, or the State Division on Aging, or county offices on aging are involved in. How would they be circumscribed in that role?

MR. DOLAN: Well, only the fact that in some counties we feel-- I'll give you an example -- Essex, Union County. Union County already has the system in place that does a lot of what this bill proposes to do. It's run through the Union County Office on Aging. We're not suggesting that, in fact, the partnership center concept is not good. We think it's an excellent concept. We just think maybe you should consider a little bit more flexibility in what agencies should be

designated to do what in each county.

For example, the certified home health agencies are very experienced in doing the nursing assessment, plan of care development, this type of thing. We see that as a very valuable and important part of this program. But when you look at other areas like coordination of volunteer services, information referral, those are services that have frequently been provided through county offices on aging, and departments of social service. So we'd like to see a little bit more flexibility in terms of shaping the program to meet what works best for a county.

SENATOR PALLONE: I just want to make one comment. You'll tell me if I'm understanding. We're going to have a lot of discussion today, I guess, about what agency should handle this, and what types of services are going to be provided, and what are currently provided. But the bottom line is, I mean, whether we talk about those covered by Medicaid or those covered by the medically needy, or those covered by the community care program for the elderly and disabled, we all acknowledge that the majority of the people out there are certainly either -- or at least a good portion -- are not getting a lot of this home health care, and that it's not, no set payment for it. In other words, if they can't afford it, there's nobody who's going to pay for it at the present time. Is that true?

MR. DOLAN: Yeah, I agree. We see it all the time.

SENATOR PALLONE: Okay, thank you very much. Further questions? (negative response) I'd like to have Marianne Rhodes, who is the Director of Governmental Relations for the Department of Health.

M A R I A N N E R H O D E S: Good morning Senator Pallone, Senator Van Wagner, and legislative staff. I am pleased to have this opportunity to appear this morning before the Committee to discuss the Department of Health's role as it

relates to home health services. The Commissioner-designate for the Department of Health, Dr. Molly Coye, has met with Senator Van Wagner personally, since her schedule did not permit her to be with us this morning. Let me assure you that the Department of Health is committed to insuring quality care for the elderly, including support for home health care services.

We recognize the fact that the majority of the elderly prefer to remain at home. In fact, statistics indicate that 85% of the chronically ill elderly do, in fact, remain in their home setting, either through the formal or informal care provided in the current system. The emotional comfort that a person gets from settling down in familiar surroundings with reminders of his or her family, with reminders of his or her past, present and future activities, is immeasurable.

The New Jersey home care industry is extraordinarily diverse, with a wide range of services and various types of consumers. The Department of Health works closely with many of the groups, providing and promoting home health care services in the State. Many of these groups are here today -- the Home Health Agency Assembly, the Home Care Council of New Jersey, community and State groups working in the area of aging. Of course, the Department of Health coordinates our activities with the other State agencies -- the Department of Human Services and the Department of Community Affairs.

Within the Department of Health there are three divisions involved in home health care. The Division of Health, Planning and Resource Development, which establishes the State health plan for home health care services, administers the certificate of need program, and collects and analyzes annual data on home health agencies. The second division is the Division of Health Facilities Evaluation, which establishes licensure standards for home health agencies and annually inspects these facilities. The third division

involved with home health care is our Division of Local and Community Health Services, which has a gerontology program with a staff of seven individuals. We're involved in such issues as Alzheimer's disease, respite care, gerontology, training of public health nurses, and the certification of homemaker-home health aides, etc.

With me this morning is the Department's expert -- so to speak -- in home health care. Our Coordinator of Home Health Care, Nancy Gripp will give you further detail on the Department of Health's role. Nancy?

N A N C Y G R I P P: Good afternoon Senator Pallone, Van Wagner, and other members of the legislative staff. I'd like to begin by reviewing the Department of Health's role in assuring quality of care. The Department of Health licenses home health agencies. As of this date we have licensed approximately 60 home health agencies, which receive annual licensure inspections based upon fairly stringent quality of care standards. Once these agencies are licensed by the State, they are certified for participation in Medicare and Medicaid programs.

In addition, the Department of Health has played a major role in the development of 21 voluntary homemaker agencies which exist today. These agencies provide homemaker services to all persons in need of home care. The Department of Health has certified home health aides for the past 20 years. The certification requires completion of the 60-hour training program developed by the Department, and based on national standards. Once a homemaker-home health aide has completed the course, a certificate is issued bearing the signature of the Commissioner of Health.

While home health care services are receiving greater recognition within the health care delivery system, we see some major constraints within the industry. One of the major difficulties agencies are experiencing is insufficient and

fragmented funding for services. The principal funding sources are Title XVIII, XIX, and Title XX of the Social Security Act, and Title III of the Older Americans Act. In addition, there are other funding sources which are narrowly defined on a community-based delivery level, creating fragmented and often inadequate services to the consumer.

If you ask the average older individual over 65 who will care for them when they become ill, they most likely will say Medicare. Medicare, originally established as an entitlement program for acute services, is increasingly being seen as a reimbursement mechanism for the elderly. Medicaid has increasingly become the long-term pair.

Today, the pattern of need for health care services is concentrated heavily on persons without a spouse, living alone, and primarily female. Neither Medicare nor our present patchwork of social welfare programs addresses this pattern. We must recognize that we as a society have a collective responsibility for all residents. Health care is a right and not just a privilege for just a few. There must be an availability of quality health services for all residents in New Jersey.

Now, to address the specific legislative proposal before your Committee -- S-2132, the Home Care Partnership Act. While the specifics of the bill are still under review by the Department, I'd like to make some general statements reflecting our philosophy.

The Department's philosophy regarding home care is twofold. In the first place, we have the responsibility to guarantee the quality of health care provided in the home for all citizens, irrespective of income. Secondly, we believe our responsibility is to insure access to home care to all who require it. It is our belief that the preferential course of action would be to expand Title XVIII of the Social Security Act to cover home health care. Since this does not appear likely under the current administration, New Jersey thus must

decide what our role should be in expanding access to home care. Should our emphasis be on the indigent population, or should we expand our traditional role to include economic relief to assist all elderly?

With limited State funds available, our first priority for financial assistance must remain to assist our most needy residents. To be more specific, the following statements reflect our thoughts on the Home Health Care Partnership Act:

1) We believe any expansion of home care should also include the disabled. In many cases, their needs for home care are as imperative as the elderly.

2) We do not want the legislation to appear to favor any one provider group. Our usual policy is to develop a request for proposals, send it to a multitude of provider agencies, and select the most appropriate vendor in each county.

3) We are not sure how the partnership would complement the medically needy legislation, or the community care program for the elderly and disabled. Much as Ken Dolan has stated, a significant number of the population proposed to be served under the partnership are receiving, or will receive similar services.

We look forward to working with Senator Van Wagner, this Committee, and various interest groups as we have in the past, to expand the accessibility of home health care services to our citizens.

SENATOR PALLONE: Senator Van Wagner, do you have questions?

SENATOR VAN WAGNER: Yes. You indicate on page three of your testimony that one of the major difficulties agencies are experiencing is insufficient and fragmented funding for services. Could you elaborate on that a little bit?

MS. GRIPP: Well, each funding source -- Title XVIII, Title XIX and Title XX -- have their own criteria for payment for those persons who can receive services. So, someone that's

handling an agency has to know the requirements that Medicare has, restrictions that Medicaid has, restrictions that Title XX to service certain portions of the population.

SENATOR VAN WAGNER: So you're saying in essence that-- For example, let's say county office on aging gets a request from a person for certain types of services. They would, in essence have to mix and match, so to speak, based on that person's coverages.

MS. GRIPP: Yes, right. Most home health agencies do receive Title XVIII and Title XIX moneys, but they have to be aware of the restrictions and limitations.

SENATOR VAN WAGNER: Pardon?

MS. GRIPP: I'm sorry, restrictions and limitations of that particular funding source.

SENATOR VAN WAGNER: Restrictions and limitations in terms of the funding source, or in terms of the kinds of coverages that person has?

MS. GRIPP: Funding source eligibility are the criteria for receiving services under that particular funding source.

SENATOR VAN WAGNER: So, both?

MS. GRIPP: Yes.

SENATOR VAN WAGNER: Okay. Also in the testimony -- I'm not sure whether you said it, or Marianne said it -- there was an indication that 85% of the people who have chronic illnesses are, in fact, basically served in the home.

MS. GRIPP: Right. They remain in the home. I'm not saying that they're served by--

SENATOR VAN WAGNER: Remain in the home?

MS. GRIPP: Yes, as opposed to being in a nursing home.

SENATOR VAN WAGNER: In other words, only 15% of the frail elderly population are in nursing homes have a need or have a chronic illness.

MS. GRIPP: It's a smaller-- The majority of persons with chronic ailments are in the home through informal or formal systems.

SENATOR VAN WAGNER: Eighty-five percent is a lot more than the majority. It's the vast preponderance of people. I don't have any way of knowing whether that's a fact or not. That surprises me. I have to tell you I'm really surprised. I really had a different view of it. Obviously I don't have any way of knowing.

So, basically, the objections -- not objections, but the analysis of the Department then is similar to the analysis of Mr. Dolan and other people who have addressed this bill. One, there is some duplication that has to be addressed. Two, there is a desire to expand the types of providers who can provide these services. And three, as far as the Department of Health is concerned, they would rather see it in the Department of Human Services, I would assume.

MS. RHODES: Well I think that--

SENATOR VAN WAGNER: That only comes from 14 years of reading these statement, okay. (Laughter) You begin to know what they mean between the lines.

MS. RHODES: Well, I don't think we made a definite statement to that effect. However, with the new Commissioner coming on, I think you can generally say that is the case at this point.

SENATOR VAN WAGNER: I was only being facetious. So, then in effect, if I were to sit in front of the three State agencies -- and I might mention that Commissioner Coleman sent me a lengthy three-page letter outlining most of what has been outlined in the three-page letters that I received from everybody else. But if I were to sit down with the three agencies, or I were to sit down with them and we were to say everybody has a kind of a cross jurisdiction in here in one area or another, then if we were to establish Human Services as

the lead agency in the Partnership Act, with a requirement for coordination with Health and Community Affairs and the county offices on aging, and other agencies involved -- nonprofit, Meals on Wheels, and so on -- with the overall assessment that it will generally answer the overall objections that everyone has.

MS. RHODES: Well, we can't speak for the Commissioner, as I indicated.

SENATOR VAN WAGNER: No, no, I don't expect you to.

MS. RHODES: It seems to me that would be the best way to go.

SENATOR VAN WAGNER: But speculatively--

MS. RHODES: It would be under review, but that is certainly a viable option.

SENATOR VAN WAGNER: I realize the Medically Needy Program just went into effect. Are you involved in any way in an assessment? Because, as you know, the Commissioner and I had a rather detailed discussion of some areas that concern us both.

MS. GRIPP: Assessment of--

SENATOR VAN WAGNER: For example, when a person becomes Medicare or Medicaid eligible--

MS. GRIPP: Yes.

SENATOR VAN WAGNER: Okay, at that point who is the first-- Who, besides the person, knows that first? Who becomes aware of that first?

MS. GRIPP: If they're in the home?

SENATOR VAN WAGNER: Yes, or anywhere-- I am assuming-- Now, all of a sudden they reach a point in their age when the medical coverage that I assume that they had as a worker in a particular company, unless as part of their retirement benefits-- Some people are fortunate enough to have that continuing care. I understand corporate America is becoming more involved in providing those services too, as a

way of holding their costs down. But let's say the average American, the people that we've talked about today, the people who are under the impression -- including myself, by the way -- that when we retire at some point in our lives, we're going to be taken care of by Medicare. Those individuals-- Who becomes aware of their eligibility first, in general terms -- Health, Human Services, the county office on aging? Is there an intake process at all? Is there anywhere?

MS. GRIPP: I don't believe there is.

SENATOR VAN WAGNER: There is not?

MS. GRIPP: I don't believe so. Probably-- I mean Human Services is certainly involved in the Medicaid process. We do not have any-- The Department of Health does not get involved directly with Medicaid or Medicare. We're really more of an overseer of the quality of care that's being provided by agencies to individuals.

SENATOR VAN WAGNER: So basically, Human Services would probably--

MS. GRIPP: Probably under Medicaid.

SENATOR VAN WAGNER: --be the agency that would become aware of the fact that people -- "X" number of people were now eligible for Medicaid or Medicare within that given year?

MS. GRIPP: I would imagine so.

SENATOR VAN WAGNER: From that point on, is there an assessment at all, that's done when that person--

MS. GRIPP: Well, the agencies, the individual home health agencies do an assessment. If someone is referred to them, they'll do an assessment. When they assess the individual -- a physical assessment as well as a financial assessment -- to see what services there are.

SENATOR VAN WAGNER: But only on referral or request?

MS. GRIPP: Generally yes.

SENATOR VAN WAGNER: Okay, thank you.

SENATOR PALLONE: Thank you Senator. I'm just trying to get a handle again now. If I understand one of the main concerns that Senator Van Wagner has, and one of the main reasons why this bill seems to be-- I'm sorry-- One of the main reasons why this was being proposed to you in this legislation is that it seems that each of these partnership centers -- and I guess there would be one in each county -- is going to do an assessment initially, and basically try to kind of organize all the home health care services for that particular individual -- I guess mainly through that assessment. I'm a little confused because when you say that we would not want the legislation to appear to favor any one provider group.

Our usual policy is to develop a request for proposals, send it to a multitude of provider agencies, and select the most appropriate vendor in each county. That seems to go against the basic notion, which is right now there really isn't any one agency -- or center, for that matter -- that is doing these things. Therefore, we want to have a statewide program and network -- at least one in each county -- that's going to do the assessment, that's going to organize the services for the individual. I'm not sure I understand what your objection is to the legislation in that respect. How would you have-- You would have us set up the program, and then have individual groups around the State make application to you?

MS. GRIPP: Yes, because there are many agencies that provide home health care services in the county. Certainly, I would say the home health agencies are licensed by the Health Department, and have to meet high standards. But there are other types of agencies that provide homemaker services in each county. So what we're saying is we wouldn't exclusively just recognize one group over another group. If we were to handle this program, we would have to look at the other types of providers in the county.

SENATOR PALLONE: So then in other words, in a given county you could have several different agencies administering the program?

MS. GRIPP: No, one would be designated in each county, but we would not necessarily exclusively choose one type over another. In each county we would look at all of the agencies that were interested in participating and not necessarily choose the home health agency, is what we're saying.

SENATOR PALLONE: Okay, maybe I'm misunderstanding, but it seems this kind of gets to the heart of some of the objections that I've heard. Why is that better than just choosing the home health agency?

MS. GRIPP: I think it's just the general policy of the Health Department that we would take it to bid and look to see who could do the best job, who would be most interested. Perhaps in some counties there wouldn't be particular home health agency interest, and someone else may have more services to offer than another agency.

SENATOR PALLONE: Okay. I'm just concerned-- The way the bill is set up, it seems like by designating a specific agency which is outlined in the legislation, it should provide, in the assessment, and the whole panoply of services that are being discussed. What you're saying is it doesn't necessarily have to be the agency that's in the bill. Another agency, even though they may not be providing those services now, could theoretically take on additional services and do the things that are being envisioned in the bill.

MS. GRIPP: There are many agencies, though, that aren't licensed and that are providing homemaker-home health aide services. That's one of the primary services.

SENATOR PALLONE: And they could be expanded to other services, or contract out to do other services.

MS. GRIPP: Possibly.

SENATOR PALLONE: Okay, thank you. We're going to try and intersperse -- as I mentioned before -- some individuals, as well as agency representatives. For that reason, I'd like to have Mr. John Tergis be our next speaker, from the New Jersey Council of Senior Citizens.

J O H N T E R G I S: This is the testimony of the New Jersey Senior Citizens concerning S-2132, Senator. My name is John Tergis. I am legislative chairman of the New Jersey Council of Senior Citizens, and its delegate to the Task Force on Legislative Concerns. Senator Pallone, I wish to thank you and the members of your Committee for holding a series of hearings on this most important bill. I also wish to thank Senator Van Wagner, the sponsor of the bill, for his outstanding efforts on behalf of the elderly.

As you know, our organization and the Task Force on Legislative Concerns have been advocating home health care as their top priority. The Legislature's own Casino Revenue Funds Study Commission, after a year's study of all priorities, has come to the same conclusion. New Jersey has become a haven for older people. We have the oldest population in the country outside of Florida. By the turn of the century, just 14 years away, authorities predict that 18% of the population -- about one in every five persons -- will be 65 years of age or older.

The numbers of older people are already causing a strain on our health care system. Most people who become elderly and frail find that they cannot qualify for Medicaid because their income is too high. They cannot afford private pay nursing home confinement, and under present circumstances, cannot afford to pay for home care. They are truly entering a no-care zone.

Let us take the typical example of an elderly man with a moderate income, and $20,000 in the bank. He becomes frail, and because adequate facilities for home care do not presently exist, his wife puts him in a nursing home. The $20,000 would

barely pay for a year's stay in a nursing home, after which the patient would attempt to stay in the nursing home as a Medicaid patient at government expense. His wife would be left home in a destitute condition, probably on welfare. This would be an unworthy end to a financially independent family.

It has been estimated that 25% of nursing home patients could be cared for at home if a long term care policy existed. Care at home is a more dignified and less costly alternative to nursing home confinement. Moreover, the problem is becoming more acute. Without attempting to judge the DRG system, we know as a matter of fact that patients are being discharged from hospitals more quickly now than formerly, while still in need of much skilled nursing care. As a member of a Medicaid Watchdog Group, I know that Medicare is cutting off home health care benefits much sooner now than formerly. In other words, the system is being squeezed from both ends, leaving many without any care at all.

S-2132 would address the need for a home health care policy in New Jersey. One or more home health care centers, which would be widely publicized, would be established in each county. A pooling of public and private funds would make it possible to continue home care after Medicaid has discontinued its payment. The patient would make a contribution toward care based on income. The object would be to make it possible for the patient to remain in a home setting as long as possible to avoid the debilitating and costly effects of nursing home confinement.

The bill, being an innovative approach to long-term care, in all probability will need amendment. The Task Force on Legislative Concerns has appointed a committee, of which I am chairman, to study the bill and report back. One of members is here today -- Mr. Tom Weber. Our Committee has two sessions, with another one scheduled on Wednesday, August 6. We hope that we can offer some constructive suggestions for improvement of the bill.

I hope that all of us will bear the objective in mind that we are trying to make it possible for older people to remain in their homes for longer periods, and at the same time do something towards solving the financial plight New Jersey will be in if the only alternative is nursing home confinement for these increasing numbers of older citizens at Medicaid expense. If we can bear this objective in mind it will lead us toward solving any difficulties we may find in the bill. Thank you.

SENATOR PALLONE: Thank you Mr. Tergis, not only for being here today but for all your input on senior issues. I know you've been one of the key people statewide in advising this Committee and all legislators on senior citizen issues.

Am I to understand at this time that you really don't want to address some of the concerns -- or the turf battle, I guess that we might call it -- that's come up at the hearing so far? You really feel the Task Force hasn't investigated it yet?

MR. TERGIS: We're personally studying the bill, and I hope our time schedule will permit us to offer our suggestions in time. I note some of the concerns this morning. I think our committee is going to meet on Wednesday, but I do think we'll have to amend the bill. We'll have to give a part to other organizations within reason. We've listened to a lot of people, and we're going to meet by ourselves. I think we're going to have some constructive suggestions about amending the bill, Senator.

SENATOR PALLONE: Okay, fine. We're going to have another hearing. Maybe by the time of the next one you could have the Task Force--

MR. TERGIS: What is your schedule?

SENATOR PALLONE: Probably within the next month.

MR. TERGIS: The next month to introduce the bill?

SENATOR PALLONE: No, we'll have another hearing.

MR. TERGIS: Oh, another hearing next month-- One comment I've heard Senator, is that some people feel there has to be some kind of economic limit in the bill -- a top limit eligibility income limit. Our organization doesn't agree with this because the family that has the $20,000-- Illness in a family could be just as great a tragedy to the family with a $20,000 income -- both financially and emotionally -- as it would with a family of $10,000 income. They're going to be some controls because the bill is going to be based on a sliding scale of contributions. Certainly the family with a higher income would pay a greater contribution.

And there's another control in that it just doesn't apply to everyone. If you're just feeling a little bit weak, or have arthritis and have to walk with a cane, this doesn't necessarily apply to you. It applies to people with one or more impairments of daily living, which are quite strict in the bill. So it's going to have a rather limited application. I think this is a control in the bill, and we certainly do not agree that an income eligibility limit should be brought into the bill.

SENATOR PALLONE: Okay, thank you. Any questions?

SENATOR VAN WAGNER: There is none now and you know that, John.

SENATOR PALLONE: That's right. I agree with the bill in that respect -- as it's presently worded -- that there is no income limit in the bill.

SENATOR VAN WAGNER: Would you agree with the insertion -- if the Committee would decide--

MR. TERGIS: On an income limit?

SENATOR VAN WAGNER: No, no, of a sliding-scale co-payment schedule--

MR. TERGIS: Yes, I think that's very good.

SENATOR VAN WAGNER: --based on a person's income?

MR. TERGIS: But that would be by regulation, as you anticipate, Senator. It wouldn't appear in the bill, I don't believe.

SENATOR VAN WAGNER: I frankly-- If we were going to do something, I would rather have it appear in the bill and indicate as such, rather than leave it to regulation.

MR. TERGIS: Well then you have control over what some department might want to see in the bill. I think that would be a good idea.

SENATOR VAN WAGNER: Thank you, John.

SENATOR PALLONE: Thanks a lot, John. David Kaiserman, Monmouth County Senior Citizens Council -- another outstanding leader in the senior citizens community.

D A V I D K A I S E R M A N: I too want to thank Senator Van Wagner, and you, Senator Pallone, for holding these hearings and for introducing the bill. It's very important. I had no intention of testifying, but last Tuesday's newspaper shook me up very badly. The United States Senate had a study of Medicare denials. I'll read verbatim from The Star Ledger -- Tuesday, July 29th: "The number of Medicare claims denied for home health care increased from 18,121 in the last quarter of 1983, to 44,855 in the first quarter of this year -- a 165% increase."

I just want to say that we've held-- I'm also a member of the Task Force. We've held two hearings on this, and I heard also this conflicting testimony that we're hearing this morning. I'm not a professional in being able to judge who would be best qualified. We have the Office of Legislative Services. Perhaps some impartial people could work this out -- see how it can work out. We have our own committee on the Task Force studying it.

But I say, let's not waste any time. Let's get through this as quickly as possible. I don't want to take up any more of you time. That's the only thing I wanted to say. This newspaper article is shocking.

SENATOR VAN WAGNER: I'd like to just mention-- I appreciate your remarks. That's why I felt it was important in the beginning, to suggest that what we might develop is a working group from individuals that I hear, to assist us in addressing some of the concerns. But also, one of the things that has continually plagued me -- and I looked at this article that you're referring to -- the explanation that was offered in some cases for not providing home care services to individuals were that despite their varied illnesses, they were not homebound. I continue to be a great supporter of the community waiver program. But one of the requirements of that is that the person be at risk in terms of nursing home requirements. So, if I can clarify -- and you've helped me clarify, to a large extent-- My own feeling is that what I hope we can aim at is a program that regardless of these kinds of criteria, can be crafted so that those individuals who need home health care can get it.

MR. KAISERMAN: Amen.

SENATOR PALLONE: Thank you Mr. Kaiserman.

MR. KAISERMAN: Thank you.

SENATOR PALLONE: Okay, we're going to back down to some of the agencies. I'd like to have Marilyn Grannemann, Health Care and the Elderly, Department of Human Services -- State agencies.

M A R I L Y N G R A N N E M A N N: I'm Marilyn Grannemann. I work in the Office of Human Services Planning in the Department of Human Services. We would like to thank you, Senator Van Wagner and Senator Pallone, for the chance to testify today.

As you know, our Department pays for the majority of long-term care services to the elderly, both in institutions and the community, and has led the way in long-term care planning and program development. The Department funds home care for elderly and disabled people through its Medicaid

Program, the new Medically Needy Program, and the Community Care Program for the Elderly and Disabled -- CCPED -- which is a joint Federal-State program covering additional elderly and disabled, whose incomes are above the Medicaid level. We also administer Social Service Block Grant funds, are currently developing a statewide Respite Care Program for caregivers, and your -- Senator Van Wagner -- Personal Care Attendant Program. In addition, we expended over $15 million to conduct the National Long-Term Care Demonstration and the AFDC Homemaker Demonstration, which are Federal research projects on community care for the elderly.

Because of our Department's extensive experience and resources in the home care field, especially in new programs which coordinate services and funds through case management, we are in a unique position to judge the impact that this bill might have on the home care system. It is always encouraging to the Department to see any bill that would provide funds to make home care more available to the elderly. We support the idea of increasing the participation in the long-term care system of the certified home health agencies, who are major Medicaid providers and have an excellent record of quality care over many years.

While it is clear that there are several programs that fund home care, we are painfully aware that there are still many people who need care and who are not now being served. Because of Federal restrictions on the use of Medicaid funds, we have been unable up to now to serve all those who need care. It is certainly desirable for the State to allocate additional resources for the home care system. However, it is critically important to ensure that proposed initiatives do not conflict with the current system, leading to operational problems and costly inefficiency.

The increasing numbers of elderly people in the State, and the potentially very high cost of caring for them require

that we work carefully to expand services and at the same time control the costs of long-term care. I think we can all agree that it is imperative to ensure that the additional services reach the most impaired and needy individuals, and that the available service dollars are maximized by reducing unnecessary administrative costs.

In order to be certain that these conditions are met, three issues should be addressed before the Partnership is considered for passage

First, the bill is not clear enough about eligibility criteria for us to be certain that those most in need will be served.

Second, because of its use of a grant, rather than a fee-for-service system which would put funds directly into client services, the Partnership Act may encourage overspending for administration, since the actual use of funds would be at the discretion of the home health agency. While it might be prudent to allow home health agencies to experiment with funds in small demonstration projects, a program of this size -- $11 million a year -- requires appropriate fiscal controls on providers. Grants are not a desirable method for funding ongoing, statewide programs. The Department already has a system in place to reimburse home health agencies for services on a fee-for-service basis, with appropriate controls on costs and fiscal management.

Third, the establishment of yet another separate program for long-term care in the State may lead to administrative difficulties. By designating home health agencies as the entry point for community care services, this bill would establish a system parallel to the one already in existence in the counties. It would bypass the Medicaid system, the Community Care Program, the Social Service Block Grant Programs and the network of offices on aging. In addition, because this program would be administered at the

State level by the Department of Health, which is not experienced in providing long-term care in the community, an new State bureaucracy would need to be developed to monitor the program sites in each county, ensure accountability for the funds, and supervise the quality of care.

The Department of Human Services spends many millions of dollars every year for long-term home care. The Department of Community Affairs expends additional millions on home and community based services. With service systems like these in place, does it really make sense for the State to create a third service-funding system?

We have some other, broader concerns that also need to be addressed. There are potential conflicts with State policy that may pose problems. First, it appears that the Partnership Act would establish a separate system of care for those individuals with moderate and higher incomes. The poor would not be covered, but instead would continue to be eligible only for Medicaid or CCPED. The problem here is that we would, in effect, be establishing a two-tiered system of care -- one for those with moderate and higher incomes, and one for those without. In the hospital and health care systems the State has always made conscious policy decisions to care for all clients regardless of ability to pay, using the same provider system, rather than to have separate but parallel facilities for those of various income levels.

Second, there is a question of equity across programs. Because of Federal cost sharing rules in the CCPED Program, clients must pay a portion of their incomes toward the cost of care. The State has elected to only absorb up to $75 of this cost share. If the Partnership Act were to be established, we would have the untenable situation of having clients receiving service under the Partnership, paying less towards the cost of their care than those who are poorer.

Over the last several years, the State has made notable efforts to coordinate and integrate funding for long-term care. It appears that the Partnership would further fragment the already complicated system. Within the Legislature itself it is also likely that at budget time, the two programs would be competing for the same State dollars, further confusing the long-term care system at the State and local levels.

In summary, the Partnership bill raises a number of significant issues which need to be addressed. We should ensure that services go to those most in need. We should maximize the dollars available for services both by reducing the duplicative administrative costs of a grant program and by ensuring fiscal accountability. We must assure that home care programs treat clients with different incomes fairly, and we should reduce confusion and fragmentation wherever possible.

In short, if the $11 million to be appropriated in this bill could be spent to expand eligibility in CCPED -- or otherwise build on the existing system -- it could be used for services rather than administrative costs. It is clear that many more clients could be served by expanding systems already in place. It is our goal to create maximum program efficiency, and ensure equity for New Jersey's frail elderly and disabled citizens. The goal of increased access to home care is one that we all share.

I would be delighted to answer questions about Medicaid, Medically Needy, or anything else that I brought up today.

SENATOR PALLONE: Senator, if you want to ask some questions-- Senator Van Wagner, I wanted her to explain what the coverage was going to be for the Medically Needy and for the CCPED.

SENATOR VAN WAGNER: Sure. Why don't you go ahead and do that.

SENATOR PALLONE: Could you just explain, or maybe answer the concerns that we already have expressed?

MS. GRANNEMANN: The way to approach it is probably from the client level. What you really want to see is a system that can look at a client and decide what the person is eligible for. We want to maximize Federal reimbursement; there's no question about that.

SENATOR VAN WAGNER: Could I just ask you, in that system, what system do you have for assessing a client and deciding what he's eligible for, and who does it?

MS. GRANNEMANN: Currently, the county welfare offices do Medicaid eligibility -- financial eligibility for Medicaid. In every county, that's consistent. That's the county welfare agency. Now, as far as home care programs, every client who gets into a home care program under Medicaid -- whether it's through a home health agency, or through the Community Care Program, has to have that financial eligibility determination -- whether they go to a nursing home, whether they get home care services under a regular Medicaid program, or whether they have Medically Needy as well. They all go through a financial eligibility.

SENATOR VAN WAGNER: How do they know where to go?

MS. GRANNEMANN: They get a phone number. They call Medicaid district offices--

SENATOR VAN WAGNER: And who gives it to them?

MS. GRANNEMANN: Probably either the nurses visiting them, if they are home health agency clients, or the office on aging, if they are receiving a service under the office on aging.

SENATOR VAN WAGNER: I thought about the instance now-- They've gone to the county welfare office, they've submitted their forms. The county welfare office has determined that they're Medicaid or Medicare eligible--

MS. GRANNEMANN: Medicaid only.

SENATOR VAN WAGNER: Medicaid only?

MS. GRANNEMANN: Right.

SENATOR VAN WAGNER: Medicaid eligible-- Do they also give them a pamphlet of some type that says these are all the numbers you can call for the various services that are available in the State, in the counties, and the local municipalities?

MS. GRANNEMANN: We have brochures on community care programs for the elderly and disabled. As to what Medicaid services are available, they are supposed to tell them what they are.

SENATOR VAN WAGNER: The county welfare office tells them?

MS. GRANNEMANN: Right, and tells them who the Medicaid providers are in the community. They can also call the Medicaid district office. They are given that telephone number. We also publish a resource guide on long-term care and community services in the community, that's available to the public.

SENATOR VAN WAGNER: At the first instance at the county welfare level, they are told: "These are the services that are available to you. Here are the numbers; you can call; these are what your alternatives are."

MS. GRANNEMANN: Probably not to the extent that it's necessary. They are probably given one phone number to call.

SENATOR VAN WAGNER: Medicaid versus the Medically Needy-- What type of services and income eligibility-- How is this going to fit in with the home health care needs?

MS. GRANNEMANN: There are differences between the Medicaid program and the Medically Needy, but not in the home care area. People who are eligible for the Medically Needy will be eligible for the normal home care services.

SENATOR VAN WAGNER: They'll get the same care that they would normally get covered under Medicaid?

MS. GRANNEMANN: In the regular Medicaid program at home, yes. They would not be eligible for things like hospital care.

SENATOR PALLONE: And that's pretty much most of the services that we've discussed today.

MS. GRANNEMANN: Well, the one that are normally funded under Medicaid -- nursing, home health aid.

SENATOR PALLONE: Home health aid, meals--

MS. GRANNEMANN: Not meals. Meals usually come through the offices on aging, which is really important to remember, because unless we put some money into those meals, we aren't going to be able to get meals to our clients. Because there are people out there who need meals now who are on waiting lists because there's no funding.

SENATOR PALLONE: On the State level that is? In other words--

MS. GRANNEMANN: In different counties, depending on how many meals they have.

SENATOR PALLONE: I know I've been reading in the newspaper that's been brought up. That continues to be a problem then -- the funding for the meals?

MS. GRANNEMANN: In many service areas we could provide services for clients if we only had the money.

SENATOR PALLONE: And that's a shortfall in State funds that we're talking about?

MS. GRANNEMANN: The client that you're talking about, that falls into the partnership area-- There are systems in place that could serve that client if they were paid to do so. In other words, there are meal programs out there who simply don't have the funding. There are home health agencies out there who could serve the client. All we need to do is supply the money. We don't have to set up a whole new system.

SENATOR PALLONE: But what I'm saying is that the lack of money is because of the lack of State funding that normally comes from the State.

MS. GRANNEMANN: And restrictions on our Federal funding that we get-- For example, in the Community Care Program, we do get 50% Federal match on those funds, but we're only able to use them for clients who meet very strict eligibility criteria. If we were able -- using State funds -- to change the eligibility criteria and add what would be like a shadow program-- In other words, treat the client the same way, but their care would be paid for by State funds, because we obviously couldn't get a Federal match because they wouldn't meet the Federal eligibility criteria that could be folded in as part of an existing program. A client whose husband or wife had different eligibilities would not have to be treated by two different case managers, coming from two different agencies, who would set up two different systems -- care plans -- for them.

SENATOR PALLONE: Now percentage-wise, again I heard the figure before that maybe 10% of the people that have home health care needs -- the groups that we're targeting today -- are now serviced by Medicaid. What would that figure be for the Medically Needy Program? How many more are going to be serviced by that?

MS. GRANNEMANN: I can't speak to that figure, because that-- We serve about 40,000 clients per year. I cannot tell you how many Medicaid -- what percentage of people who need home health care are Medicaid people. What I can tell you is that national research figures show that about 20% of those who apply for help in an agency that's open-ended and provides home care services are Medicaid eligible clients -- about 20%. So if you opened up a store that said "Long-Term Care Services Here" about 20% of the people who applied would be Medicaid eligible.

SENATOR PALLONE: And what do you think that figure is going to change-- How is that figure going to change with the Medically Needy Program?

MS. GRANNEMANN: We're not sure. We would be more prepared to testify at a later hearing on what our experiences showed us. We're not sure how many people are going to want to go through the paperwork requirements of consistently keeping up with their spend-down. That's a major issue -- from the client point of view -- of why this program needs to coordinate with Medically Needy. Because people will sometimes be eligible for Medically Needy due to their spend-down and their medical bills. At other times they will not be eligible for Medically Needy, and therefore the partnership could pick up the cost for their services. So it makes great sense to have at least the Medically Needy Program and the partnership together because we could have a Medically Needy client who is the husband, and the wife is not because she doesn't have any medical bills. In other words, they could be treated under a coherent program, rather than have two different sets of people coming in to take care of them.

People's eligibility-- People will go on and off Medically Needy as their medical bills come in from surgery or from doctors after a spell of illness.

SENATOR PALLONE: What about this CCPED program -- Community Care Program for the Elderly and Disabled? How was that-- I just would like some more details about how many people you expect to be covered by that. Is it going to take care of these needs? How are you certified or eligible for that?

MS. GRANNEMANN: We have 1600 people currently being served in that program. That program was especially designed for those people whose incomes are above the usual Medicaid limit patient -- in other words, above $350 or so, up to $982, but whose assets are limited. So your assets have to be limited, but you may have income -- each month -- up to $982.

Now, the reason that program was designed was because people were going to nursing homes, because they didn't qualify

for regular Medicaid community care. But yet we would be delighted to pay for them under the Medicaid program in a nursing home. So this is a Federal program which allows us to pay for their care at home. So they must meet qualifications for nursing home placement -- financially, physically, or mentally, whatever their limitations are.

SENATOR PALLONE: So that's Federally financed, right?

MS. GRANNEMANN: Well, it's 50/50. We get a Medicaid match.

SENATOR PALLONE: But the numbers-- Based on the kind of numbers I've been hearing today-- sixteen hundred -- that's pretty miniscule, isn't it?

MS. GRANNEMANN: That's as many slots as we've been able to get from the Federal Government. We have just received favorable word on an additional 300 slots that we'll be allowed to have probably October 1st.

SENATOR PALLONE: And how does that dovetail then into the Medically Needy Program? Will that relate in--

MS. GRANNEMANN: Yes. Some of the clients that are currently covered under Community Care Program will be covered under Medically Needy, but may not choose to go into it because of the different spend-down requirements. The spend-down requirement in Medically Needy is stricter than it is in the Community Care Program. So if a person has a choice, they'll probably stay in Community Care, which is difficult, because we might like to move them in there. But they have a free choice.

SENATOR VAN WAGNER: Isn't that duplicative?

MS. GRANNEMANN: Yes, it is, but we don't want to give up--

SENATOR VAN WAGNER: The fact of the matter is -- if I might -- you really don't know what's duplicative and what's not duplicative at this point, right?

MS. GRANNEMANN: Oh, no, we do. The Medically Needy Program is duplicative of Community Care Program and in fact, came in four years later.

SENATOR VAN WAGNER: It was designed that way.

MS. GRANNEMANN: Excuse me?

SENATOR VAN WAGNER: The Medically Needy Program was designed to -- in effect -- be a more permanent solution to the Community Care Program.

MS. GRANNEMANN: Yes, yes, because Medically Needy covers people who are not nursing home eligible. It covers people who need home care. Through the waiver program-- Everyone in the waiver program would probably be covered by Medically Needy. Everyone who's Medically Needy would not be covered in the Community Care Program. You have to need nursing home care to be in the Community Care Waiver Program. You do not need nursing home care to be in Medically Needy. You simply need to have the doctors sign that you are in need of home health care. It's a less needy population.

SENATOR VAN WAGNER: Earlier, it had been indicated that about 85% of the population that is chronically ill -- let's say. I don't want to misstate or misspeak what was said, but basically 85% of the population is served in the home at this moment -- not served, but is in the home.

MS. GRANNEMANN: I'm awfully careful when I give a figure. I don't know what that figure means. When you talk about people who need home care, you can mean people who need one nurse to visit once a month, or people who need care almost 24 hours a day. I can't tell you what that 85% figure means. I don't really know.

SENATOR VAN WAGNER: Okay. Of the 1600 or so people, you presently-- The CCPED program is serving 1600 people. Has the Department assessed-- These people are people who have been determined to be at risk in terms of nursing home placement, I understand. Has the Department assessed how many actual people are perhaps at risk? Have they done any assessment of that? What I've been trying to get out is, have you been able to determine the gap between the 1600 people that

are presently served, and the number that need to be served at all costs?

MS. GRANNEMANN: We don't have the number, but we have a very good sense that there's lots of people who need home care services, who don't qualify because of the financial requirements. I'm not worrying about anyone qualifying on the need for nursing home care. These people who really need help, really need help. We don't have a lot of people who are rejected from the program, for example, because they don't meet nursing home criteria. That's no problem. It's the financial criteria that are too strict.

SENATOR VAN WAGNER: But now, if I understand your testimony, with the Medically Needy Program in place -- based on your testimony and other -- approximately 20% of that population will be eligible for Medically Needy assistance?

MS. GRANNEMANN: Some people will be eligible. I don't know how many, but the key factor is that their eligibility will vary from time to time based on their medical bills. If they want to participate in even a stricter spend-down than the Community Care Program, they go all the way down to 133% of the AFDC standard, which is lower than what we charge people in Community Care. So, it's going to have benefits, but only for a population who can afford to spend out to that level on a routine basis. So, for people who are living with other people, it will be helpful. But I don't think it will be too helpful to people who live alone. The asset limit in Medically Needy is also higher. It's up to $3200 to $3400.

SENATOR VAN WAGNER: In assets?

MS. GRANNEMANN: Yes. You can have more assets and be in Medically Needy. So it's a fairly complicated system for the worker in the community, let alone the client.

SENATOR VAN WAGNER: Right now I'm listening to this, Mr. Chairman. I'm wondering how a potential client can even understand what they could have available to them.

MS. GRANNEMANN: That's why we have case managers.

SENATOR VAN WAGNER: I pride myself on being able to read very complex documents. I think, sooner or later, that ability is going to leave me. I just wonder where the hell I'm going to be when I have to sit down and figure out what I'm eligible for. I'm going to be in a lot of trouble. I can imagine what an elderly person today is going through to determine-- I applaud everybody who works in the field of delivering services to the aging. I don't mean this at all as a criticism, believe me.

MS. GRANNEMANN: We don't take the blame for the Federal regulations.

SENATOR VAN WAGNER: No, I know that. Assuming there was developed in legislation a co-payment provision that triggered in at the threshold of the spend-down level -- 133% -- and dovetailed then to the Medically Needy Program, what would your assessment then be?

MS. GRANNEMANN: That way makes a lot of sense, provided that we can short equity. In other words, we can't have a conflict where a person is Medically Needy--

SENATOR VAN WAGNER: But that's up to the Department of Health, to ensure equity.

MS. GRANNEMANN: Not really, because we don't want to set up a system where people with more income pay less, and people that have less income pay more. We have to make sure--

SENATOR VAN WAGNER: No, I'm not even implying that. Obviously, I'm sure the Legislature and staff would acknowledge that they certainly don't want to put a bill together that would have people that make less pay more, and people who make more pay less. Obviously, we don't want to do that. We'd have to structure it as such. But would you see that as perhaps a longer range solution?

MS. GRANNEMANN: Yes. What would be great is to have Medicaid be the first payer. If you're not eligible for

Medicaid, well, then try Medically Needy. If you can't get your Medically Needy, than we'll use all State funds. That's what makes sense from a fiscal perspective and from a client level management perspective -- that people can get Medicaid if they want to get it.

SENATOR VAN WAGNER: Mr. Chairman, if I might just point out that this is not a new concept. In fact, educational services in this State and in other states -- under certain Federal programs and State programs that have been passed subsequent to those Federal programs -- operate in that same way -- not using income as criteria. For example a student at one time who might be determined to be Title I eligible -- be below a certain average in reading and mathematics -- if they could not receive services from available Federal funds, then that would trigger them into an area where they would receive services from available State funds -- for example, compensatory education.

In drawing an analogy, if I might, the same kind of structure could be built into this type of legislation. So, assuming level quality of care, each level of eligibility triggers services to those individuals under that eligibility criteria, on up through Medically Needy and hopefully -- should the Legislature agree and we can come to an agreement -- on up to a comprehensive home care program which provides for more client participation at the fiscal level, but much less participation than that client might ordinarily have to pay if they were going into primary care, or being forced into primary care. That's basically what I'm trying to get at here. You're shaking your head. I don't know what that means.

MS. GRANNEMANN: Well, if what you're saying is that every client needs case management no matter what they're financial situation is, I think you're quite correct.

SENATOR VAN WAGNER: Thank you.

MS. GRANNEMANN: We would support that forever, because a person could not get through the system by themselves. And if what we're doing is having people pay fairly for a service for what they really need, that would just be excellent.

SENATOR PALLONE: I just wanted to-- Just a couple more questions-- On the Community Care Program-- Going back to what I said before, you said the Medically Needy Program would provide the same kind of home health care as would be covered under Medicaid. Is that also true for the Community Care Program, or is that covering different types of needs?

MS. GRANNEMANN: The Community Care Program has some additional services that it covers, like social day-care. But the bulk of the service is the same. Basically, the service that people need is a homemaker-level service. That's what they need the most of. That's what we spend most of our money on. Most of our units of service go for that. They're eligible for that service, which is the most important of all.

SENATOR PALLONE: Now, when I read your testimony here and I see that towards the end you're basically saying that you feel further partnership would further fragment a complicated system and we probably would use the $10 million or $11 million within the existing structure. Explain that to me. I mean, how would we, within the existing structure -- if we just threw money -- provide for all the same services and needs that we discussed today?

MS. GRANNEMANN: Well, I think that what we see in the system is that people can't get their services paid for. The services are there, but no one will pay for them. For example, the visiting nurses association withdraws-- The home health agency has to withdraw from the client, because there is no longer money to fund the continuing visits. We want to make sure that if the continuing visits are needed, that they are

funded -- that someone will pay for them -- if not Medicare, then Medicaid; if not Medicaid; then Medically Needy; and if not Medically Needy, the State funds will pick them up for the clients that the Legislature decides are going to be eligible for this program.

SENATOR PALLONE: So you feel that if we just take the $10 million or $11 million, and allocate it to existing programs, that's all that needs to be done. You don't need any other mechanism.

MS. GRANNEMANN: Well, I think what we need to do is to decide-- The Legislature needs to decide who is going to be eligible for the program. Are there income limits or not? Must they be eligible for nursing home care -- that kind of thing? In other words, do they really have to be physically frail, or do we want to do more of the preventive aspect? In other words, you can't prevent everything from happening. We can't serve everybody who needs a meal. Even $11 million isn't enough. Massachussetts spends $100 million a year on their home care program. So you can see how extensively it can use up State dollars.

SENATOR PALLONE: Well, see, maybe I can't get an answer. But when Mr. -- I don't want to mispronounce his name again -- Mr. Marosy testified before, I said to him, "Okay, you have a framework in place here that we're talking about. You're estimating the $10 or $11 million that is within this existing framework, those people who have home health care needs and who can afford to pay for it on a sliding scale basis will be cared for. In other words, those who can pay the full amount will pay it; those who can only pay half will be serviced, and this is a mechanism to accomplish that." I'm not sure that-- I can understand it. I mean, it makes sense to me based on the partnerships and what's been laid out here in this legislation. I'm not sure I understand how those same needs would be cared for -- maintained -- with the same amount of

money under the existing system. I don't know if you can explain that to me. Maybe it's too complicated.

MS. GRANNEMANN: It's really not. It depends on what kind of clients you're talking about. That's how you can guess your expenditures. You really can't say how much money you'll spend to take care of them until you decide how many you have, and how much service they're likely to need over time. There are some clients that if you decide to keep them on at a nursing home, it's going to cost you a lot of money because they need almost 24-hour care.

So, if you're going to offer a service like that, it's much more expensive. If you're going to just offer a nursing visit once a week to an older person to make sure that they're all right and to make sure that their health condition is not deteriorating, that's a different idea that costs less. To figure out how many people might require it, you'll use different figures, different estimates. You can't really say how much money it will cost until you decide exactly who you are going to serve.

Now, what makes sense is to take the people who are probably most limited in the group -- they're not financially eligible for other programs. That's what seems to make sense, that if you're not eligible for Medicaid but you really have some severe, long-term care needs and maybe looking towards nursing home placement -- or at least getting into that area of limitation -- then we would want to have the comprehensive assessment. However, that would be worked out with the nurse and social worker team -- about what services you need.

But then the next step is to get the services to the person. It doesn't make any sense to give them a nice assessment if we don't have anything to back that up. But who's going to fund that? Social service block grant moneys -- they're used up. You can't go to the county and say, "I need 5000 more hours of homemaker." They'll say, "Where's the

money?" So if we could put that money into the services to serve the group that's above the Medicaid program limit, but who have fairly severe limitations -- at least to start -- that makes sense from an incremental point of view. If we don't know how high the $11 million is going to go, we start by targeting to the frail elderly, and maybe we can work into a more preventative focus. But I think there are plenty of people out there who really are in dire need of service in that income group.

SENATOR VAN WAGNER: Isn't that what this bill does?

MS. GRANNEMANN: Yes.

SENATOR PALLONE: See, I still don't understand. Maybe some of the other speakers can clarify how you would do these things with the existing system.

MS. GRANNEMANN: I can tell you very practically.

SENATOR PALLONE: Do that.

MS. GRANNEMANN: We have a Medicaid vendor payment system. You have to sign up to be a provider. You send Medicaid a bill every month. We pay it. You can just simply draw down money off of another account. You can simply use current Medicaid providers, have a State-funded account, similar to what we have to draw down our State funds for the Community Care Program, and simply charge that off, at the fiscal level in Medicaid, to another account. The systems could remain intact. It could go down on a little computer card as an "X" instead of a "Y", so we could use a different funding source. To the client, the program would appear seamless. The client wouldn't know, particularly that month, where the funding for his program was coming from, and it wouldn't matter. He wouldn't have to be concerned about it.

SENATOR PALLONE: Okay, just one more thing, because I know we have to move on. With regard to the Meals on Wheels, a red flag went up there and I became kind of concerned when you mentioned that we seem to be very underfunded. What are we talking about in terms of dollars for that?

MS. GRANNEMANN: I'll have to refer you to Community Affairs for that.

SENATOR PALLONE: I'll ask them when they come up.

MS. GRANNEMANN: I don't really have a number on it.

SENATOR PALLONE: Okay, any further questions?

SENATOR VAN WAGNER: No.

SENATOR PALLONE: All right, thanks a lot. Again we're going to try to go back to the format where we get some individuals up, before we call some of the agencies. Two names here -- Jacqueline Rogers and Toni McGuire-- Is Jacqueline Rogers here, from Senior Consumers? I don't know if you're representing any organizations, or are you just here on your own. Maybe you can tell us.

J A C Q U E L I N E R O G E R S: Yes, sir. My name is Jacqueline Rogers, a senior citizen consumer from Mercer County, New Jersey. I am a past vice president of Chapter 459, American Association of Retired Persons, and member of the Older Women's League, and of the Mercer County Stroke Club. The importance of home care and long-term health care, as well as improved geriatric research and training has long been a matter of concern to me and has been fully expressed in my association with other seniors. But a recent bout with illness and hospitalization has served to focus my attention on the vital importance of home health care, and on the need for a solution to our widespread health care problems.

We all know of neighbors or friends who have been caught in the web and hassle of Medicare and Medicaid procedures, and who have become case histories. Each year, their numbers increase, as the older population escalates. With just one serious illness, modest savings become a pittance swept away on doctors, hospital medication, X-rays, treatment -- and an alarming awareness of how easy it is to go downhill and be perceived as a second-class citizen.

The questions that challenge us are these: What happens to older persons when they can no longer care for themselves, or their families can no longer care for them, or when there is no family available to be responsible for them? What happens when Medicare runs out, or when personal funds run out? What is the doctor's attitude? Will a nursing home accept a Medicaid patient easily? For that matter, will a nursing home have room for them? What then happens when they have need for custodial care? What good judgment and compassion is used in individual cases? Should such problems be left to chance, or should there be the possibility of care and attention for every senior who has aged to the point of vulnerability and who needs assistance? And finally the big question, what can we do about it?

Seniors intend to let their government -- local, state and national -- as well as our churches and social groups know that we want these problems solved. Such problems must be a first concern of all segments of our society, public and private. Each year, formal conferences and committee meetings are held, but there has not been a cohesive or coordinated plan of action to tie all the elements together -- that is, health, home care, and finally, the goal of high morale.

New Jersey Senate Bill S-2132 is such a plan, and is a long-needed practical solution to senior health problems in our State. It is urgent that it go forward to full passage as soon as possible for the benefit of New Jersey citizens. With our respectful appreciation to its sponsors in the New Jersey Senate, as well as to the Legislative Committee of the Home Health Agency Assembly of New Jersey, Inc.

It has been said, "Show me the treatment of your very young and your aged, and I will tell you the true culture, stature, and strength of your society." Thank you.

SENATOR PALLONE: Thank you. That last sentence couldn't be more true. Any questions?

SENATOR VAN WAGNER: I have no questions.

SENATOR PALLONE: Okay, thank you very much.

MS. ROGERS: Thank you very much gentlemen and ladies.

SENATOR PALLONE: Instead of Toni McGuire we had a request that Morris Forer be the next speaker from the Senior Consumers.

M O R R I S F O R E R: My name is Morris Forer. I'm a resident of Princeton. I hope that the members of the State Committee or Aging will give consideration to this statement of conviction that passage of Senate Bill 2132 is of extreme importance to many older citizens of New Jersey.

My belief stems from living in this State for almost 78 years, with more than half a century as a neighborhood pharmacist, and five years as a hospital pharmacist. I feel that I have had the opportunity of intimate contact with many senior citizens and their problems through serving as Vista Volunteer for several years with the New Jersey Federation of Senior Citizens and as a member of the boards of the Princeton Joint Commission on Aging and the local Senior Resource Center. As a pharmacist on the medical team in recent years, I have found increasing interest and activities by pharmacists in home health care. Hospital journals feature articles about the benefits resulting from hospital pharmacists actually monitoring the medical regiments in the patient's home.

The New Jersey Pharmaceutical Association holds seminars showing the help given when neighborhood pharmacists are in direct contact with the patient. For example, when refills for prescriptions are asked for, the patient's records are checked to impress the importance of adherence to schedules set by the physician for major infirmities like cardiovascular and hypertensive irregularities. Simple warnings given directly can help avoid complications, such as explaining that nitroglycerin tablets should never be stored in plastic vials and never kept together with other tablets in the same container, since loss of potency will occur.

In order to be as succinct as possible, I have limited my remarks to my personal knowledge in the medical field. Similarly, may I present one single medical procedure -- namely, intravenous therapy continued at home -- which should indicate the important role of home health care. I am attaching some extracts from reports at a hospital seminar with a section on intravenous therapy. I will merely read a few statistics from the quoted discussion.

It should be borne in mind that the deliberations in the conference concerned problems inside institutions with professional staffs and conclusions should be extrapolated in assessment of potentialities in patients' homes, without home care as preventive medicine. Now, the quotes -- the direct quotes I will give, and they're very short -- are from "The Medical Meeting Monitor," a publication distributed by the Armour Pharmaceutical Company, and is a reprint of highlights of the 20th midyear meeting of the American Hospital Pharmacists Society of December 1985.

"Catheter or cannula sepsis is another serious complication associated with intravenous fluid therapy, occurring in 6% to 27% of the patients.

"Phlebitis, the inflammation of a vein, is one of the most common complications of intravenous therapy. The literature places the incidence of this problem as 12% to 50% in IV therapy patients.

"The literature places the incidence of extravasation" -- which means the escape of blood from a blood vessel into a tissue -- "at 11% to 22% of patients undergoing intravenous therapy. Younger children and the elderly have a higher incidence of extravasation." The article points out when these things are not controlled properly, there are such potentialities as amputation and even death.

Now, that as a pharmacist is basically all that I can contribute to this meeting. But it's my personal conviction--

I would like to emphasize my last sentence. My hope is that if sufficient care at home can be arranged through this legislation, there will be many fewer readmissions to hospitals and much savings in hospital costs and public money. Thank you.

SENATOR PALLONE: Thank you very much. Any questions?

SENATOR VAN WAGNER: No, I think Mr. Forer pretty much spelled out what he meant.

SENATOR PALLONE: Thank you for coming today. Would Toni McGuire like to speak now?

UNIDENTIFIED SPEAKER FROM AUDIENCE: I'd just like to say something if I can.

SENATOR PALLONE: No, go ahead, Ms. McGuire.

T O N I Mc G U I R E: Shall I go ahead?

SENATOR PALLONE: Yes, please.

MS. McGUIRE: Good afternoon, Senator Pallone and Senator Van Wagner, and members of the Committee. My name is Toni McGuire, and I live in Mercer County. By profession, I am a social worker with clinical experience in crisis intervention, correctional work with adolescent girls, and counseling troubled children in a school setting. This wide range of experience, however, did not even begin to prepare me for the role that I have now assumed -- the adult child of a frail elderly parent -- which is why I am here today.

I am the only child of a mother who turned 95 in March. She was widowed when she was 62 and supported herself through a dressmaking business over the years, proudly paying her way, accepting help from no one, and fiercely maintaining her independence. She loved her work but admitted she continued working because it enabled her to maintain the expense of her little yellow VW bug, which gave her the freedom of movement that she cherished. This is just by way of description of the woman that I am now caring for.

Just three months after my husband's death in 1982, my mother, at the very tender age of 92 -- I repeat, 92 -- decided

to close her business and retire. My mother has lived in Public Housing for Senior Citizens -- a cozy, garden-type apartment -- for the past 17 years. I live in a community 10 miles away.

Though my mother's condition has deteriorated over the past three years, her goal has been to stay in her own apartment amidst familiar surroundings as long as possible. I give her a wake-up call each morning, and sometimes it takes 20 to 30 rings to rouse her because she is hard of hearing. She no longer cooks for herself -- which is a blessing -- and a hot meal is delivered daily through the Nutrition Program for the Elderly, a Federally subsidized program. This is not the same as Meals on Wheels, incidentally. In the last three years my mother has had pneumonia and shingles, which has weakened her general condition. At that time, and at her doctor's recommendation, I sought assistance in bathing her and monitoring her condition. The charge for a visiting nurse was $35 a visit, a prohibitive amount for us, and not covered by Medicare, because she did not, "require skilled nursing care and had not been hospitalized."

I learned of a home health ministry program sponsored by the Catholic church in my mother's community, and now a nun comes twice weekly to bathe my mother, and this is at no cost. This, in itself, was a godsend. I got a communication device which my mother wears, which can be activated if she falls or needs emergency help. These are the community resources I've used. In addition to this, I've gone in daily to do the marketing, cleaning, laundry, and cooking for a period of almost three years.

Things have worked out for a while, then I would find that my mother's dinner was untouched. I began to realize that she needed assistance in taking the food out of the container and cutting the meat, and so forth. She is becoming forgetful and she has experienced bladder incontinence.

Realizing that she needed more care than I was able to provide, I inquired about SSI. I was advised to spend down any assets she had to a minimum of $1700. I had been paying to have occasional help to relieve me from the whole burden, but was surprised when I tallied up the cost and realized we'd gone through $5000 in "baby-sitting" fees in the course of one year. This was just a matter of heating up the TV dinner and staying with my mother a couple of hours at a time. In order to spend down her assets, I made her funeral arrangements last November -- the day after Thanksgiving -- and prepaid the expenses. This put her in the clear for SSI, which I applied for in December.

My mother is now eligible for homemaker care, four hours daily, six days a week. This began April 1st of this year. In just four months since it began, this help has made all of the difference in the world in my life, and in my mother's overall well-being. She thus gets her daily bath, something she would not allow me to do. It has given me tremendous support just knowing there is someone else there whom I can depend on for those four hours a day. I'm not frantically driving back and forth twice daily. Now I go in only once a day to give her dinner, prepare for bed, and spend some hours with her in the evening. It's a positive experience for my mother to have another person with whom to interact. But most of all, it keeps my mother in her own familiar environment, versus putting her into a nursing home. The cost of this homemaker aide is $200 a week, versus $525 a week for a nursing home -- that's at the rate of $75 a day at the nursing home.

Isn't it too bad that hardworking people such as my mother are caught in the dilemma of not being covered for home health care and Medicare which she has paid into for 30 years, and yet not eligible for Medicaid because she had too much

pride to seek public assistance? What happens to the dignity of such people who are really the backbone of this country? If this Partnership Bill S-2132 that is being proposed had been in effect with co-payment, my mother could have had this help long ago, and I would have had some relief from the anxiety that I've experienced these recent years. Isn't it too bad that an independent, self-supporting citizen such as my mother has had to impoverish herself to get this kind of aid? With the passage of S-2132, the Home Health and Community Care Partnership Act, many elders and their families would not have to experience the humiliation of pauperization such as we are having to do at this time. I thank you.

SENATOR VAN WAGNER: You have listened, so far, to the testimony, and you obviously have a clear view of what is being attempted in this bill. In developing the services-- When your mother had to retire -- I think she retired a little early, God bless her. I hope to be able to do that myself. When she chose to get out of business and retire, obviously prior to that, I guess, had she made any determination of her eligibility under Medicare or Medicaid, as to what she might be entitled to, or did she just assume that would be there?

MS. McGUIRE: Well, she had paid her own way for so many years. Her Social Security was something like $323 a month, and she supplemented that with her business. So she really never looked down the line to a time when she might need assistance. Fortunately she's been blessed with good health. The only time she was hospitalized was when I was born. So she really has not been a drain on Medicare, or on any kind of public assistance.

SENATOR VAN WAGNER: That wasn't really the gist-- What I was wondering was-- Obviously, she hasn't been a drain on anybody, really. You know, you're to be commended too. I understand what you're dealing with. What I'm wondering is at some point in time prior to her retiring and giving up the

business, and therefore not having that supplemental income, did she ever, in effect, attempt to find out or did you ever discuss what types of medical coverage she might have?

MS. McGUIRE: No, she never made any inquiries. She carried a private Blue Cross Insurance in addition to the Medicare. As I say, even with a social work background, the complexities of all of these programs is absolutely mind-boggling.

SENATOR VAN WAGNER: Right. That's what I was getting at.

MS. McGUIRE: Yes, and someone else had mentioned -- I think you did -- that you can read complex documents, but really, what's going to happen to people who don't have a daughter, or who can't really reach out and try to help themselves?

SENATOR VAN WAGNER: Well, see, I hear people touching on something else too, and that is that a lot of us who over a period of time, through our own businesses or through our employment that we contribute to, gives us coverage through so many years of our lives, and then we retire, or we stop working, or we sell our businesses, or otherwise liquidate-- If we have not provided a nest egg, a large amount of money as the hedge against the possibility of long-term illness, there is just no way we can rely on any kind of public assistance.

I mean, I agree with the Health and Human Services Department when they said the State and the public's first priority is those poor people or indigent people who cannot or did not have an opportunity to share in the economic growth, or whatever. But beyond that, there are, I think, a huge number of people who have been working people. Mr. Chairman, if I might-- I don't mean to editorialize, but that's what we're aiming at -- those individuals who have worked for a number of years and although they may be eligible for Medicare, find it almost impossible to give up everything in order to become eligible for Medicaid.

MS. McGUIRE: Exactly.

SENATOR VAN WAGNER: That's the nub, I think. If I sensed some of your questions earlier, that's the nub of where we are right now. What we're trying to deal with is the-- I don't think we want people to impoverish themselves, as Ms. McGuire said, in order to become eligible for Medicaid. I don't think people in the system want that kind of system that requires people to impoverish themselves in order to receive services. I guess whether it's the proper approach or not, that's my goal in this legislation -- in order to focus on some of the questions you were asking.

SENATOR PALLONE: I agree. It not only doesn't make sense, but it goes against the grain. I mean, you shouldn't have to do that because that's not the purpose of Medicaid, at least in theory. You shouldn't have to sell your assets and do things some people have to--

SENATOR VAN WAGNER: But you do. There's no other way, in terms of criteria.

SENATOR PALLONE: No, I agree.

MS. McGUIRE: Senator Van Wagner, also, how many people-- You said had we looked ahead, had my mother thought that far down the line-- Who would have dreamed that she would have lived to be 95 and a half? How do we know how long we're going to be around, and what our needs are going to be?

SENATOR VAN WAGNER: Well, how often do any of us really put money aside for that purpose?

SENATOR PALLONE: Well, yours was certainly one of the most thought-provoking testimonies that we've had this morning. It kind of put everything in perspective.

MS. McGUIRE: Thank you.

SENATOR PALLONE: Thanks a lot.

MS. McGUIRE: Thank you for giving me the opportunity to speak.

SENATOR PALLONE: Thanks for coming. I just wanted to tell everyone we're not taking a break, so if you feel you want to, you can. But since we have so many speakers, we're just going to go right through. Consistent with what I said before, I'm trying to have individuals and then going back to agencies. I'm going to ask Sandra Bosna, who's from the Division on Aging, Department of Community Affairs, to be the next speaker.

S A N D R A B O S N A: My name is Sandra Bosna. I'm representing the Department of Community Affairs, Division on Aging.

SENATOR PALLONE: Can I just interrupt you for one second? I just want to make it clear, because I see people coming in and out. Everyone will have an opportunity to speak. We will not leave until everyone who wants to will have an opportunity to speak. You may have to wait around a little, but we're not going to just cut it off and say, "Come back another day." Just so you know. Thank you.

MS. BOSNA: Commissioner Coleman joins you in supporting the concept of extending community based services to those elderly persons whose impairments threaten their ability to continue to live independently. National patterns applied to New Jersey would indicate that by the year 2000, 213,000, or 18% of the elderly State citizens will be in need of assistance with their daily activities due to severe functional limitations. The current and anticipated magnitude of the affected population underscores the importance of a remedy to this growing health problem. We appreciate that S-2132 addresses local availability of home and community based services, the need for functional health assessments, and concern for the financial ability of elderly people to pay for the care they need.

We do, however, have various concerns with the bill as currently written, which we would like to share with you. The Commissioner's first concern is the potential for duplication

of services. Under the Older Americans Act, the county offices on aging are mandated to plan and coordinate services for the elderly. Title III of the Act provides $7 million for home and community based services annually, including nursing, homemakers home health aides, home-delivered meals, friendly visitors, telephone reassurance, hospice and respite care. The county offices on aging also have State and Federally mandated advisory councils which currently coordinate with the Human Services Advisory Councils to plan and fund local services with Social Services Block Grant dollars. Additional home care services, including day care, are provided and/or reimbursed by County Boards of Social Services, the Medicaid Program, the Community Care Program for the Elderly and Disabled, and the new Medically Needy Program.

With this network already in place, we believe local government agencies such as the county offices on aging should maintain control of funding for planning and service delivery. The existing systems now have the capacity to coordinate, assess, monitor and provide services if given the appropriate opportunity and source of funding. Assessment functions would best be attached to a program that would divert clients from inappropriate nursing home placement.

The Department's second concern is the limited eligibility provided in section 6 of the legislation. Only licensed and certified home health care agencies in New Jersey are eligible to apply to the Department of Health to be designated as a Home Health and Community Care Partnership Center and thus receive a grant. Other local home health social service agencies and the Aging network are equally competent in providing these services and should be given an opportunity to compete for funding.

The Commissioner of the Department of Health should be granted the flexibility to select the agency who could best provide these services within the county network through a

request for proposal process. Furthermore, the Commissioners of the Departments of Community Affairs and Human Services should be actively involved in the selection process since both departments work closely with existing providers and are therefore in a position to make recommendations for selection. The three departments work closely on other issues affecting the elderly through participation on the Governor's Interdepartmental Task Force and can similarly work together on this issue.

Commissioner Coleman has also expressed concern over the $11 million appropriation provided in the legislation. There is no evidence to substantiate the need for this particular dollar amount, and we would request that a fiscal note be prepared by the Department of Treasury prior to making a final determination.

We are also concerned that there is no income ceiling provided in the legislation. With a limited appropriation, it is essential that those services should be encouraged to seek the aid of private agencies. In addition, if the Legislature was willing to fund existing agencies rather than create a new bureaucratic structure, a great deal of the administrative cost would be eliminated, thus allowing those dollars to be reallocated to service delivery where they are most appropriately spent.

As a suggestion, possibly a demonstration program could be initiated in one county as an introduction to a more comprehensive package. A pilot program could provide some necessary data to substantiate the need for a statewide effort in this area.

Thank you for your interest in home health care and for allowing the Department the opportunity to comment on S-2132.

SENATOR PALLONE: Thank you. I wanted to ask you a few questions to clear up some confusion. Well, first of all,

getting back-- Before I forget, getting back to what was mentioned before about Meals on Wheels and the availability of the meal programs, what kind of a shortfall are we talking about?

MS. BOSNA: I'm sorry but I really did not come prepared to talk about that program.

SENATOR PALLONE: I know.

MS. BOSNA: If you would like, I can get the information back at the office and mail it to you.

SENATOR PALLONE: I'd appreciate it. Just send it to us -- a written statement -- so that we have it. Again, I'm not sure I understand exactly what you're saying. You're concerned about the $11 million appropriation, because you said there's no evidence to substantiate the need for this particular dollar amount. Now I take it that doesn't mean that you question the need for a significant amount of money in order to implement a program that would take care of the home health care needs of those who we feel are not being serviced at this point. Is it just a specific amount that concerns you?

MS. BOSNA: Yes. The specific amount we feel that there has been no demonstration that it would be either be too much or not enough. We don't know. It may not be enough.

SENATOR PALLONE: Okay, but in other words, I kind of get the impression that two different positions have been suggested there -- on the one hand, going ahead with this new mechanism of the partnership centers. On the other hand, we have an existing mechanism; all we need is money pumped into it. If we talk about a demonstration program -- you know, a pilot program that we're going to look at, put in place in one county and wait a couple years to see how it works out -- I have a real problem with that, because I feel, based on the testimony, that there's a tremendous need out there. Whether that need is met by a new mechanism that this bill suggests, or that need is met by simply pumping in dollars to the existing

mechanism, I think we should do something now. I don't like the notion of coming up with a pilot program for one county and then waiting for two years. I mean, there is an immediate need. So I'm not sure I understand why that's being suggested, unless I misunderstand.

MS. BOSNA: I believe that suggestion was included by the Department in the event that this bill should be put into place, to determine how much money will actually be needed.

SENATOR PALLONE: Okay, so what you're saying is if we decide to go the route of the new mechanism, you assume that you'd rather see that done on a pilot basis. But you wouldn't be opposed to our simply pumping money into existing programs to take care of these needs,

MS. BOSNA: I believe that the Department's position is that with the current structure that is in place, if there were more funding, we could address the problem adequately -- not only adequately, but much better than having a new administrative bureaucracy.

SENATOR PALLONE: Okay. I'm not sure if I understand exactly how the State Division on Aging and the local county offices on aging administer -- if they, in fact, do administer home health care programs right now. Would you just give me an overview of that? I guess the county, primarily--

MS. BOSNA: The county offices on aging would be the ones who would actually be subcontracting to the service providers. I do believe that we have someone who will be testifying on the part of the county offices on aging. He might be better prepared to give you that information.

SENATOR PALLONE: Is that--

MS. BOSNA: Mr. West.

SENATOR PALLONE: --Mr. West. Okay, well then maybe I'll just ask him to come up next and explain that to me. I just want to review one more thing here. Okay, I think I'd like to have him be the next speaker. Thank you very much. Mr. West?

C A R L F. W E S T: Senator Pallone, my name is Carl West, Executive Director of the Mercer County Office on Aging. I am a member of the board of directors of the National Association of Area Agencies on Aging, and the National Caucus and Center on Black Aged. I appear before you today as the legislative chairman of the New Jersey Association of Area Agencies on Aging -- NJ4A, for short -- to indicate our Association's unanimous position on Senate Bill 2132, which established the "Home Health Community Care Partnership Program."

Without exception, the membership of the NJ4A fully supports the need for additional home health care for our State's elderly population. With an ever-increasing emphasis being placed upon the prevention of premature or inappropriate institutionalization of our nation's elderly, it is essential that viable alternative services be made available and readily accessible to those who are in need of same.

As the "dean" of our nation's 627 area agencies on aging, I and many of my colleagues have witnessed a significant shift in the manner and attitude that our national and State's policymakers have adopted in dealing with the delivery of comprehensive health and social services to our 60-plus population. The changes in our Medicare system, the creation of the Supplemental Security Income rogram, the de-institutionalization of our State hospitals, the development of the Medicaid program, the creation of the Community Care Program for the Elderly and Disabled -- CCPED -- and the recently adopted Medically Needy Program are just a few of the many programs which our aging network has played a significant role in the development thereof.

An essential element which existed in the development of each of the aforementioned programs was the opportunity for input by those agencies responsible for the planning and provision of services to the targeted clients. Unfortunately, the proposed Home Health and Community Care Partnership Act

provided little opportunity for input by many of the social service agencies responsible for the planning and delivery of services to New Jersey's elderly residents. As a result, it is our considered opinion that the proposed program is deficient in a number of areas.

The proposed act recognizes the existence of the area agency network and the human services advisory councils. However, their role is relegated to post-funding activities of an advisory nature. In essence, the legislation, if adopted in its present form, would require representation of existing agencies on advisory councils without similar requirements for their involvement in the planning phase.

NJ4A recognizes the need for better coordination of existing services. However, it is universally agreed upon by those currently responsible for same, that the creation of the Community Care Partnership Act, in its present form, will only further compound and exacerbate our ability to develop a cohesive comprehensive coordinated service delivery system. Any new proposal must -- and I must emphasize "must" -- out of necessity, address our current delivery system with an eye on improving or redesigning such, in order to maximize the utilization of available resources.

NJ4A is also concerned about the restrictive legislation which allows only licensed and certified home health care agencies to apply for designation as Home Health Partnership Centers. There are existing systems in place which can be utilized, including county offices on aging and county Boards of Social Services, both of whom have proven track records in the areas addressed by this legislation. In addition, other local home health social service agencies have demonstrated a keen sense of competency in the delivery of social services, and should also be allowed the opportunity to compete for funding.

In addition, the present proposal does not clearly define those individuals who are to be served. Eligibility

criteria for the receipt of services, or how the program will interface with CCPED of the Medically Needy Program do not seem to be adequately addressed. Inasmuch as the Departments of Community Affairs and Human Services presently provide funds for the provisions of similar services, it is essential that they be included as full partners in the development of this legislation.

The New Jersey Association of Area Agencies on Aging feels that if $11 million is to be made available from the general fund to support this endeavor, that a thorough review and analysis of the CCPED and the Medically Needy Programs be undertaken to determine how we may maximize the benefits in the utilization of these newly created resources. Every effort should be made to assure minimal administrative overhead, thereby allowing for as many available dollars to flow into the system for the provision of "hands-on" services to the elderly.

There are some proponents of this legislation who argue that we should not be concerned about any additional bureaucracy that may be created by the adoption of this bill. It is the contention of NJ4A that bureaucracy translates into costly administrative overhead and severe deficiencies in the program's service delivery system. In view of the foregoing, NJ4A respectfully submits that the current legislative proposal should be reviewed and revised where appropriate, with the explicit intent of reducing administrative bureaucracy and strengthening cost-effective methods which would be designed to maximize those services to be provided under the legislation.

In conclusion, the New Jersey Association of Area Agencies on Aging stands ready to assist the Senate Committee on Aging in any way you feel may be most appropriate. Our primary concern is not who would be the conduit agency for those funds authorized under this legislation, but rather how through the enactment of this bill, the elderly of New Jersey can be better served. The avoidance of duplication of

services, maximizing the coordination of our social service delivery system, and the prudent utilization of our limited resources are concerns which we all share. It is only with the consideration of these elements in the planning phase can we expect to insure a program which is fiscally sound and administratively efficient.

On behalf of the New Jersey Association of Area Agencies on Aging, I would like to express our sincere appreciation to the Committee for the opportunity of sharing our thoughts and concerns on Senate Bill 2132, and again extend an open invitation to you in calling upon our Association to assist this distinguished Committee in your deliberations on those matters which impact upon New Jersey's elderly community. Thank you very much.

SENATOR PALLONE: Thank you Mr. West. We do have some questions.

SENATOR VAN WAGNER: Mr. West, first I would personally like to thank you for communicating with our office, and expressing some of your concerns. You've been kind enough to do that with the demands of this hearing, and we appreciate that. I assume then that if this bill were amended to reach into the coordination aspect, and to be further amended to address some of the concerns that were earlier addressed -- and addressed in your testimony -- that you would find yourselves supportive of measures such as that.

MR. WEST: Without a question.

SENATOR VAN WAGNER: That's the only question I have.

SENATOR PALLONE: Mr. West, I wanted you to just briefly outline, if you can for me, exactly how are these services provided through the county offices on aging right now? In other words, what role do they play with the home health services?

MR. WEST: Primarily most of our county offices on aging-- As you must understand, the Offices on Aging primarily

are administrative offices that do not, by and large, provide direct services. I can give you an example of the manner in which-- For example, Mercer expends funds for the provision of home health services. In our planning phase we try to, and we're mandated by Federal requirements under the administration of the Older Americans Act, that we must give priority to those individuals who are in greatest need. In order to assure that we do comply with that mandate, we have -- in the development of funding of the home services program -- we try to identify an existing agency that was presently providing -- or in that point in time providing -- home health services.

It appears the most logical aspect in funding is to look at the county Board of Social Services. In that way, we recognize in many instances they deal with those who are in greatest need. But also we recognize that there are many people who applied to the Board of Social Services who did not qualify. What it provided for us is a built-in mechanism, which meant, in our instance, no additional administrative costs to our program, because of the fact that the county Board of Social Services was already providing these services. It was a matter of us supplementing their existing programs to provide additional services. So, it also meant that an individual who would need this service would not have to be shifted to another agency to determine his or her eligibility. At first, they would be determined to be eligible for the Medicaid program, or Title IV, or whatever. If it was in fact determined that they were not eligible, then it would be just a simple process of sliding them on to our Title III program though purchase of services for homemaker-home health servicing.

SENATOR PALLONE: But in other words money is coming through the Division on Aging through the county offices on aging for certain home health care services. Are we talking about funding through Medicaid, primarily now?

MR. WEST: No, we're talking about funding through the Older Americans Act, which basically is the primary source of funding for county offices on aging.

SENATOR PALLONE: But you are appointing the county Board of Social Services as the agency to--

MR. WEST: As the provider agency. We, in fact, contract with the Board of Social Services whereby there is an agreement where an individual is determined to need service and is not qualified under one of the categorical programs, that they are then provided services under our Title III Older Americans Act agreement.

SENATOR PALLONE: So we're not talking about Medicaid, Medically Needy, or the continuing care at all now.

MR. WEST: The only eligibility requirement to remit under the Older Americans Act is age 60-plus. There can be no means test applied to determine whether in fact the individual is eligible to receive services, other than age.

SENATOR PALLONE: So that once this money-- Now you've made a designation of the county Board of Social Services as the agency. What happens next?

MR. WEST: Okay, it's based upon the clients that are referred to the agency for the services. Now the manner of referral can be any number of ways, as previously indicated. It can be as a result of the home health visit, whereby a nurse may determine that, in fact, the individual needs some additional service, although in that instance, the person would already be receiving some home health services. We have a program in Mercer and many other programs throughout the State have it. Many other counties have it. That's where we do outreach, where we employ elderly individuals who actually canvass neighborhoods to determine the need for service by the elderly community.

SENATOR PALLONE: So in other words, this is all separate from what you call the categorical programs. We're not talking about people who have Medicaid eligibility.

MR. WEST: Well, one important factor is that we attempt to coordinate our services with those categorical programs, to assure that we get the maximum utilization of the limited dollars that we have available to us.

SENATOR PALLONE: Okay, I don't want to prolong it too much, but I want to understand what I'm talking about. Somebody comes into my Senate office and says that they would like to have home health aid for their mother, and meals provided -- Meals on Wheels, whatever. I call up the office on aging. They send someone out to visit this woman, to visit the mother. She makes certain recommendations. Then do you pay for certain of those services, or charge a fee?

MR. WEST: Well, first we pay for the individual to visit the client's home.

SENATOR PALLONE: Okay.

MR. WEST: We do not put the burden on the client to call. The outreach worker is responsible for doing an assessment of the need, and then waking that individual to what available service that may be available within the county. We try to minimize the impact of the individual having to go from agency to agency in an effort to determine which service they may be eligible for.

SENATOR PALLONE: So once someone has visited this individual, the office on aging would try to make the contacts to different agencies that would provide these different services.

MR. WEST: Right.

SENATOR PALLONE: And then the county Board of Social Services contracts with those different agencies to provide those services?

MR. WEST: Well, in some instances the client may be

eligible for services that are provided through the Board of Social Services. They may meet the income criteria. In that instance, it makes the process fairly simple. Because then the intake is done through the Board of Social Services, and through the Board of Social Services certain social services are made available to that individual. Okay? As an example -- taking it one step further -- if in fact it was determined as a result of that referral to the Board of Social Services that the client was ineligible for Medicaid, for home health services, because of the fact that they have an additional resource available to them being Title III -- in which the only criteria for eligibility is age -- they immediately have available to them additional resources which they can then tap into the client, and make available to the client.

SENATOR PALLONE: Well, what is the reason why we had so many people out there who aren't having their needs cared for?

MR. WEST: Well unfortunately, the amount of resources that are there is extremely limited. We in fact, in the offices on aging, recognize that the amount of money that we administer is miniscule in terms of the overall resource availability. However, I think the Department of Human Services that does provide a wide range of services will be the first to admit to you that in fact, the resources they have available are extremely limited. That is one of the reasons why, in many instances, we have to put caps or restrictions on eligibility of services. It's just a matter of how many dollars are available, or how many people are in need of those services.

What we're saying then in effect is that if we do an analysis of the existing programs to see how we may be able to expand the service areas, we can, in fact, service more people who definitely need the services but due to restrictive resources, don't have the opportunity to receive services under

the existing program. So what we want to do whenever possible is to maximize the use of those additional dollars that come into the system. I think the only way we can do that is that we have to deal with it prior to the enactment of legislation. We must do an analysis of what's out there, then base our legislation around that to ensure we get the maximum use of those dollars there, and that the maximum amount of people can be the beneficiaries of those programs without an overextension of administrative costs, which is very important.

SENATOR PALLONE: I don't want to belabor the point too much longer, but in other words, right now when you send someone out to visit this individual, you find that they need certain services, but they're ineligible for Medicaid, for example. Let's assume they're ineligible for Medicaid, they're ineligible for the three -- the Medically Needy, the continuing care. Let's assume they're not eligible for any of those. Right now there may be certain things available to them through existing agencies. For example, you might be able to refer them to a homemaker agency, or a home health aide. But at this point, although those services may be out there, you have no way of paying for them. Is that the problem?

MR. WEST: We're paying for some services under Title III.

SENATOR PALLONE: But you can't pay for a lot of them.

MR. WEST: But there is more demand than the actual dollars that are there.

SENATOR PALLONE: Okay, I'm just confused because when you say that you're concerned about the restrictive nature of the legislation, which only allows licensed certified home health care agencies to apply for designation, and you say you'd rather use existing county offices on aging--. In addition, other local home health social service agencies that have demonstrated a keen sense of competency and should also be allowed the opportunity to compete for funding. I'm not sure

what kind of alternative you're suggesting to this bill, I guess is what I'm saying.

MR. WEST: What I'm saying, in effect, is that offices on aging currently are doing a lot of coordination. As a matter of fact, by law the Legislature has mandated that the offices on aging be responsible for the coordination of services. Unfortunately, what has occurred in many instances when new legislation is created, is that mandate has not been recognized by the Legislature.

SENATOR PALLONE: So you would like these partnership centers to be set up, but you would rather the county office on aging make the decision about which agency to implement the program.

MR. WEST: Okay, we are not-- Again, I don't want it to appear as if we're involved in a turf issue argument. We are not-- That is not our primary concern. Our primary concern is not who is to be the designated agency, although we do have some concern about that. We feel there are existing service agencies out there who can compete, who would not be able to if this legislation were adopted in its present form. What we're saying is that if there is that opportunity through an analysis of the existing service delivery system that's in place now, we might determine that there is a better opportunity to serve this client community through the utilization of those existing agencies, then we would be better off doing that, rather than creating a whole new structure that says we now have new Community Care Partnership Centers which may be completely different based upon the present form.

SENATOR VAN WAGNER: But that's simply fixed, isn't it? That's a matter of form, really. That's something that has a solution.

MR. WEST: Right.

SENATOR VAN WAGNER: I think what Senator Pallone is getting at is that even with all of that-- Let's assume that

we've eliminated redundancies and coordinated this through the existing county agencies and so on. Isn't it a fact that under present Federal law regulation, threshold parameters and other restrictions, that the dollar amounts will still be limited?

MR. WEST: In most instances, yes. However, we feel that there is in place a mechanism that can be developed as a piggyback, or as an adjunct or supplement to those existing programs, that we can tap into, that would allow a greater dollar to pass down to the actual delivery of that service to the client himself.

SENATOR PALLONE: So if we demonstrate the need for $10 million or $11 million program to take care of all the home health care needs that are not being presently met. We just assume--

MR. WEST: I can assure you that you can pump $25 million dollars in the program, and we still wouldn't come close to meeting the needs that are there.

SENATOR PALLONE: I think we're going to stop here.

SENATOR VAN WAGNER: I think what's being pointed out, Senator, if I might, is the fact that as part of the consideration that the Committee might give to this bill is the consideration of a co-payment schedule of some type -- a participatory program, in effect -- so that more individuals might find themselves being able to participate in a home health care program. I think that's really what we're talking about. Because if I understand what's being said today, you and others have said that a portion of what's being covered under this bill is in fact covered by many of our agencies under Older Americans Act, Title XX, Title XVIII, and so on down the line. The amount of dollars you have to pump into that might be $50 million, if you were going to give comprehensive care to those individuals now covered, or considered to be covered, Senator, under those programs. But this bill really is aiming at going beyond that. I think that's where some of the confusion lies.

SENATOR PALLONE: I understand from my gathering up of what's been said this morning-- I understand the parameters of the bill and the type of program the bill is trying to set up. What I don't understand is how what's being suggested out here is that we could use the same money, and operate through existing agencies, programs, and systems. I still don't understand how that would be? I mean, I understand what you're suggesting. I understand how the bill lays all this out. I don't understand how the same thing could be done with the existing system or not. I guess everybody is trying to tell me that, but so far I haven't been able to exactly garner how that would be done.

MR. WEST: Well, I think if we just look at the facts we're talking about-- There are certain structures that are already in place that do not have to be created. To create them would be costly. What we're saying is that we can piggyback on some existing services that are there, that would ensure, to a great extent the dollar-- I think that's the key factor. We want to get as much of the dollar down to the individual as possible.

There are certain administrative structures that are there that we can piggyback on. For example, the Medically Needy Program is one that many of us here were in favor of. However, we recognize the fact that it is extremely limited. There needs to be an expansion of that to create greater eligibility for people who don't qualify at the moment. We have to look at how that program sits now, and what needs to be done to take care of some of those people who are in desperate need of medical services, but who could not afford them -- who do not qualify for the Medically Needy Program as it currently exists.

SENATOR PALLONE: Maybe I could just sum it up. My concern is-- I mean, if I'm looking back at this individual again, you're saying that once this person is referred to the

office on aging, and somebody goes out to visit them, we would now have certain agencies -- whether they be home health care, Meals, etc. -- that can provide them the services that they need, but right now are not getting funded sufficiently for that individual to provide those services. You just assume that the money be pumped into those existing service agencies or whatever, and that we use the existing mechanism to--

MR. WEST: Well, no, we're not talking about using the existing mechanism per se. What we're talking about is expanding upon what is already there, with the end result that we would have individuals who are currently not receiving services. The bottom line is more to increase the level of services that currently exist, and through the proper utilization of dollars, we could further expand even further in terms of making sure that as many people as possible get the benefit of these additional dollars as we can.

SENATOR PALLONE: Whereas this legislation would suggest that the Health Partnership Centers be the central mechanism to perform those services and to create a new mechanism.

MR. WEST: It is creating a whole new mechanism, as we see it.

SENATOR PALLONE: Okay.

SENATOR VAN WAGNER: But there is in fact nothing wrong with the establishment of a partnership center, as long as -- if I understand correctly -- as long as there is a coordination and a recognition that the licensed service provider could be expanded to include county offices on aging, and other mechanisms that are now in place. Is that correct?

MR. WEST: I think you kind of expressed it early on, Senator Van Wagner, when you indicated there was a need or potential for getting some folks together who are going to have to play a role in this legislation, once adopted, who'll get together to go through what some of their concerns are, and

that this be done prior to the enactment of the legislation. In order to assure that we are getting the maximum.

SENATOR VAN WAGNER: Right.

MR. WEST: I think that may be the key.

SENATOR VAN WAGNER: A working group?

MR. WEST: A working group.

SENATOR PALLONE: And the main advantage, Senator, of having the partnership centers is that we're going to have a center now, where home health services are going to be provided in a package for all purposes, in a sense.

SENATOR VAN WAGNER: That's one thrust.

SENATOR PALLONE: All right, thanks a lot. The next person we have is Catherine Tedeschi, who is replacing Susan Magyar, of the Long Branch Public Health Nursing Association.

C A T H E R I N E T E D E S C H I: I appreciate the opportunity to testify at this hearing concerning Medicare, and in support on Senate Bill S-2132, the Home Health Care Partnership Bill, sponsored by Senator Richard Van Wagner.

Our agency has seen a gradual narrowing of the interpretation of the regulations by Medicare for Home Care Services for quite some time. They are using more restrictive guidelines in determining a person's eligibility for home care services, mostly in the areas of "homebound status" and "skilled nursing services." It is even occurring that some people are determined too sick to qualify for Medicare at home.

Example: An 82-year-old elderly, frail woman lives along, and was just discharged from the hospital after a two-week stay with compound fractures of the humerus in both arms after she sustained a fall. She is essentially dependent upon others for personal care since mobility is limited, and cannot prepare her meals since both her arms are casted. We can provide extremely short-term intervention with HHA placement 2-3 times per week for 2 hours -- nursing supervision of cast care with instruction to the patient. Medicare deems

this patient not homebound since the upper extremity fractures do not limit her mobility to leave the home. She is essentially not homebound and other services which are not billed to Medicare need to be explored.

"Homebound" is coming to mean "bedbound" to be eligible for home care, and the additional few visits we used to be able to deliver to reinforce patient teaching about their care, diet, and meals are no longer considered "skilled nursing" care. The result is a significant increase in the number of denials of coverage for services we deliver, and delivery of fewer services to clients over a shorter period of time. This shrinking of Medicare home care benefits is occurring at a time when patients are being discharged from the hospital sooner, and in greater need of home care services.

The widening gap between restriction in hospital stays and more stringent guidelines for eligibility for home care is becoming known as the "no-care zone." Also falling into this "no-care zone" are the patients with chronic illnesses, for whom periodic nursing visits to evaluate their physical condition, reinforce medication and diet compliance, and some home health aide assistance would help to prevent more costly hospitalization or nursing home care.

Homemaker services to assist with laundry, shopping, housekeeping and meal preparation is greatly needed by the elderly while in both the acute and chronic stages of illness, for which there is very little financial assistance to help them purchase these services at this time. Very few can afford to pay privately.

We support the Home Health Care Partnership Bill because we believe it is proposing a method and a mechanism for providing services to the growing elderly population who are in this "no-care zone." Thank you.

SENATOR PALLONE: I just want to ask you, now you were one of the-- Going back to Mr. West's testimony, you would be

one of the licensed certified home health care agencies, along with MCOSS, which will be the next group to testify.

MS. TEDESCHI: Correct.

SENATOR PALLONE: Tell me why-- Obviously, you support the bill. Tell me why you think it would be preferable to have your agency and MCOSS -- pursuant to the way the bill reads -- as the certified agency, rather than opting for one of the other home health social service agencies that's being suggested by Mr. West. I'd just like to get that clear.

MS. TEDESCHI: Being a nursing supervisor with the Agency -- I am not the director -- I can answer this from a supervisory standpoint. It's easier for us to refer out to various other agencies -- referral sources -- when we know the patient, and we know what's going on with that particular patient. When we refer out to CCPED, or office on aging, or Title XX, or Title III, we are the ones who are making the referral. We're generally the spokesperson for the patient, and could really give the next referring source a very good idea of what's going on. It would just give us another means to refer appropriate services to that patient. Again, I am speaking from a supervisory point of view. I am not fully, totally aware of what the bill would detail down the road. I really couldn't answer that. I could answer what it would help -- you know, additional resources for the patient -- and what it would do to help us.

SENATOR PALLONE: I can ask the same question of the MCOSS person.

MS. TEDESCHI: Yes, because the director--

SENATOR VAN WAGNER: I think that would dovetail in nicely.

SENATOR PALLONE: Okay, thank you very much. Are you Marly Auerback?

SENATOR VAN WAGNER: That's Marly Auerback.

I might add, Senator, that one of the agencies that we

-- my wife and I -- contracted -- or contacted, I should say -- in my wife's mother's illness was MCOSS. They did, in fact, provide both nursing service and homemaking service through the county office.

M A R L Y A U E R B A C K: Thank you. Before I begin I just want to say thank you for the opportunity to testify. Throughout the day I've been very impressed with the difficulty of being a legislator. So to those of you Solomons assembled here today, I have points of view that I guess contradict some that were raised before.

MCOSS Nursing Service, Inc. supports S-2132 for three reasons: The first is we all agree that it's geared towards assisting the frail, aged individuals with functional disabilities remain in the community. I think it's important that the bill calls for the provision of case management services to eligible people. Case management means that a plan has to be developed with the participation of the patient and the family. Such a move is very consistent with national and statewide demonstrations of research of care for the chronically ill who live in the community.

I mention that particularly because one or two of the people before, stressed homemaker home heath aid services as what they see to be the greatest number in volume of service. While it may very well account for the greater number of hours, it's not the main directing force. It is the assessment and the ongoing management of a care plan to make that care plan stick for a family, that I feel is the guiding light in the thing.

The second is -- despite what some others might have said -- I thought there was a strong emphasis on coordination of community resources, which would seek to eliminate fragmentation among service providers, and thereby preserve and protect scarce public dollars. One of the reasons why I would cite certified home health agencies as useful here -- and it

doesn't mean that any other good service network is not also a useful network -- but where I see a certified home health agency being of value is that they are able to combine the Medicare reimbursement and the Medicaid reimbursement for a person with the next piece, which is to say chronic care types of services.

In a number of agencies, we've done a small study -- especially those who have Medicaid populations, and find that among the chronically ill, about a third of them will have an acute type of episode -- either hospital or a Medicare episode of home care throughout one year. So, that would be to say if you had 100 people with chronic illnesses, who required long-term home health care, 33 of them would require either a Medicare episode or hospitalization.

I think it's important that a chronic home care program be placed in a system where there is a close coordination with that Medicare benefit. The Medicare benefit, as we've seen, has taken a terrific knock. People are thrown off, that 10 years ago you wouldn't even have seen out of the hospital, much less not considered homebound. But it's still there, and it still does a lot of things. You can't separate yourself from it totally, and pretend just because it's taken such a big beating, it doesn't do a lot of things for a lot of people. So I see a nice connection between chronic home care service, and acute home care service.

The third thing I like about the bill is that the prospective partnership center is supposed to actively seek donated funds and develop volunteer services. That really separates the genuinely concerned and committed. I think it calls for, in addition, standards for decertification of programs. Now, it doesn't specify what they are, but it requests that such things would occur. I think standards like that, and an attitude like that, help to ensure that new programs are entrusted to agencies with both accountability and

a track record. I think those were three very strong pieces in the proposed legislation.

From the viewpoint of MCOSS Nursing Services, we are fortunate to be one of those agencies selected by the Department of Human Services to be a case management site under the CCPED program. As a small aside, I believe the State number is 1800 persons in the CCPED program. Recently I had conversation with a few agency directors at a meeting, and we were just trying to go back among our own Medicare denials, and so on, and give an estimate. We came up with a seat-of-the-pants estimate that about 1800 people were thrown off Medicare this year.

So, I wouldn't hold up going forward on the one program, because you have CCPED. It's a very useful program, but put that in its context. At any rate, we are a CCPED provider. We're considered to be one of the foremost home health agencies in the United States. We have a senior team which does health screening and assessment in buildings in which elderly people live. We have recently been awarded Robert Wood Johnson funding to provide a Mobile Boarding Home Clinic, which goes to boarding homes to provide health needs assessment to elders and other disabled persons who aren't in the system. We provide caregiver seminars to people who care for their families and either need to learn how to do it better, or need to talk to somebody else who's doing it. We have a separate respite program in addition to training aides and so on. So what I'm telling you is based on a little bit of experience both with the acutely ill and the chronically ill.

A few statistics about Monmouth, I think, are pertinent here. Our consensus is that there is a need for this program in this county. Currently, two-fifths of New Jersey's older population is over 75 years of age. Of the elderly, two-fifths of those are over 75. Monmouth ranks second in New Jersey in terms of the total of 75-plus residents, in relation

to the total county -- the first being Ocean. Twenty-nine of the 51 municipalities have an elderly population in excess of the national, state, and county norms. The national norm is 11% population. We have, in some of our districts, much higher -- 12.3% or 13% respectively. In the south shore districts of the county, which is served by the Manasquan Health Center, the percentages of the municipalities around there range from 13.73% elderly to 27.7% elderly. So we think we have a lot of people here in Monmouth who could very well use such a program should we be able to have it.

To sum up, we think there are three things that we think are strong in the legislation. First, it is current with state of the art in community health care to the frail aged, and with its case management focus it works hard to be comprehensive. Second, it provides incentives for providers to keep costs at a reasonable level. The sliding fee scale works to prevent over-utilization and the requirement for fund raising and volunteer services promote the use of appropriate services. Third, by mandating a comprehensive assessment and plan of care development to be available without fee, the system works towards preventing impoverishment for those who need assistance, but don't know where to turn. Thank you.

SENATOR VAN WAGNER: I just wanted to point out in terms of coordination, Mr. Chairman, on page 4 -- editorially, if I might, point to the sections that have been raised on page 4 of the bill. Among the criteria requiring an establishment of a Community Care Partnership Center is that the agency has to have a plan for the operation of a partnership advisory council which includes representation from the county office on aging, human services advisory council, and other local religious, business, labor, and such groups. So I think that if I get your point, that's what you were aiming at in some of the strengths that you saw in the bill.

MS. AUERBACK: Yes. That is one, and the other-- I believe that earlier it was said that in the case-- There was a criticism that in case management, it says it "arranges for," it doesn't necessarily "provide," and therefore that was a shortcoming. Yes, throughout all of today we've heard very many fine people explain what they already have, and what they already do. So, case management, in arranging for provision of that which is available, is still a worthwhile thing. That is in addition to your other point, Senator, about the advisory committee.

SENATOR VAN WAGNER: Thank you very much.

SENATOR PALLONE: If I could just-- Again, I'm trying to put things in a little perspective. MCOSS would most likely be the only agency that would be able to qualify for this -- you know, to set up the home health community care partnership, for example, in Monmouth County. You would be the certified agency most likely, correct?

MS. AUERBACK: Most likely in cooperation with the Public Health Nursing at Long Branch.

SENATOR PALLONE: In Long Branch, which deals with-- That's geographically based, right?

MS. AUERBACK: Yes.

SENATOR PALLONE: Okay. What would be the-- Now, you don't provide the homemaker services, right?

MS. AUERBACK: We do have homemaker services and home health aide services.

SENATOR PALLONE: In addition, because there is such a tremendous need for that-- There are many occasions, for example, through CCPED where MCOSS does call other providers in the county. However, there is a home health aide within MCOSS, and MCOSS also provides, through an affiliate, the ability to purchase home health aide services, and we call any accredited agency who can also help in those situations where we don't have personnel.

SENATOR PALLONE: In the case of Monmouth County, what would those other agencies be, for example?

MS. AUERBACK: I'm not sure if she's still here, but I think you had the representative from Family and Children here in the room. There are a few other agencies. I know in particular, the CCPED people are on the telephone a heck of a lot.

SENATOR PALLONE: But then in other words, the way the bill is set up-- If you were the lead agency for the center, then you would then still contract, for example, with Family and Children's Services for home health aid, homemaker services, etc?

MS. AUERBACK: Yes, yes because there is a tremendous need, and in terms of the actual hours, that is for the great volume of services. What I would like to plead for would be the controlling assessment, plan of care, and follow-up with monitoring. I think that's what helps to make the thing work and do what it should do. Otherwise, you have the situation in which you have perhaps intergenerational conflict, and you call up and say to some individual, "You're now the home health aide. Step foot through that door, and make it work for these people."

SENATOR PALLONE: All right, and the reason you feel that's important is what you stated previously, which is your agency traditionally deals with-- Well, you have the skilled nursing care; you talked about the situation with people that are chronically ill, where you can tap better because you deal with the more serious health care problems.

MS. AUERBACK: Correct, because I think the coordination with an acute care service is very important. Because it's very often the health problems that bring people into the service system doesn't mean that they don't have a heck of a lot of social types of problems that require skilled social work counseling, for example. But they may not come

forward for that. They tend to come forward with the health needs first, so you have to deal with that; help people with that; take that pressure off, and then they're free to work with the other side.

SENATOR PALLONE: And the alternatives, for example, under the present system-- Going back to what was stated before, where a referral might go -- right now, for example -- to the office on aging, and somebody may go out to visit that individual. But the problem there is that, you know, they may be contrary-- I'm trying to see what the alternative would be. In other words, let, for example, the offices on aging you're suggesting as an alternative to what you're saying-- The danger there is that there's no central assessment; there's no central agency that has these acute health concerns and skilled individuals involved taking control of the situation.

MS. AUERBACK: That's my opinion. Yes. I don't know, because I don't know statewide, but I'm not aware of offices on aging that do have direct nursing services to do this. I know one in particular has been praised because it subcontracts for nursing service assessment. We in our county are very grateful for the use of our own office on aging, and we tend to call them-- Our staff calls them very frequently. But I don't believe that there is another source that has direct coordinated assessment and plan of care development, other than within the certified--

SENATOR VAN WAGNER: I've gone carefully through the various letters from the various county agencies, and tried to ascertain if there's a commonality of concern. One, I find the Human Service versus Health Department problem a real concern and something I think we can address. But as such, I think there's something of a misunderstanding over what the bill is designed to do, on the part of many of the county offices. For example, I have a letter from a Passaic County Board of Social Services which talks about the duplication, and so on and so

forth, of homemakers and home health aides, but doesn't indicate whether or not they in fact provide services. It does indicate that they coordinate and work in cooperation, etc. I'm not being critical; I'm just pointing it out. But it does not indicate that they are a service provider.

SENATOR PALLONE: See, this is basically what I was trying to get to before. I don't understand how if you don't have an agency like MCOSS being the lead agency -- the one that does the assessment, the one that contracts out, that provides the basic services, or finds others to subcontract and provide those services-- I don't see how the county offices on aging would perform the same function. Wouldn't they ultimately have to come back to you anyway to perform those functions, or am I misunderstanding the situation?

SENATOR VAN WAGNER: That then becomes-- Now you're into case management, in a sense. Again, this is not criticism at all. This is part of the system, if you want. What happens, I think to a large extent, is that all of the agencies would have great professionals and great people involved, but the tail wags the dog.

In other words, they have to go first to Title XXIII, etc., and analyze and assess whether or not they have a person here who's eligible for one of these services. Then they have to decide -- assuming now we have a person who is eligible -- where are we going to get that service? So they look through, and they have -- I assume -- a directory of service providers, and they have a pretty good sense of knowing-- Now they call, and they say: "We have a person who's eligible for these services, who needs this type of service once or twice a week," -- whatever it is, "Could you schedule them?" And then it becomes a function of how much money is available: "Yes, we can schedule them; certainly we want to provide the service; but we don't have any money."

SENATOR PALLONE: I understand that, and I'm glad you clarified it for me, Rich, because when I look at the statement that Mr. West made about-- He said the legislation restricts you because it only allows licensed and certified home health care agencies to apply for designation. We'd rather have the county offices on aging basically utilized and make the decisions about which services and which agencies are going to be provided. In addition, other local home health social service agencies demonstrated a key sense of competency, and they should be allowed to compete for funding. I don't understand how they're going to compete.

Obviously, the only thing you can do is take -- for example, in Monmouth County -- take MCOSS and allow them to provide for more services, and allow more funding. You can allow, I guess, the Family and Children's Services to provide more services and more funding. You know, more people eligible for their existing services-- The only difference that I can see would be that if you use the existing system, as you said, the referrals-- The county offices on aging would have to seek out the different agencies for the different purposes, whereas under this bill, the MCOSS would be the lead agency. They would be there all the time. They would be making the decisions, and they would--

SENATOR VAN WAGNER: Well, not exactly.

SENATOR PALLONE: No?

SENATOR VAN WAGNER: When you say who is eligible, there are criteria beginning on page 4, that say who would be an eligible home health community care partnership center. Who's eligible would be all of the above, if they met certain types of criteria in this bill.

SENATOR PALLONE: And then they could take on the additional services?

SENATOR VAN WAGNER: They might, by demonstrating that they meet this criteria, take on those services, yes. In my reading of the bill, at least, I don't see it as necessarily

precluding anybody from becoming a certified agency as such. However, what it seems to do-- And I will acknowledge that from those who brought it to my attention, and I think it can be fixed-- What it seems to do in its language is limit it to only those agencies that are now presently certified or licensed. And that, in effect, is true. Those are the agencies that would, in fact, provide that service.

But again, getting back to this dilemma we're in, they are, in fact, the agencies that do provide those services. So we're back to where we were in the beginning. The point is that we've got to try to -- kind of I think -- cut through what are clearly some objections over turf, and get into what are real objections in terms of coordination, redundancy of services, higher costs, and making sure that the right payments get to clients.

In the PCA bill which people talked about earlier -- which was also a bill under my sponsorship -- one of the areas of the bill was that the client himself, or herself, had to in effect indicate and check off whether or not they did in fact receive those services before any reimbursement or payment could be made. That sure as hell makes sure that the money goes directly to the client, because under the way the Department of Human Services conducts the program -- and it's a model program, I think, in 11 counties -- if in fact that client does not sign off and does not say he has received those services, they don't get the money.

SENATOR PALLONE: Okay, thanks a lot.

MS. AUERBACK: Thank you very much for the opportunity.

SENATOR PALLONE: Is Mr. Joseph Burns still here? Okay, you're next. Community Health Care of North Jersey?

J O S E P H J. B U R N S: I'm the Executive Director of a visiting nurse association in Essex County, called Community Health Care. Bear with me; my bones are a bit stiff, having sat for four hours to come to the table to conduct a few

remarks. In my desire to sit here, I forgot to give my two-page statement, which I will present at the end of my testimony, which will be very brief. I represent an agency in Essex and Hudson counties, and I thank you for the opportunity to come to Long Branch. If I had known you were coming to Hudson County, I would have joined you there. So I apologize to all, but having left it this long, please bear with me.

My statement is one of support for the Partnership Program. If I can extrapolate from the presentation, I would appreciate that. No one has yet mentioned that the concept of Partnership goes beyond the State, and either the office on aging or a home health agency client. I thought the genius of the Partnership bill was to bring in new players to the relationship of providing care to the people who are our turf. Whether it be my agency in Essex and Hudson, whether it be the Office on Aging in Essex, I, personally and professionally, couldn't care less.

My turf -- and I say it very proudly -- is that the elderly and the frail in Essex and Hudson Counties are not currently being served to the degree that they're entitled to be served. Something new and creative is required. So I plead with this august group to bear with the tedium of more hearings, and to come up with whose other turf -- whichever agency, whether it be the Department of Health, Human Services, home health agencies, homemaker agencies, or God himself-- I couldn't care less who's going to provide the care to the elderly, some of whom have spoken this afternoon.

I'm rapidly approaching that age where I'm looking for help quicker than you, Senator Van Wagner. I have left hospital administrator jobs, where I was an administrator for 15 years, so that I can plan for my own retirement professionally, if not financially. I want to be sure that there are measures in place eight years from now when I turn 65, that I can look to a rewarding, professionally satisfying,

and healthy environment with either a home health aide, or a homemaker, or a therapist, or a nutritionist, or a social worker, or an LPN, or an RN. Least of all do I want a bureaucrat getting in the way of me getting care when I need that kind of care. So please, legislators, press on.

Plus, press on with the creative approach that you will bring industry and the private sector into augmenting and maybe showing some of the ways in which a marriage, if not a partnership, can occur. That hasn't been mentioned until this moment, for my tired ears, so I ask that it be considered.

We are the largest home health agency in the State of New Jersey, serving the urban poor, and the frail and elderly. We are second to MCOSS in the number of visits. In 1984, we provided some 210,000 visits to the frail and elderly, and a lesser amount of that amount to the youngsters in Newark, particularly. From 1984, when we had about 210,000 visits, 1985 we're projecting approximately 180,000 visits. The interesting point for this group, I think, is that in Medicare we had reduced our patient population, who are backed up by Medicare, by almost 1000. We have lost, in effect, 1000 Medicare clients because of the retrenchment in Washington as to who is entitled to what under the Medicare legislation. That, to me, is obscene.

We have physical therapists who give physical therapy to Medicare patients in their home on how to walk stairs. When they take that client outside the home and teach that client how to walk the stairs outside their home, or their apartment, or their shack -- depending on where they live -- the bureaucrats in Millville who administer the Medicare program, decline payment for the physical therapy for those services rendered in helping a client walk up a stair outside a house.

To me, if that's not sheer idiocy, I don't know what is. The fact that they are able to leave a house to walk up a handrail guided by a therapist to help them get out of the house eventually, is tantamount to not being homebound to the

eyes of bureaucrats of the Medicare program at Millville. That's craziness. Our Medicare client population has diminished by 30% over the last two years -- and the numbers I've cited, over 1000 clients.

There's another item I'd like to refer to in passing, that while we belabor this point as to whose turf is going to handle the dollars, I'm experiencing in my agency a 35% turnover rate in the level of professional, skilled, registered nurses. Now that's to me a very ominous sign that the nursing profession is itself reacting to the craziness in funding for the elderly today, by showing their dissatisfaction by walking away from the profession. We run a great agency in Essex County. We have good people; we have 82 years of experience in providing care, not all of which have I been at the helm at community health care. But the nurses, over the past two years, with a double entendre facing them--

Everybody talks about home care as the wave of the future. There's money to be saved in home care, and the denials in Medicare are astronomically greater today than they have ever been before. The paperwork that our nurses must meet each morning and take home each night to their own families to complete at home, occupies 60% of their time. If I pay a nurse $23,000, and 60% of her time is required for that paperwork, mathematically speaking that's almost $12,500 that I'm paying for the paperwork, and not for the hands-on expertise that I employ that nurse to offer that frail, elderly person. The Medicare forms are not only 485, 486, and 487 that are devastating my nursing staff with paper requirements. They are the double side of the double entendre whammy, that we get denials for services already rendered; we get paperwork to keep us in the office, so I have a staff of people who are going topsy turvy, meeting themselves coming and going in what was their profession of choice to serve the frail elderly. A true minister of today -- the nurse out in that community

environment providing care to the people that are ignored by many others.

I would like this legislative group to know that there is a revolution, not only a no-care zone occurring in health care, but there's going to be another no-care zone, meaning that you're not going to have trained, competent, committed professionals to give the care, unless certain restrictions of paperwork that we've talked about-- The refusal of service to people who our nurses know need the service-- Unless that's undone, a lot of our nurses could not stand that pressure much longer. Their hearts are broken over what they see as a need to be given to the folks they serve, and to know that they're unable to do it because their crazy administrator will ask them, "Is this a billable visit, or is this an administrative visit?"

I can tell you that we have provided 25,000 administrative-type visits for which there is no dollar coming back from any source, other than our outreach for philanthropy. My little agency in Essex County has not historically been into fund raising. But we face mountainous deficits because we've continued to provide free care -- irresponsibly in the eyes of some -- because in our judgment the people needed this care; they needed this nurse; they needed this homemaker, this home health aide or therapist. And at the end of the bottom line, at the end of the year, I've got no money to pay my bills.

I would rapidly run out of work and my board would summarily fire me, unless we can go into a restructuring mode where we will be able in the future to provide nursing care and home health care cheaper in a restructured organization, than under the current Medicare cost reports which load up all sorts of crazy costs onto my professional nurses and home health aides, which require me to charge for a nursing visit to a frail elderly person $60 -- up from $55 just a few months ago,

and for a home health aide $40 -- up from $33 or $34 -- because the Medicare cost report shows me that I'm running at a deficitual (sic) setback. With my board's blessing, we are restructuring so we can go into a new profit-pay mode, and hire nurses and home health aides, and charge less to the clients than what the Medicaid cost reports mandate us to charge at the moment. That to me is craziness, but I have to admit to that publicly, that's some of the reality in the home health business today.

Please, may I continue, and then may I conclude? I must point out that any apparent rivalry between the home health care industry and the State-supported offices on aging must be addressed. That's the turf issue that others have addressed, and I beg you to ascertain which way you wish to go. My problem is that I don't care who gets the money. I just hope that care is provided to the competent, qualified, well-recognized agency that offers the best care in a particular locality.

I can say that because I have a secret agenda. We were chosen as the CCPED manager in all of Essex County because the Office on Aging was supposed to submit a proposal. They couldn't get their act together. Then the welfare office was supposed to do that. They couldn't get their act together, so they came to us and asked us to submit a proposal, which we did. We were selected, and we've been told by the State that we run an excellent program. But in my own county, in Essex, the lack of coordination and the lack of planning, and the lack of cohesiveness is something that I don't expect the State legislators to resolve. But I, in a day-to-day battle with all the interested parties attempt to bring together, to coordinate, and avoid duplication. But competition is not to be equated with duplication. If we don't have effective competition that's going to provide a better mousetrap at a better price, don't come to me and say that I'm duplicating all

the mousetraps in my kitchen. If I can do a better service at a cheaper price, I think that's great -- that's the American way. I don't find that it's necessarily to be equated with duplication.

Last point: The State Legislature, and I believe the Office of Human Services recently negotiated an agreement with the Federal government, with HCVA, to provide the moneys for various counties throughout the State to offset past expenses that the nursing homes of the counties had encountered in their provision of services. The State Legislature, through the Human Services office, mandated that each county would get a certain dollar amount. In Essex County, the figure was $1.9 million. The mandate of Human Services was that 50% of that should be allocated back to community based services. I got eager; I got excited. Oh, I was thrilled. We are going to get some new-found dollars. When push comes to shove, of that half of $1.9 million, which say, for our purposes here, would be $950,000--

Because I went to the Office on Aging, we were asked if we would bid on a $50,000 contract for home friends. The rest of the money, for the most part, was taken by Essex County to handle some of its own financial needs -- offset property tax increases, offset other costs of the Geriatric Center that had been incurred over the past number of years. In good faith, they believed that moneys allocated back to community based programs were better served by replenishing the county coffers. I fought like hell to get more money for community based services, not for my agency. I coordinated with other home health agencies in Essex County, and to date have been unsuccessful.

So I say to the political leaders of my State be aware that when you send a dollar to the poor guy up in the north part of the State, realize that only a nickel or a dime may wind up in that agency's pocket for the services that you may have believed were going to be provided.

Concluding, we've talked about cost-effective measures. We have in Newark, in the projects, programs now that serve the frail and elderly, for which we're looking everywhere for additional funding. To provide two days a week a nurse, an MSW, and a nutritionist alternating with the MSW weekly, we provide assessment and maintenance programs to the elderly. That costs us, for the whole year, based on those two half days a week for the whole year of this one project -- Scudder Project, which is ringed with barbed wire, by the way-- That costs us maybe $11,000 and change.

We have pleaded with our people in Essex County, and we have pleaded with the peer group money people that that's a kind of a model for the frail elderly that's cheap, that's cost-effective, and that does the job of maintaining the elderly with just simple nursing assessment skills and some simple, hands-on treatment by our social worker, or our nutritionist, or the nurse for the medications, to keep that frail elderly person in their little apartment in this particular project. I, as quick as anyone else, would be interested in a cost-effective program, and interested in a quality-laden program. I would urge that this particular bill, which is on the table for discussion today is a movement in the direction of a creative partnership of interested players whose only turf are the frail and elderly that we're here privileged to serve. And whether it's the home health industry, or the homemaker, or Department of Health, or Human Services, I could care less.

But I plead with you to press on and to ask yourself, "Is the current system working?" I have my answer. You have to decide yourselves. If it's not working, then is not this a possible step forward to improving the particular situation. That's why I ask you to press on, in spite of all the doubletalk, mine included, that you may hear in further hearings. Thank you.

SENATOR PALLONE: Thank you Mr. Burns. Any questions.

SENATOR VAN WAGNER: You can come to Hudson County too.

SENATOR PALLONE: He can talk to Chris Jackman, then. He has requested the Hudson County hearing.

MR. BURNS: Thank you very much.

SENATOR PALLONE: Thank you. Joan Leonard, Discharge Planning?

J O A N L E O N A R D: I'm delighted to address you, particularly after Mr. Burns, because I've worn many hats, and my last one is as a burned-out professional. I resigned as discharge planner as of last Friday because of the absolute craziness of the health care system. As Kathleen said, homebound no longer means homebound. It means bedbound. I've had patients-- Out of my high risk patients that I pick up in the hospital, I may be able to get one out of six, Medicare home care coverage for one or two weeks. The public health agencies are in a bind, as Mr. Burns so eloquently mentioned. They're into retrospective review by Medicare. They provide the services; they pay for it up front.

SENATOR VAN WAGNER: Could you just define "retrospective review"?

MS. LEONARD: Okay, what happens is I contact-- As a patient is leaving the hospital, I would contact a public health agency, and with doctor's orders and approval, would want that patient monitored at home by the agency, with skilled care and homemaker care. The agency provides it. It gives them two hours of homemakers twice a week, and pays the bill. Medicare comes along at some later date -- six months or two years later -- and says, "Oh, you shouldn't have provided those services to that patient. She was not homebound. She had two broken arms, and she was blind, but somebody led her out to the car, and she is not homebound."

I've had an 84-year-old husband take his wife home with NG -- a nasal feeding tube. He was 84, she was 79. The

most I could ask for was two hours twice a week for a homemaker to come in and relieve him. He had no one else. I shook my head. I told everybody he'd be back in two days with his wife, which is frequently what happens because there's no home care. Much to my surprise, he left at six months. She came back in six months with a virus, and died -- not even a bedsore. Had she gone to a nursing home, I guaranteed she would have died much sooner and in worse condition. That's a successful story.

My other story is of a man doing essentially the same thing, who because he had no home care provided, he, the primary caretaker, died of a heart attack, therefore putting the wife into the institutions which we're trying to avoid. I congratulate your bill and the thrust of it. Administratively, there are a lot of problems and I recognize those. I come from a county that's unique -- to both Monmouth County. I was a nurse for MCOSS, and for Community Health Services in West Essex and Hudson. So I know of what I speak.

The poignant story of Toni McGuire-- She was one of the fortunate ones that was able to keep her mother out of the hospital. I get the ones that get dumped because the families can no longer cope. We're talking about CCPED and PCA, and all these other programs that -- thank God -- are beginning to bridge the gap that Medicare doesn't. As far as I'm concerned, Medicare doesn't even exist anymore.

But we're talking about people who have $1700 in the bank. It reminds me of a story when I was a student nurse. A very pragmatic social worker came to talk to us. I was very idealistic and starry-eyed. She said-- The thought came to me, the more things change, the more they stay the same. She said there are two groups you don't have to worry about -- the very, very poor, and the very, very rich.

Believe me, in my discharge planning, that's what I've seen. The very poor do have Medicaid, and I can provide home care and other supportive services. The rich can afford to

have it privately. It's that middle group that I think you're trying to address, that desperately need it. It seems to me a shame that somebody who's come through the Depression, has earned his keep and has been a substantial taxpayer, and has helped to make this country great, has got to be reduced to what Mrs. McGuire was. All her savings had to be depleted in order to qualify for some home care. That's really the story.

SENATOR VAN WAGNER: You know, since there is a limited audience, I can now say this without the risk of appearing to be playing to the crowd. But really what we're talking about with a bill like this, and a bill that attempts to establish a different direction -- if you will -- is really the dignity of people -- the very issue of dignity. I don't mean at all to demean those of us who have to participate in the public assistance programs that are available. As you say, "thank God we were there." Thank God we have CCPED and Medically Needy, and thank God we have some semblance of Medicare still left, and Medicaid for poor people. Absolutely, we should focus our attention on those who are less able to help themselves.

But if I could only make this comment again, the focus of this legislation, the focus of my concern is exactly the people you're talking about. The people who have worked all their lives, who have come to rely on the fact as part of being an American, and part of being in the system, they are entitled to some semblance of quality health care. And at the same time, if they wish to participate in a system of public health care, they do not have to demean themselves by hiding their assets, spending down, or otherwise making themselves paupers so that they can adhere to the regulations and thresholds in the system. That's what this bill really, hopefully, is a beginning of. I appreciate your finally putting it in such a succinct fashion.

SENATOR PALLONE: Well said. Thank you. I'm going to go down the list of speakers here. I don't know if all the

people are still here, but we will simply proceed. We have Thomas Weber, Chairman of the AARP state legislative committee.

SENATOR VAN WAGNER: Tom, would you move that mike towards you a little bit? That's it.

T H O M A S W E B E R: I'm Thomas Weber. I'm Chairman of the State Legislative Committee for the American Association of Retired Persons. I appreciate very much this opportunity to make a statement here at this hearing.

The American Association of Retired Persons appreciates very much the efforts of the Legislature to develop an extensive system of home health care services for those functionally impaired elderly who can benefit from them, which would keep them out of institutions and enable them to continue to live reasonably independent lives. Home health care is a matter of top priority with the AARP's State Legislative Committee. No coordinated statewide system of long-term care, of which home health is one significant part, exists today in any state in the nation. If New Jersey were to institute such a program for home health, it would be very much in keeping with the leadership provided by this State in legislation helping the elderly to meet more effectively the problems they face.

We think, however, that S-2132 needs extensive discussion and change before it becomes law. First of all, there needs to be some assurance that this legislation will not result in simply adding services that already exist under another agency or program. There are already a variety of services available through county offices on aging through such programs as the Community Care Program for the Elderly and Disabled, and the Medically Needy Program. Also, there is presently a bill before Congress providing for extension of the home health care benefits under Medicare. It is not an easy task for the potential consumer of these services to find the

right place to get to in order to meet his or her particular need. If partnership centers are created as an addition to what is already there, the result would be confusion for the elderly consumer, who would be faced with more difficulties about where to turn for help.

This proposed bill has generated critical comment from a number of agencies and departments which would play an important role in whatever system was established. From the consumer point of view, it is best if everybody who would be involved in its organization and administration and in its provision of services is in agreement in the first place that it meets the needs that exist. The elderly should not be victims of bureaucratic disputes. On the other hand, the systematic effort to coordinate local volunteer services would certainly be a great help in making it easier to find what is available.

We are also concerned that only medically certified home health agencies would be eligible to become partnership centers. Other agencies might equally well fulfill this role. The Department of Health should have greater flexibility in designating which agency is best able to provide these services in each county. The overall program would then be fairer to all concerned.

Finally, the AARP sees an important opportunity here. At the present time, most home health care services are available only in a limited way from Medicare; such services are covered only for those under Medicaid, the waiver program of CCPED, and the Medically Needy, all of the latter involving people with limited income. Insurance plans, too, are very limited and very expensive in this area. The use of a sliding fee schedule would be very helpful in making more people eligible for these services under fees that they could afford.

The opportunity here is to provide on a systematic basis for some broader form on continuity of care from hospital

to home. With hospital discharges coming sooner and with hospitals forced to deal in some systematic way with discharge planning, it becomes very important to make available, and to make affordable to a large number of people, a variety of services in home health that would fit into the kind of social and medical circumstances that face the elderly today.

With AARP, this legislation is still under discussion. We have no specific amendments to suggest. We support wholeheartedly the need for legislation in this area. We think also that this bill should be revised to meet the concerns that have been expressed. I should like to add, parenthetically, that for the AARP, this is kind of a first statement. We are very much interested in monitoring and noting that the progress that this bill makes and the changes that occur in it, and we may want to make a further statement at a later time. Thank you.

SENATOR PALLONE: Thank you, Mr. Weber. You mentioned private insurance, and I guess you're the first person to touch on that. I hadn't heard any comment about to what extent private insurance or group insurance plans cover home health care.

MR. WEBER: I don't have any figures on that, Senator. It's just my impression that it only is limited in availability, and it's very expensive, especially for the elderly. It would be better for a young person to buy that kind of insurance at this point, where the premiums would be spread over much more of his life. But it doesn't play a very important role at the present time.

SENATOR VAN WAGNER: The private insurance industry, even under some of the new policies that it's presently writing, has not become totally cognizant of home health care as a alternative. Part of the problem-- And I don't mean to be repetitive in saying this, but I have to say it-- Part of the problem is the issue of home health care, the issue of

caring for someone in their home as an alternative to the system of care that we have now, has not been clearly defined. It has instead been tied up and mixed up in issues revolving around some of the concerns expressed today -- who's going to pay; who's going to administer; who's eligible? Is it Medicare, Medicaid, CCPED? Is it Medically Needy? That accounts for a certain percentage of people who in fact might be eligible. But in terms of looking at it as a viable, health care alternative in society today, no one, whether it's the insurance industry or legislators, or other officials involved in this concern other than professionals, care providers, and people who are affected by it-- No one has really been able to define and clearly delineate the difference between meeting the concept of home health care under the programs that are now available, and establishing a new kind of system of health care delivery.

That's what I'm trying to do here. I'm trying to establish, if you will, another direction and say, "Okay, we appear to be failed by some of the systems that have been set up to care for the frail elderly people." Medicare -- You know, it's been documented, I don't know how many times, of what's happening there? CCPED? You heard it has a limitation. You have to be at risk for nursing home placement. Okay, Medically Needy assistance? Spend down provision. Medicaid? Spend down provision. So in all those areas, as laudable as they are, there are severe restrictions involved with people -- particularly people who have taken care of their retirement, let's say, and do have an income above what Social Security, basic retirement, and pension benefits may provide, but not an income that is so high that they could address any long-term chronic illness that might come about. These individuals, of which there are many, are not eligible for any of the things that we've just talked about, unless they are willing to impoverish themselves in order to become eligible.

MR. WEBER: I think the AARP is very much in accord with the objectives which you have so clearly stated.

SENATOR VAN WAGNER: Thank you.

SENATOR PALLONE: Thank you, Mr. Weber. Our next speaker on the list is Joseph Riordan, consultant with the Home Health-- Oh, we had him already.

J O S E P H R I O R D A N: No, I only tried to fix the machine.

SENATOR PALLONE: You assisted us with the TV.

MR. RIORDAN: To make you aware of what my function is as the consultant of the Home Health Agency Assembly of New Jersey, the Agency received a small grant, and was asked to put a couple of senior citizens in the field to try to bring the message of health care to the senior population. We do this by going out to speak at seniors' meetings, and try to make them more aware of what the real problems are in the health care system. Now I will proceed with my testimony, and say that there's probably not a word in here that hasn't been said at least four times before. But thank you for allowing me to testify on S-2132.

My name is Joseph Riordan. I'm a resident of East Windsor in Mercer County. During the past 10 years I have been involved in many areas of civic and governmental matters. My activities included the State Chairmanship of New Jersey Common Cause, membership on my township planning board, current membership on the East Windsor Township Economic Development Committee and the Utilities Authority, member of the advisory boards and a volunteer paralegal for the Mercer County Legal Services for the Elderly. My business career prior to retirement in 1983 included a long period in management both as an Industrial Engineer and Plant Manager. This was followed by 10 years in classified State Civil Service in the Department of Labor. My last assignment was as a referee in the Wage Collection Section. Of all these activities, those of prime

concern to me at this time are the legal aspects of health needs of older Americans. It is because of this that I want to address to you my support of S-2132.

All of us surely feels that every person in the United States is entitled to decent health care. Providing this care is a problem that is reaching crisis proportions at this time. Persons who have adequate resources may be able to buy Medi-gap insurance to meet most situations. Those in the very lowest income groups qualify for Medicaid. In between are the largest group -- those people on Social Security and having some pension or other income which allows them to maintain a fairly decent standard of living.

My problem with this group is that many of them have their head in the sand. They feel that with Medicare and perhaps some health insurance provided by past employers, they are covered in the event of a major medical situation. Little do they seem to realize that very little provision exists for the payment of nursing home care and many aspects of home health care.

S-2132 starts to address some of these problems in a way that particularly pleases me. Remember, I'm not a health care professional. It brings together all the players involved in really developing some solutions to meeting the seemingly ever-increasing costs of health care. The important components are that the State Department of Health, or whoever, will have direct control of funding with the requirement that:

A) A Partnership Advisory Committee be established by selecting representatives from business, labor, religious and civic organizations with specific responsibilities. Partnerships would probably bring some new thinking to health care needs.

B) County offices on aging would have a specific role in fiscal oversight, outreach and community education, providing volunteer service and coordinating community

services. This would involve an expansion of some existing functions.

C) The Partnership Center itself would be involved in intake, establishing protocol, assignments to other certified home health and homemaker agencies who would provide required services and case management.

D) Business and labor would have a place because they are in many instances the groups who are very directly involved in meeting obligations to their employees, both active and retired. They are very much concerned with the increases in these costs, particularly since they are unfunded obligations which are creating a draw on their assets. If they see that this Partnership Act might address in some part their problem, they might very well participate by underwriting a volunteer coordinator; providing space or equipment, or making direct contributions to the Partnership.

E) Family involvement: One of the problems that families as care providers face is the feeling of futility. Not knowing where to go, or what to do when trying to make decisions about loved ones. The presence of a Partnership Center in their area gives them a resource which may very well resolve their problems. At least, they would have someone to talk with.

The other aspect of this Partnership Act that really impresses me is the provision for co-payment. All the existing programs that I am aware of have definite cut-off points, i.e., PAAD and Medicaid. If you meet the requirement, you're in. If not, there is no consideration and you perhaps see the breakdown of such systems because of some measures of chicanery on the part of people seeking to qualify. There is no doubt that people of varying incomes have varying abilities to pay. I believe that most people are willing to assume their responsibilities in this respect. I have a strong personal feeling that one of the practices that created abuses in the

health care field was the coverage that provided "first dollar" payment. This, as you know, has now become apparent to many groups that include health coverage in their benefits package, and they are attempting to correct it.

I sincerely believe that passage of S-2132 would have a favorable direct effect on the delivery of overall health care in our State. There is a potential for addressing the situation which is currently of great concern to some seniors and their families. The State of New Jersey has for a long time been in the forefront of providing innovative means for handling problems. I ask that you give favorable consideration to this bill and release it from committee. Thank you. I would ask anybody here-- I'm not hustling this book, but the book that Joseph Califano wrote, "The Health Care Revolution: Who Lives, Who Dies, Who Pays," is recommended reading for anybody who's concerned with the health care problems of this country. Thank you very much, Senator.

SENATOR VAN WAGNER: Thank you.

SENATOR PALLONE: Thank you. Any questions?

SENATOR VAN WAGNER: No.

SENATOR PALLONE: The next person is Bonnie Scott, Chairperson of the Public Affairs Committee, New Jersey League for Nursing.

UNIDENTIFIED SPEAKER FROM AUDIENCE: May I say something, Senator? Would it be appropriate for me to say anything? Should I say something, or would you rather I didn't?

SENATOR PALLONE: Well, we're going in order. What do you want to say?

UNIDENTIFIED SPEAKER FROM AUDIENCE: Well, I think that many of the obstacles that I've heard today--

SENATOR PALLONE: If you're going to give us a speech, you're going to have to wait.

UNIDENTIFIED SPEAKER FROM AUDIENCE: --could be addressed in the bill if we keep in mind the problem that we're

trying to solve. For instance, the problem of non-duplication of existing benefits--

SENATOR PALLONE: We'd better just continue on. If you want to help us later, or give us some advice, we'll do that later.

UNIDENTIFIED SPEAKER FROM AUDIENCE: All right.

SENATOR PALLONE: Thank you.

B O N N I E S C O T T: I'd like to thank the Committee, and Senator Pallone and Senator Van Wagner for giving us this opportunity to testify. It's been a long day. Most of our concerns have been addressed, so I'll just go over them rather quickly.

First of all, the New Jersey League for Nursing is an organization that is not only comprised of all nurses, going from LPN to RNs, but also consumers of nursing care and health care. We have a rather unique perspective in that. That's part of where our concerns come from. We did review the legislation and want to applaud Senator Van Wagner for taking the lead in this area, that we heard today is so needed.

A few areas are:

1) The duplication issue. We hope to see that addressed so that we wouldn't be duplicating services, but providing for those areas where we need new services.

2) It is restricted to the 50 certified agencies. I think we've heard that addressed today too. Maybe that should be not so restrictive, and that we should be able to have agencies with the best ability to do that. We've heard from a couple of counties in the State, but we're a State where our counties are very diverse. What works in one area may not work the best that way in another area. That flexibility of freedom should be there.

3) The issue of the Department of Health, which is basically administrative, or an insurance of quality control as opposed to administering programs, has already been brought up and was addressed.

4) In the bill -- or perhaps we missed it -- there's no standardization of control and how these moneys are being spent -- if they're being simply funneled through these 50 agencies -- was one of our concerns. So that we can be assured again that a lot of this money doesn't get spent setting up another administrative kind of thing, but actually gets spent on services.

On the whole, we think this is a very needed kind of thing. We're very much in support it. We would just like to see these issues addressed so that we can do what we really intend to do, which is serve all of these people, and don't somehow get all mixed up, and a lot of money gets tied up, spent administratively, and just doesn't get to where we want it to go. Thank you.

SENATOR PALLONE: Thank you very much. Tex Perry? Is there a Tex Perry? He must have left. Linda Coffee? George Coply, Middlesex County Office on Aging? Alexander Couster, New Jersey Federation of Senior Citizens? Sir, your name is Nick Alexander?

N I C K A L E X A N D E R: Yes.

SENATOR PALLONE: Okay, Nick Alexander, President of New Jersey Federation of Senior Citizens.

MR. ALEXANDER: Thank you. I thought you almost forgot me.

How does one rise in opposition to a bill which will improve community care for the elderly? Well, I'm not in total opposition, as we shall see.

My first concern is how will this bill improve the standard of living for the senior citizen? There are few challenges to the fact that the Home and Community Care Partnership Act is a needed piece of legislation to extend community based services to elderly persons whom impairments prevent them from living independently.

My second concern is in the mechanics of the bill, and procedures for dispensing funds and services to the intended recipient. Past experience has proven that when pending legislation does not include as partners in the planning stage representatives of senior groups -- other participants concerned in senior citizen service -- the usual result is denial of service, duplication of services, duplication of cost, and jurisdictional conflicts. This bill as written poses problems in all of these areas.

My third concern is that under the Older Americans Act Title III, $7 million is provided for home and community based services. The county offices on aging are mandated to plan and coordinate services for the aged under this Act. Somewhere along the line, I get the feeling that we are bordering on a conflict of interest here.

My fourth concern is for the cost of this legislation as it pertains to the actual gains to the elderly. This legislation provides for an $11 million appropriation. When the Legislature is not willing to fund existing agencies, one can come to a quick conclusion that the motivating interest is the creation of a new bureaucracy rather than concern for the elderly.

My fifth concern is the limited eligibility provided in this legislation for home health service agencies. With the infamous impact of DRG, "Diagnostic Related Groups," on the elderly population, there will be a greater need for local home health social service agencies. This legislation has not fully addressed itself to the need for an expansion of eligible agencies as Home Health and Community Care Partners.

In conclusion, this legislation will improve community care for the elderly. My objection is to the administration of this legislation. It seems to follow a predetermined pattern: create a bureaucracy, duplicate services and cost, and failure to utilize existing facilities and agencies. Thank you.

SENATOR PALLONE: Thank you very much. I have no further questions at this time, but thank you for coming, and I'm sorry you had to wait so long.

MR. ALEXANDER: Oh, you intended that.

SENATOR PALLONE: No, no.

MR. ALEXANDER: Now, all kidding aside, it's a good bill, if that bill were refined. You heard more of it from other people than you did from me, but it needs to be addressed too.

SENATOR PALLONE: That's what we're going to do. That's why we're having a hearing. I appreciate your input. Mrs. Stella Lassworth, Broward Homebound Program? Mary Lou Cronin, CCP Program of Atlantic City, or Atlantic County? Okay, I guess they left. Is there anyone else here who would like to address the Committee? (no response) Okay, I guess a lot of these people had to leave.

I just want to take this opportunity again to thank everybody who came here today. I know it was a long day. We didn't have lunch; we didn't stop for anything. Particularly let me-- I didn't mention the OLS recorders, Mary Jane Zimpleman and Don Gephart. I appreciate your coming.

We are, as I mentioned, going to have a second hearing in Hudson County which was requested by Senator Jackman. We haven't set the date yet, but it will be within the next month. We also will take into consideration the request that Senator Van Wagner made, that we have a working group of some of the different organizations to work on the bill, and we'll get back to you on that. With that, I'm going to conclude the day. I think it was an excellent hearing.

(HEARING CONCLUDED)