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

before

ASSEMBLY HEALTH AND HUMAN RESOURCES COMMITTEE

To examine the Medicaid and Medicare programs
from the perspectives of recipients and providers

November 17, 1986
Room 341
State House Annex
Trenton, New Jersey

MEMBERS OF MEETING PRESENT:

Assemblyman Harold L. Colburn, Chairman
Assemblyman Rodney P. Frelinghuysen
Assemblyman George J. Otlowski

ALSO PRESENT:

David Price
Office of Legislative Services
Aide, Assembly Health and
Human Resources Committee

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New Jersey State Legislature
ASSEMBLY HEALTH AND HUMAN
RESOURCES COMMITTEE
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October 21, 1986

NOTICE OF A PUBLIC HEARING

THE ASSEMBLY HEALTH AND HUMAN RESOURCES COMMITTEE ANNOUNCES A PUBLIC HEARING TO EXAMINE THE MEDICAID AND MEDICARE PROGRAMS FROM THE PERSPECTIVES OF RECIPIENTS AND PROVIDERS.

Monday, November 17, 1986
Beginning at 10:30 A.M.
Room 341 of the State House Annex
Trenton, New Jersey

The Assembly Health and Human Resources Committee will hold a public hearing on Monday, November 17, 1986, beginning at 10:30 A.M., in Room 341 of the State House Annex, Trenton, New Jersey, to receive testimony on the performance of the Medicaid and Medicare programs from program recipients and participating health care providers for the purpose of considering the impact of these programs on the delivery of health care.

Address any questions or requests to testify to David Price, Committee Aide (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 to each witness.

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ASSEMBLYMAN HAROLD L. COLBURN, (Chairman): Good morning. If we can have your attention now, we're going to get started. If you'd like to talk about something, please go out in the hall. There are just too many of us and too few seats, I'm afraid. I'm Harold Colburn and I am Chairman of the Health and Human Resources Committee of the Assembly. We have with us Mr. Frelinghuysen, who's an Assemblyman, and we're hoping that George Otlowski will arrive. He told me the other day that he will be here. Mr. Deverin can't be here, and Mr. Felice had car trouble this morning, so we don't know if that will get fixed in time for him to get here. I hope so.

In addition to the Assemblypeople, we also have very capable aides. We have David Price, who's the nonpartisan aide from the Office of Legislative Services, and we have Mary Messenger, who is a Democratic aide, and we have John Kohler, who's the Republican aide, and Donna Bahnck, who may come later. She's at another meeting right now.

I think you all know by the announcement that the purpose of the meeting today is for the Committee to gather information on the question of how Medicare and Medicaid are working in the State of New Jersey. We're not here to really consider specific bills at this point. We're at an information gathering position and this is an important part of our information gathering. I expect there will be more. There will be people that can't testify today or couldn't be here, and we will be taking information from them, too.

We have a list of people who have asked to speak. I think we stopped counting at about 27, 28, or 29, and that's really all we can handle in a day. So, anybody else -- unless we have major absences or something -- anybody else who has signed one of these things, we'll be glad to read your name, then it will go in the record, and if you have some written testimony within a month, send it to us because we'll include it in our considerations.

Also, if any of you would like to receive -- and Dave Price might kill me for this -- if any of you want to receive notices of the meetings that the Health and Human Resources Committee has or the hearings, I'm going to ask you to just write it out on one of those slips. We have paper up here. Give it to David and he will mail you a notice of the things that we do in this Committee; that is, the bills we're going to consider and also the hearings that we have. The next hearing that we're going to have is on health planning and it's going to be on December 4. That has to do chiefly with the fact that the Federal government is stopping its support of health planning and the State has to decide whether that should be continued either in its present form or in a modified form.

Now I think all of us by the experiences that we've had, have gotten some idea what we think of Medicare and Medicaid. Of course I have my feelings and you have yours, and there are a lot of different feelings represented in this room. So, I know that we're all going to behave, at least for the day, humanely towards each other. We want to be fair, and I'm asking you to kind of keep your temper, because I'm going to try to keep mine and our purpose again is to get information. The hearing record will be left open for a month. Any of you who want to submit further information or experiences or whatever you want, please, just send those in if you don't get a chance to voice them today.

I don't think that you will be hearing a lot from the Assembly members as to how they feel about things, because we're still again in the learning phase. The first witness today is Dr. Altman, who is the Commissioner of the Department of Human Services. Dr. Altman, would you like to come up here? They just told me when I tried to use it a minute ago (referring to mike), that that is used for recording. It doesn't help anybody who's trying to hear you.

COMMISSIONER DREW E. ALTMAN: Okay. Well, good morning. Thank you for inviting me. It's good to see you all, and at such close range this morning. With me is Alan Wheeler, who you may know. He is the Deputy Director of the Medicaid Division of Medical Assistance and Health Services. He may assist me in some of your follow-up questions. I have submitted for your record a more detailed statement. What I'd like to do here this morning is to summarize some of the high points that I think are particularly important.

As you know, my Department is responsible for administering the Medicaid program and as you may know, improving Medicaid is one of my top priorities. In fact, there is probably no issue I have been more concerned with throughout my entire professional career. Over a period of time through a number of steps, I think you will see us trying to make a noticeable shift, philosophically in the Medicaid program moving it from a program which serves primarily as a reimbursement mechanism that pays the bills, to a program which attempts as well to serve as a catalyst or a shaping force in the development of a more effective health care system, certainly for the clients we're responsible for serving through Medicaid.

I will be happy to discuss with you at some future time or in the questions period, later, my broader plans for Medicaid or any issue that relates to my responsibility that you are concerned with. But today, in what I hope will be rather brief testimony, I'd like to focus on just one issue and make really just one point; and that issue is the problem of low levels of reimbursement for medical professionals of different kinds who serve Medicaid clients.

Let me start by saying, and this is something that I have believed for a long time, that in my view the Medicaid program is one of our successful programs, I would submit,

perhaps, the most successful program to come out of that group of programs first launched in the mid-1960s. I think it is important that we protect it and important that we improve it in every way we can. As a matter of fact, today in this country and in New Jersey, poor people now see a doctor and go to a hospital at least as often as the non-poor. That is a truly significant accomplishment and it is due primarily almost entirely to the good efforts of the Medicaid program since its inception.

It is also the case that Medicaid serves sicker people. The poor are sicker. The levels of chronic illness is two to ten times greater than the general population and it does cost about the same as, and in some instances is less expensive than -- popular preconceptions to the contrary notwithstanding -- private insurance. And lastly I would say, because I think it's important to keep in context what this program is all about, that this is a program that serves some of our most needy and some of our most vulnerable groups. It serves three groups: it serves low income mothers and childrn, it serves the blind and the disabled, and it serves the low income elderly, the poor elderly in our State. So, it's not just one program -- Medicaid, but it's really three programs in one, and each one of them serves a very vulnerable group that I think we all have to be extremely concerned about.

Having said all of that in a positive way, I would also be the first to want to add that without question our Medicaid program also faces some problems. For one thing, despite the fact that it is sometimes regarded publically as a comprehensive insurance program for poor people, it is not that. Medicaid around the country and in New Jersey covers only about half the poor and the near-poor, so there's a significant group not covered by the Medicaid program. And in some areas, despite the success I mentioned a moment ago, Medicaid's effectiveness is either slipping or is in danger of slipping. We think a prime culprit here in New Jersey are

low rates of reimbursement for medical professionals, not just for physicians, but others as well. We believe that they have caused Medicaid recipients to delay needed care and we're absolutely certain that they have resulted in increased use of costly and I would submit in some instances, less effective hospital emergency rooms and outpatient departments.

Let me give you just a couple of examples of how our rates really are. Today we pay seven or nine dollars for a general office visit. That compares with $35 as a rule through private insurance -- $22 under the Medicare program in New Jersey. We pay seven and half bucks, and nine bucks for tooth fillings and extraction -- dentists are important. In fact, often the care by dentists is even more dramatic than physicians; I'll talk about that in a minute -- versus $40 for those same items through private insurance. Five dollars for eyeglass frames which are certainly unpopular and I would venture in some instances to say substandard as well. I think most discussed of all -- $236 for obstetrical services versus $1500 to $2000 -- I wish I could have found it for $2000 two months ago when we had our first child -- in the private sector as well.

So that gives you a feeling for the disparity in the rates. What does all this mean and why is it a problem? I'd like to be blunt today to make my point. I'm not at all concerned about physicians in our State or in our society. I think after our health care system which is changing rapidly shakes out-- Granted they're being buffeted about in a changing system, they will do fine. And I think they will continue to enjoy high standing in our society, which is exactly as it should be. So, I'm not really concerned about physicians in testifying today about low rates. I'm concerned about access to care for the groups and I'm also concerned that we meet our responsibility that Medicaid gets the best buy for its dollar, that we use our Medicaid resources as

cost-effectively as possible, and the data that I look at gives me concerns on both of these fronts. For starters, we know that some parts of our State our low rate of payment for OB services, for obstetrical services, has resulted in the denial of prenatal care to low income women. We hear report after report that it is difficult or impossible in some areas to get obstetrical care.

We know that our already low physician participation rates, the number of physicians who serve Medicaid clients, are declining further. As a matter of fact, today about one in five physicians in New Jersey serve Medicaid clients at all and many of those don't serve a great many. And in each of the last six years that number has dropped. In fact, the total number of physician visits has declined about 20% under the Medicaid program in the last six years, numbers of which I think tell a lot of the story for me.

While total health spending has gone up in recent years in New Jersey and around the country, with the position component in the last couple years being the fastest rising, our expenditures in New Jersey for physician services in Medicaid at the same time and in sharp contrast have actually gone down from $62.6 million in FY '81 to $52 million in FY '86. So in sharp contrast to everything else going up, our payments for physicians under Medicaid have gone down. And that compares to annual increases in the last couple of years for the physician component of Medicare of 20%, 25%. So it really is in sharp contrast to what is happening in the rest of the health care system.

And lastly I would say though I suspect that patients are delaying needed care because of this problem, we know for sure that they are being driven to higher cost care when they do receive the services they need, because while our physician visits and expenditures are down, as I just described, our outpatients and our emergency visits are up by $100,000 over the last four years. And we know as well that on average, care

in an ER or in an OPD hospital base, care is about six times as expensive as primary care delivered in a physician's office. So much so, that you can think of it this way: If the increase in hospital base care over the last couple of years had gone to physicians' offices instead, we would have saved as a Medicaid program some $6 million last year alone.

As I mentioned before, I would submit that in some instances -- and you can judge as well -- care in emergency rooms certainly and in some outpatient departments is less effective than in a physician's office. I think it is undeniably the case that most of our ERs and many of our OPDs are not well set up to serve as family doctors or as personal physicians in quite the same way as a primary care physician -- a family practitioner -- may be.

So, that's really what I came here to say. As you mentioned, your interest today is largely in fact-finding. I would close by saying to you that although I intend to promote about as diligently as anyone can, more cost-effective delivery systems, I doubt that there is anyone in this room who is a stronger advocate of developing case management and group practice and prepaid options for Medicaid recipients.

It is crystal clear to me that we will always need to have a viable fee for service system. As I look at New Jersey's health care system for the Medicaid system, for the Medicaid patients, and for the Medicaid clients, we have to take some steps to make sure that it's a viable and meaningful fee for service system.

So, in closing I would urge the Committee to recognize that our fee structure under Medicaid across-the-board, not just physicians', deserves close attention and we would like to work with you over the coming months and over the coming years to try and improve that fee structure in the future. With that -- I ran on, I will apologize, longer than I had hoped. We will answer any questions related to that or anything else you have for us today.

ASSEMBLYMAN COLBURN: We certainly appreciate your comments. Mr. Frelinghuysen, do you have a question or two?

ASSEMBLYMAN FRELINGHUYSEN: Not at the moment.

ASSEMBLYMAN COLBURN: One thing that I wondered about in the new Medically Needy Program-- Someone did come to see me the other day that seemed to me ought to be in that, and apparently, it sounds like there was almost a quota system for how many people could be handled to sign up under that right now. Is there a problem with that program?

COMMISSIONER ALTMAN: I can't speak to the individual case and there's no quota system. Yes, the program is not working as effectively as I'd like it to work in two respects: It is an expensive program to administer, and it is not serving the large numbers of people that everybody hoped it would serve. We are working hard on that. I hope that we will be in a position to come forward with some recommendations in the very, very near future.

ASSEMBLYMAN COLBURN: You know, when we passed that, I really thought that it would probably just be tacked onto Medicaid the way it was. It needed a whole new set of rules or methods or something?

COMMISSIONER ALTMAN: As the program is currently designed, there are a number of features that require that-- Most important is managing a spend down process. You know that's the way the program works. I hope that we'll be able to streamline and improve the program.

ASSEMBLYMAN COLBURN: Because I think there really are some people that are kind of in desperate straits right now that aren't getting the advantage of that. Okay, well listen, thanks a lot. If you can stay around, if there's a chair left for you, feel free, otherwise go back and do your work. (laughter)

COMMISSIONER ALTMAN: Good to see you. Thank you.

ASSEMBLYMAN COLBURN: Thank you. The Department of

Health will not be heard today, so we're going to move on to Edith Edelson of the New Jersey Federation of Senior Citizens. Good morning.

E D I T H E D E L S O N: Good morning, Chairman.

ASSEMBLYMAN COLBURN: Please have a seat. Unfortunately this darn microphone doesn't magnify your voice. So everybody, please keep quiet. Sorry about that.

MS. EDELSON: Dr. Colburn, Mr. Frelinghuysen, and members of the--

ASSEMBLYMAN COLBURN: That one is allowed to speak back there. That's okay. (referring to crying baby) I didn't realize we had a young one there.

MS. EDELSON: (laughs) --and members of the Health and Human Resources Committee. I'm Edith Edelson, Chairperson of the Health/Welfare Task Force of the New Jersey Federation of Senior Citizens. We appreciate the opportunity to bring to your attention some important aspects of the Medically Needy Program.

This program provides a list of services under Medicaid to certain persons whose income is above the Medicaid guideline but who cannot afford to pay for their necessary health care. It was estimated that it would cover 100,000 persons 65-years-old and older and blind and disabled people, 100,000 children, and 3000 pregnant woman.

After an extended period of preparation in setting up the administration of the program, the program became available to the public on July 1 of this year. It is now almost six months later, and what do we find? As of November 3, 2603 persons are actively eligible for the program, or one percent of the estimated 203,000 persons. For seniors and the blind and disabled, 545 persons or a half of one percent of the estimated 100,000 eligibles have been accepted for the program. At that rate, we'll never reach the estimated number in the budget allocation of $23.5 million for Fiscal Year 1987.

The income eligibility guideline as mandated by Federal law is $333 a month for one person and $416 for two people in the case of the elderly. In the case of the elderly, blind, and disabled person, this guideline is $34 dollar a month lower for one persons than the $367 guideline under SSI and Medicaid. There's a similar drop for a couple. And let us remember that the SSI guideline is itself below the Federal poverty level of $447 a month for an individual and $603 a month for two people.

Why are so few seniors and disabled persons eligible for this program? There is a provision in the Medically Needy law to cover people whose income is above this low $333 and $416 level. If they can incur medical expenses that will bring their income down to this level, they then can be covered by the Medically Needy Program. Thus, a person whose income is $447 a month -- the Federal poverty level, mind you -- they would have to incur medical expenses of $144 a month before becoming eligible for the Medically Needy Program. Let's just think about it. What are the seniors and the disabled who campaigned for this law for 10 years getting out of it?

And yet, there are so many people whose health desperately needs medical attention, so many people who cannot get it before they run into acute illness and have to be admitted either into the emergency room or an inpatient room in a hospital. Not only do they suffer, but the State and Federal governments also lose out because of the higher hospital and emergency room costs.

In passing the law, the State Legislature and the Administration saw the need for private health care for these people, and they appropriated money for it. The job that remains now is to find ways to really help these people in need.

Obviously, we need a Medicaid waiver from the Federal government to increase the income and asset guidelines to a more realistic level to do what the State law says we want to do.

Here I might point out that OBRA recently enacted gives the states the power to provide Medicaid to the pregnant women, to children up to the age of five, and to the elderly and the disabled, all of whom have an income up to the Federal poverty level. That is a humane approach which we hope New Jersey will fully implement. While this will take care of some of the people who were rejected from the Medically Needy program, it does not detract from the importance of a Medically Needy Program, since people with an income of even one dollar above this poverty level, would not come under the provisions of OBRA. Thus the Medically Needy Program is vital, and a waiver is vital.

Furthermore, the Medically Needy law should be amended to include the caretakers of the eligible children. A sick parent cannot adequately meet the needs of their child. We ask you to put some realism into the provisions of care for the medically needy.

We also ask that the medically needy provision for the elderly and the disabled be funded by the General Fund instead of the Casino Revenue Fund as at present. The Casino Fund can barely cover the current assistance programs for the elderly and the disabled. There is no reason why assistance for these people cannot come out of the General Fund the way other programs do. Thank you.

ASSEMBLYMAN COLBURN: Thank you. As usual, it's obvious that you've done your homework. I've heard you speak before. Is there a person from the Department of Human Services still here -- the assistant to Dr. Altman, by any chance? (negative response) No? Because I thought some of the things you're asking ought to be addressed by him. I don't know how much flexibility there is in either our own law or the Federal law, you know, to overcome these things. But obviously we have to address them. Mr. Frelinghuysen, do you have any questions at this point?

ASSEMBLYMAN FRELINGHUYSEN: We noted your comment in the last paragraph about casino revenues.

MS. EDELSON: Thank you.

ASSEMBLYMAN COLBURN: He's on the Appropriations Committee.

MS. EDELSON: Thank you.

ASSEMBLYMAN COLBURN: Thanks a lot. We certainly appreciate your coming. That's bears out what I observed in my office the other day. Now, Vincent Maressa, representing the Medical Society. He is the Executive Director of the State Medical Society. Good morning to you.

V I N C E N T A. M A R E S S A: Mr. Chairman, members of the Committee, and staff; I am Vincent Maressa, Executive Director of the Medical Society of New Jersey and I am speaking today on behalf of the Medical Society of New Jersey and also the New Jersey State Society of Anesthesiologists.

Medicare and Medicaid are two very different Federal health programs. Medicare applies to all persons over age 65 and certain persons under age 65 who are disabled. It is essentially an insurance indemnity type of program. All persons meeting the age requirement are covered. All persons meeting the disability requirement are covered regardless of their personal standing or their assets, income, health, or any other circumstances. The elderly living on Social Security and nothing else have the same entitlement under Medicare as does the elderly who is the captain of industry with a global corporate empire and a multimillion dollar annual income. Medicare which is funded through various taxes, also includes deductibles and co-payments. For the last six years the Congress, in an effort to control the cost of this program, has begun a scheduled curtailment of benefits and has increased the areas and amounts of patient liability. Medicare is best defined as a limited benefit program.

Medicaid which is jointly funded by the State and Federal governments is a full service program. It covers our most economically deprived citizens. There are no deductibles or co-pays. There are very few exclusions.

While both programs have socially and politically accepted goals, they have not lived up to their promise which was made in the 1960s to move the elderly and the poor into the mainstream of health care and to do away with and prevent a bi-level or tri-level system of care and payment.

Medicaid in its treatment of physician services in our State is an embarrassment. We are faced with a fee schedule essentially as it was adopted in 1970. Doctors are paid seven to nine dollars for office visits while the same patient going to a hospital outpatient department will generate a payment that averages more than $70 for the same service. The Medicaid Services budget exceeds $1 billion annually. Of that amount, a maximum in the previous fiscal year of $60 million, at best, have been paid to physicians for all types of services, from office care to neurosurgery to heart surgery. Recently the Administration has advanced special programs to care for the pregnant poor. One of the reasons that effort is necessary is that Medicaid reimbursement for obstetrical care is pitiful. A physician receives from Medicaid $247 for a routine vaginal delivery. The average fee statewide for private patients for that same type of service is at least $1400. In this situation, a doctor would have to deliver about 120 babies annually simply to pay medical malpractice insurance premiums and meet no other expenses.

The result of inappropriate and insufficient payment where doctors do not receive their usual fees and are precluded from billing for the balance, is lack of access. Ten percent of the physicians under Medicaid provide about 90% of the care. The balance of the medical community for very sound reasons, avoids becoming involved.

Medicare which started out in a better position than Medicaid has been the victim of poor planning, faulty design, underestimation, actuarial miscalculation, and poor management. Obviously, these factors are not easily corrected. That Congress and its advisors underestimated the number of senior citizens, their life span, and the care they might require is understandable. That Congress did not, for example, realize that offering in-stage renal disease services under Medicare would be expensive, is not as benign a mistake. They were warned about that and several other errors. That Congress tilted reimbursement to institutional care and then became alarmed at the bill, is not at all consoling. Several years ago, when confronted by a shortfall in the Hospital Part A Trust Fund, Congress removed some $12 billion from the Part B where the Phyiscian Services and Professional Services Trust is, and transferred it to Part A. Congress has not replaced the transferred monies.

In the past six years, congressional efforts at cost containment have forced elderly patients out of hospitals before they are completely recovered, by the implementation of the DRG and PRO systems. In 1984 physician fees were frozen at 1982 approved levels. Medicare does not in effect pay the stipulated rate of the 75th percentile, but probably about the 65th percentile. Claims processing by the Medicare carriers have become a nightmare. The same service by a different physician produces a different rate. Because of the vagaries of the program, the most experienced physicians are receiving the lowest reimbursement. The same physician will receive different amounts for the same services. Payments are inordinately delayed and the program is in disarray.

On October 1, 1986, Senator Bradley wrote to the Medical Society about some of the shortcomings of the program. I have supplied you with a copy of his letter, but would like to quote a portion for the record today.

Senator Bradley's words are as follows: "Recently, however, the Health Care Financing Authority has increased delays in processing claims to an intolerable degree by directing all Medicare contractors to deliberately delay processing claims. This policy has resulted in an 88% increase in the number of unpaid Medicare claims, and has reduced the actual payment cycle in many cases to 45 days or more.

"I believe these policies have caused undue hardship to thousands of Medicare beneficiaries by lengthening the waiting period for claims payment. In addition, these delays have discouraged many physicians from participating in the Medicare program, thereby, reducing the quality and convenience of service to all Medicare beneficiaries and providers."

Senator Bradley's comments relate only to a single defect in a very large and severely stretched program. He does, however, make a telling point. If the program functioned well, doctors would want to participate in it. Mandatory assignment is not the answer to fixing the defects of the program. Reason, judgment, incentives, and common sense, applied after careful analysis, are what will correct the situation. Medicare is a Federal program. Its correction is the responsibility of the Congress.

Mandatory assignment based upon licensure is a poor idea. It is not a valid licensure criteria, and would among all other factors, result in our State government abdicating to the Federal government licensing and regulation of health professionals. Under the best of circumstances, it will produce another Medicaid scenario, with very few physicians participating. The result could be disastrous, particularly in specialties like anesthesia. The anesthesiologist cannot pick and choose his or her patients. They are required to serve all those patients that are in need of their services. If he or she cannot bill their regular fees to those that can pay, and

if Medicaid continues paying 30% of the regular rate and Medicare 65%, there will be no alternative but to leave New Jersey or to avoid it at the outset.

In conclusion, I can assure you that we are willing to work with you on programs which ensure that the economically disadvantaged receive necessary care and that reasonable fees are charged to those with the ability to pay. If you or the Committee has any questions, I'd be happy to make an effort to respond.

ASSEMBLYMAN COLBURN: Thank you. Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: Yes, Mr. Chairman. Mr. Maressa, on page three, could you further elaborate on that portion that says, "Several years ago, when confronted by" and I quote, "by a shortfall in the Hospital Part A Trust Fund," et al? Could you explain exactly what those trust funds are and their solvency?

MR. MARESSA: Yeah, well just one question. Are you an attorney?

ASSEMBLYMAN FRELINGHUYSEN: I'm not, but I'd like to, maybe for the record, have a better explanation.

MR. MARESSA: All right. For the record, let me explain that if an attorney dealing with trust funds mixes the funds of a client with another or uses them for another purpose, he or she has committed a violation under the rules of court and would likely be disbarred or at least suspended. A number of years ago, the Medicare Hospital Trust Fund -- I believe it was about Fiscal '82 -- ran into severe financial difficulty. At that point the U.S. Congress took the monies that had been paid into a separate trust fund known as the Part B Trust Fund, because it had at that time an invested surplus. It transferred $12 billion of that invested surplus into the Part A Fund, in order to make payments to hospitals under the Part A Program. It never replaced the $12 billion it transferred out, and essentially what you are seeing today is

under Medicare, the government -- in order to make up with the completion of the reserve, the government decided that to hold the lid it had to freeze physicians' fees, and increase co-payments and deductibles and provide for a greater number of noncovered services, to make up for the shortfall that had been produced with the transfer. And it is indeed a documented fact.

ASSEMBLYMAN FRELINGHUYSEN: I just had one other question, through you. Relative to some of Senator Bradley's comments, this letter you drew from, is it your estimation that the deliberate slowdown in the processing of paperwork is just to capitalize on the funds that are there and use them for other purposes?

MR. MARESSA: Well, it does two things. If you hold the funds, they continue to gain interest, and if you generally slow down paying your debts, you appear to be more solvent than you are. I did send to Assemblyman Colburn the complete letter from Senator Bradley. The Senate Finance Committee, among others, has passed resolutions to attempt to break this mess that was caused by HCFA, but yes, it was indeed a deliberate slowdown. They went from a 10-day reimbursement cycle up to a 45-day cycle.

ASSEMBLYMAN COLBURN: I was going to ask you, isn't the Part B Trust Fund contributed to by the recipients? They pay a premium for the Part B, don't they?

MR. MARESSA: Yes.

ASSEMBLYMAN COLBURN: Well, was that money that was transferred into the-- Was that part of their money then?

MR. MARESSA: Well, the recipients pay a Part B premium. The Federal government also pays a contribution into the Part B Fund. So that, yes, when the transfer was made, the Federal government took the patients' money -- or, if you will, the Medicare persons that have paid in, they took a portion of their money along with the other money and moved it into Part A. It may have been thought that since there was $18 billion

in the fund, maybe what the individual recipients pay is the equivalent of one-third that went into the reserve fund. So Congress took two-thirds of it out and left the other third in. Therefore they can argue that they did not mess with the recipients' funds.

ASSEMBLYMAN COLBURN: Okay. Thank you. By the way, you are a lawyer, is that right?

MR. MARESSA: Yes, sir.

ASSEMBLYMAN COLBURN: Okay. I just though you should know.

MR. MARESSA: And if I took Assemblyman Colburn's escrow account and used it pay Mr. Kohler's escrow account, the Supreme Court would have my license and a paid vacation somewhere, I'm sure.

ASSEMBLYMAN COLBURN: Well, just be careful because I'm getting close to getting on Medicare. Okay. Mr. Hooper? Good morning.

G E O R G E H O O P E R: Thank you and thank the Committee for holding a much needed public hearing on the performance of Medicare and Medicaid programs to get testimony from recipients and providers. A series of hearings on selected area of the health care system instead of one across-the-board hearing would be, in my opinion, a better approach and it's hoped such a series can be developed.

My name is George Hooper. I'm an officer or Legislative Chairman of several senior citizen organizations at both State and local levels, such as Legislative Chairman of the Essex County Council of Senior Citizen Clubs, Task Force Chairman of the New Jersey Federation of Senior Citizens, and Secretary of the AARP State Legislative Committee. I'm also a member of the Task Force of the Legislative Concerns of the Commission on Aging.

I am also Co-chairperson on the Essex County Medicare Assignment Campaign sponsored by New Jersey Citizen Action

and my testimony today will focus on this phase of the New Jersey Medicare problem since we have been advised that this is the hearing intended by your Committee to hear testimony on A-2511 providing--

ASSEMBLYMAN COLBURN: Mr. Hooper, I apologize for interrupting you, but the notice clearly stated that it was to gather information on the way Medicare was working. I have no problem with you telling us that you support that legislation or you know, the problems are such that we should do that. But I just wanted you to know that it's on the overall broad implications of Medicare and Medicaid. The notice, very clearly as David wrote it up, said that it was just the overall thing and not specific bills.

MR. HOOPER: Okay.

ASSEMBLYMAN COLBURN: But we will certainly not cut you off. But I just wanted you to know that. Gosh, I don't knoe how that misconception could have gotten out.

MR. HOOPER: Okay. I'm going to touch on this, but I will not go into all kinds of details. That's why you see a lot of buttons here.

ASSEMBLYMAN COLBURN: Well, that's all right. We're used to buttons. There's nothing wrong with that.

MR. HOOPER: A lot of people would like you to understand why, because we've had no hearings to date.

ASSEMBLYMAN COLBURN: Well, later on this hearing and other information is certainly going to lead to consideration of the legislation that's in the hopper and maybe other legislation down the line. But right now, this is informational.

MR. HOOPER: Well, my focus is acquainting you with what senior citizens' organizations and senior citizens have been doing in this area.

ASSEMBLYMAN COLBURN: No problem. Thank you.

MR. HOOPER: This subject has been an active one among senior citizens and their organizations for many months

and the success of the senior action in Massachusetts in having legislation enacted prohibiting those servicing Medicare patients from charging more than Medicare approved charges for covered services has been closely followed. The subsequent U.S. District Court decision in Massachusetts, Medical Society vs. Dukakis on June 5, 1986 in which Judge Keeton found for the defendants on all claims and ruled against the claims of the Medical Society regarding conflicts of statutes and preemption of Federal law.

Support for similar legislation in New Jersey was strong and as a result of resolutions in various senior organizations, a resolution by the Task Force on Legislative Concerns requesting passage of similar legislation in New Jersey, was passed 3/4/86 by seven statewide member organizations and approved by the Commission of Aging. The Task Force on Legislative Concerns and the Commission on Aging subsequently adopted a resolution on 9/2/86 thanking Assemblymen Doyle and Karcher for introducing A-2511 and Senator Orechio for S-2473 and resolved that any amendment to directly or indirectly include a means test would change Medicare from an insurance program to a welfare program, and would contradict the principle of quality health care as a right for everyone.

These resolutions were sent to the members of appropriate committees in the Legislature and the Governor and at least four bills are now in legislative committees. We urge the Committee to schedule hearings specifically devoted to this subject in at least three different locations so the Committee and the Assembly can learn of the widespread concern and need for the legislated acceptance of reasonable medical fees by Medicare providers.

No single issue keeps reappearing at meetings of senior citizens' organizations as frequently as does the high cost of health care, and gaps in Medicare and other insurance

coverage. While Medicare was intended to cover 70% of health care costs, it actually covers 44% or less. Senior citizens are spending 20% of their income on health costs and this is a ratio similar to 1965 before Medicare was passed. Lack of coverage for vision and dental costs, hearing and prescription drug costs, or long or custodial care costs contribute to the cost problem.

Costs related to doctors bear a heavy share of the health bill as demonstrated by recently released Department of Labor statistics. While the overall consumer price index rose 1.7% for the 12 months since June 1985, medical costs increased 7.5% for the same period and the two key reasons for the sizable medical care increase were a 7.2% increase for physician fees and a 5.4% increase in hospital room charges. The 7.2% physician fee increase occurred despite a government and voluntary AMA freeze on doctors' Medicare fees. The trend of health care costs rising three times faster than cost of living has been a 20-year trend, and the latest figures are a continuation. The monthly premium deduction increase 1/187 for Part B doctors is a climb from $15.50 to $17.90 or 15.5% while Social Security benefits climb 1.3%

The Essex County Medicare Assignment Committee and New Jersey Citizens Action has engaged in a campaign to encourage doctors to accept assignment in 100% of their Medicare claims as a participating physician. We regret to report that out of 250 letters sent to Essex County doctors, responses of which-- Three have been verified and publicized as affirmative.

Since the introduction of A-2511, representatives of senior citizen groups have been invited by the representatives of the New Jersey Medical Society to exchange views and aid in the planning of seminars on the health and financial concerns of senior citizens. Several meetings have been held, and working to correct inequities and faults in Medicare administration and rates has been discussed as a worthwhile

venture for both groups. The New Jersey Federation of Senior Citizens has had many campaigns in earlier years to correct the under reimbursement of Part B New Jersey doctors' fees under Medicare and will work with doctors to get action at the Federal level to correct outdated indexes and other inequities.

Senior citizens and their organizations are concerned with the huge gaps of coverage in the present health care system and the lack of access to medical care of so many senior citizens because of financial priorities forced on them by fixed incomes and spiralling medical and other costs of the necessities of life. Many doctors, though well-intentioned in accepting assignments voluntarily in a few cases, do not understand that the inability to pay huge medical bills limits access to care for many patients and senior citizens who are not patients, particularly in the area of preventative medicine.

Following the example of Massachusetts and requiring doctors as a condition of licensure for charging their Medicare patients no more than Medicare approved fees would be a substantial step in making affordable health care more available in New Jersey. We urge your Committee to hold public hearings on A-2511 in all regions of New Jersey so that the need for such a bill can be demonstrated. The statement or explanation on A-2511 and S-2473 should be replaced by the statement on S-2585 since Medicare approved charges permit billing the 20% of the approved reasonable charge not covered by Medicare insurance. The statement under 2511 has to do with billing the unrecovered balance and that's not quite correct.

ASSEMBLYMAN COLBURN: What's S-2585?

MR. HOOPER: S-2585 is a bill by Senator Garibaldi and his statement is much more precise.

ASSEMBLYMAN COLBURN: His statement is better?

MR. HOOPER: So, that concludes my testimony.

ASSEMBLYMAN COLBURN: We appreciate you coming. Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: No comments.

ASSEMBLYMAN COLBURN: I wanted to ask you what happens-- I know in Essex County where I grew up, I think the fees are probably higher than where I am now, I'm in Burlington which is South Jersey. In the case of the doctor that you go to for most of your services, what is his fee for a regular office visit? Do you know?

MR. HOOPER: I happen to be an exception to the rule. My doctor accepts assignment.

ASSEMBLYMAN COLBURN: So, you don't know what his fee is?

MR. HOOPER: Well, yes. He accepts assignment and his charge is $35 or $40 -- in that area.

ASSEMBLYMAN COLBURN: Do you know what he gets of that money? Do you have any idea?

MR. HOOPER: I believe the Medicare reimbursement is something like $28.11.

ASSEMBLYMAN COLBURN: $28 for the $35 visit?

MR. HOOPER: Yes.

ASSEMBLYMAN COLBURN: That's his routine follow-up for any, you know, blood pressure or whatever?

MR. HOOPER: Yes.

ASSEMBLYMAN COLBURN: Okay. Suppose you had to pay. Let's say he didn't accept assignment. Do you know how much you would have to pay as a differential after you've met your deductible?

MR. HOOPER: The difference between his Medicare approved fee is 35 bucks.

ASSEMBLYMAN COLBURN: Well, between $28, I guess, and so you will pay six or seven?

MR. HOOPER: Yeah, we would pay the difference.

ASSEMBLYMAN COLBURN: Okay, so that would be the difference for you on that visit. Okay, thank you. Mr. Otlowski, this gentleman represents the Essex County Group of

Senior Citizens and I didn't know if you wanted to ask him anything. He's given his testimony.

ASSEMBLYMAN OTLOWSKI: No, thank you very much.

ASSEMBLYMAN COLBURN: This is Mr. Otlowski, who was the Chairman of this Committee for six years, so he's a lot more experienced than I am, I'll tell you. Thanks a lot.

MR. HOOPER: You're quite welcome.

ASSEMBLYMAN OTLOWSKI: I'm not going to let him get away with that, however, he does a better job.

ASSEMBLYMAN COLBURN: We have been asked by both Assemblyman Doyle and Assemblyman Singer to speak and I told them they would be scheduled right after lunch in the afternoon, but then Assemblyman Doyle said he had all sorts of things he had to do this afternoon, so as soon as Assemblymen Doyle and Singer get up here we're going to-- Since the Republicans are now in the majority for this brief time and we hope longer, we're going to have Assemblyman Singer speak first and then Doyle and then they can go back to -- at least Doyle, can go back to the things that they have to do.

So, we'll proceed with our normal series. Dr. Shivers. I have to confess that I did call Dr. Shivers and asked him to speak this morning for a number of reasons. One is, he's a family physician from Haddonfield -- that's South Jersey. Another one is, he teaches in the Rutgers Medical School as it's now set up in Camden at Cooper. And another one is that he has been a prime mover in setting up-- Would you call it an IPA, Dr. Shivers?

D R. H O W A R D F. S H I V E R S: Yes.

ASSEMBLYMAN COLBURN: Like an Individual Physicians Association that would then negotiate with HMOs to provide services. And I have to confess that I have helped to participate in the formation of what I suppose is a competing one. Everyone is competing with everybody nowadays. But I think he has a lot of information and a lot of knowledge

across-the-board, and that's the reason I've asked him to come up here. Dr. Shivers.

DR. SHIVERS: Thank you. Mr. Chairman, members of the Committee, I appreciate the opportunity to appear before you.

UNIDENTIFIED MEMBER OF AUDIENCE: Speak a little louder, Doctor.

ASSEMBLYMAN COLBURN: Yeah. This thing only records, I'm sorry to say.

DR. SHIVERS: I am going to speak directly to the legislation requiring Medicare assignment for a State licensure as my priority. However, many of the comments that I make regarding the physicians' income and the impact on the business side of the medicine applies both to the Medicare assignment as well as to our current schedule for Medicaid reimbursement, even though I will not illustrate the Medicaid areas.

I want to deal basically with three different issues. The first issue is the inappropriate use of the license process to solve social and political issues. The second is the recognition that some Medicare recipients do need financial assistance. And the third is the impact, on the business of practicing family medicine.

In dealing with the inappropriate use of a license process to solve social and political issues, I feel that the license and the license process is designed to ensure professional competency for the physicians that are serving the public of the State of New Jersey. The social implications of Medicare problems are basically societal and should be shared by all citizens and not asked to be shared by one profession. I think that some of the speakers before me actually made this implication quite clear.

Number two: the recognition that some Medicare recipients need financial assistance. I think we as family physicians-- I've been in family practice for 26 years and have taken care of senior citizens for that period of time,

and I certainly recognize that there are many needy people within our over age 65 population. I feel that there should be a process to identify the needy citizens and that we should therefore establish a plan to direct resources to these people rather than using a broad brush and trying to paint all senior citizens as being in need of financial assistance.

The statistics show approximately 70% of all discretionary wealth in the United States is held by senior citizens. This is defined as persons over the age of 55 and may include more of us that want to be included. Not all senior citizens require subsidizations of health care costs. The income of over 50% of the population of persons age 65 and above is sufficient to classify them as middle or high income earners. The large majority of persons in the Medicare population can afford supplemental private health insurance in addition to Medicare, and even in the combined low/poverty income group, 72% are covered by some form of supplemental insurance in addition to Medicare.

There's an interesting quote from one of the most recent journals -- this is "Medical Economics," April 1985. The article goes into some depth of talking about what is actually happening with our aging population and in projecting some of the problems that we're going to be facing in the next three decades. But I'd just like to draw out a few little quotes. One is that the elderly are not just getting more numerous and longer lived, they are getting healthier, more affluent, more active, and more independent, which I think is a very fair and favorable comment.

As far as under the title of how much money they have, the quote comes directly: "Older families gained nine percent of real income between 1980 and 1983 while the real income in younger families dropped four percent. The median income of families headed by a person 65 or older was $16,862, almost two-thirds of the $26,000 median for families with household head under the age of 65.

"Adjusted for family size, the median income for older families reaches 90% of the median of all families. This does not take into account that older people typically have lower tax burdens and in many cases, lower housing costs." Now this shows the positive side. I think we spoke about the negative side that they are needy. But it also amplifies the fact that there are many senior citizens that do not need supplemental assistance.

To get to the area of the business of practicing medicine -- we really are talking dollars and cents here-- The family medicine-- And I must address family medicine. This is my expertise. Family medicine is provided primarily in an outpatient environment, specifically in offices and/or in the home. It's been shown, and there are more statistics every day that are trying to demonstrate that this is the most cost-effective area in which to practice medicine.

The care of family doctors is classified in a term that we use as cognitive. Cognitive is addressing the area of problem analyzing; taking a situation and trying to solve what is wrong with the patient. This is an area that conflicts with the technical, such as performing various technical procedures. The reason for mentioning this is that under both Medicare and Medicaid, the remuneration for cognitive or the thought processing services -- the services that require that physicians talk to their patients -- is the lowest pay scale per unit of volume of time spent with that patient. Or as a technical service, that of using a tool or as we refer to the toys of the profession, are things that are remunerated at a much higher scale -- certainly one that presents great contrast.

The Medicare reimbursement schedule-- I think that even our senior citizen friends have come up and said that this fee schedule is unrealistic. It basically only approximates paying for the fixed overhead of a family practitioner's office. I'd like to give some illustrations of this. I happen to have a chart that I made up this morning. I hope this is not presumptuous of me.

ASSEMBLYMAN COLBURN: As long as we can understand it.

DR. SHIVERS: If you can understand it. I'll be glad to hold this thing up. My typed out sheet shows the same thing. Now this is in contrast to the North Jersey area. The average office visit in the tri-county area of Camden, Gloucester, and Burlington is approximately $25 a visit. The average patient encounter to that, office is approximately $28 an encounter. Now that would be if physicians spent longer time, i.e. comprehensive physical, did some technical prodedures, perform laboratory test in the office. When you take this and flush it out through the average encounter of all the patients you come out to $28 per patient per encounter.

The average overhead, now this is a national average -- our person overhead in southern New Jersey is 54%. But we use a national overhead of 49%. This gives an overhead per encounter of approximately $13.72. Now, contrast that to the Medicare allowable in southern New Jersey, the Medicare allowable is $14.40. Medicare reimbursement is $11.52. We are allowed to bill the patient for $2.88. So therefore, the possible total fee under assignment is $14.40 if we do collect the amount billable. Our overhead per encounter is $13.72. Our net income per encounter to the patient is 68 cents.

Now this is the reality of what family physicians are faced with. You take those same numbers of what we get paid for Medicaid -- and I think in our office it's something like $9.65 for every time we see a Medicaid patient -- we are actually subsidizing the State for the difference between $9.60 and $13.72.

Now obviously, the practical implication to this is the loss of income to the family physician if the proposed legislation is passed, would be tremendous. The larger the patient population of Medicare recipients in any given practice, obviously, the greater the impact. In our practice

which is pretty typical of that of the doctors that I represent. in southern New Jersey approximately 30% of the office visits of established family physicians come from Medicare and to taking of Medicare patients. This would take a net reduction. Approximately 30% of your income would be immediately deleted under this current law. That's the best case scenario.

I could use median income from family doctors. I think that many people feel that physicians earn a great deal of money. And I think that it's sensible to say -- and I've never griped about my earnings -- but the median income for physicians throughout the United States in family practice is $76,000 a year. The median income for general practitioners is slightly lower. The differentiation between the family physician is the person who's board specialized in family medicine; a family doctor is a non board specialized person. The income is slightly less.

If we assume a 30% reduction due to Medicare patients, the earnings post assignment would be approximately $52,000. From these incomes, by the way, we have been able to take care of our needs for retirement so the income is before monies are taken out for pensions, profit sharing, etc. So as we become senior citizens, the chance for us to be able to provide for ourselves in our older years will become much more difficult under this scenario.

The solutions that are possible to this, leave us with some of the difficulties that we face. Number one is that if we are forced to do this, I think that the realization, as in any business, you would have to increase your volume to help to offset this. And to increase your volume, you therefore would have to allocate less time for each person that you see. And I think that no person wants to come in a family physician's office and feel that the doctor doesn't have time to find out what his problem is.

The other aspect would be to refer patients who are, if you will, your clients who are losers in the practice -- where you cannot make money from them, or can't even exist. You would try to refer them to other areas. So, you could therefore refer patients to the emergency rooms or to hospitals, or to maybe specialists who get paid a higher degree of remuneration, or to various physicians who specialize in being able to see patients more rapidly and be able to make a living out it.

So, these are some things that I think that you have to be concerned about -- the ultimate avoidance of the Medicare patient, as is now happening with the avoidance of the Medicaid patient under the same scenario. I think that the solutions that society should look at would be to investigate a mechanism to assist only the needy senior citizens, to revise the Medicare fee schedules or realistic relative value scale so that all physicians, cognitive and technical, would be remunerated on a fair schedule. Obviously, don't pass this legislation, and I would ask you to look to Medicaid from the same perspective as the presentation that I made here today. I appreciate your indulgence in allowing me to speak.

ASSEMBLYMAN COLBURN: Thank you. Mr. Frelinghuysen, do you have any questions?

ASSEMBLYMAN FRELINGHUYSEN: No comments.

ASSEMBLYMAN COLBURN: Mr. Otlowski?

ASSEMBLYMAN OTLOWSKI: Doctor, the thing that you brought out about the fact that many senior citizens have an income that is substantial-- Admitting that to be true, one of the problems that senior citizens have is the fact that there's an anxiety that usually takes place with senior citizens about that income being used up quickly in the event that there's a catastrophic illness. How do you overcome such a feeling and such a situation?

DR. SHIVERS: I think that many times the anxiety of senior citizens is what we as family doctors spend a lot of time in trying to alleviate. This again is a time consuming area in our office encounter. I think that Medicare was probably designed as a mechanism to alleviate the fear of health care costs actually destroying a person's economic security. I think it's fallen far short of that. I think that the fact that the system has come close to bankruptcy-- It's a societal answer. I don't have an answer to that. I certainly think that catastrophic insurance, insurance that would place limits on people's ability to pay, I think that the realization of where people are, as far as being able to budget health care costs in the beginning of the year, to know what the limits are, to have realistic co-payments-- There are many ways of devising this.

So people have talked-- Well right now the HMO industry is working with the Federal government and is therefore trying to supply all health care costs at 95% of the current going cost of Medicare. So far that has proven to be reasonably disastrous for many reasons. I don't want to get into that today. But there are major problems there, and there are a lot of people who are actuaries and brilliant economists that can't answer that directly. I can't answer that.

ASSEMBLYMAN OTLOWSKI: So, Doctor, what you're saying in effect is that while you are very unhappy with the present pay scale and from the data that you presented, obviously the physician by that data isn't being compensated properly for the time and effort that he is putting in. And in many instances you show that he is losing money. And you say that brilliant economists have not been able to come up with an answer. While you pose the problem, you haven't come up with an answer.

DR. SHIVERS: Well, I think that basically I've come up with some solutions that people can at least investigate. In other words, if there are people who are in threat of

actually having their economic security taken from them, we ought to find out why that is. Under our Medicare system currently, as I said, the majority of people have private insurance. Over 72% of even the low income have supplemental insurance which will pay for virtually 100% of their health care costs. And in this instance we should look to that other 25% and find out why they don't have adequate insurance, because the fear is that you're going to run out of income, and your health care is going to be deprived from you, or the cost of health care will wipe out all of your life savings.

And I think the realistic thing is to see to it that we have a means to insure that. Now 72% of our population have that already. I think the concern is, why not the other 25%? But what we're proposing here is a broad brush to take a 100% -- you absorbing increased costs, if you are realistic about the payment system -- and as you increase you're paying, in a sense -- or you're compromising -- a whole system for 25%. And actually out of that 25%, a large portion of that 25% are people who are classified as wealthy, who could very well absorb the 50% of the people who are not covered by extra insurance beyond Medicare, have decided to self-insure-- So there's a large segment of that population that is self-insured.

ASSEMBLYMAN COLBURN: Doctor, excuse me. I guess I'm addressing this to both of you. Wouldn't you say that the worst thing that can happen is a huge hospital bill? I mean, generally speaking. I'll get to the physicians' fees in a minute. Isn't that the biggest part of a disaster, the hospital fees or a nursing home, maybe?

ASSEMBLYMAN OTLOWSKI: I think that the hospital costs and nursing home costs probably far exceeds anything that that the physician would get. But that's the total cost of medical care. And of course I believe that people don't separate that.

ASSEMBLYMAN COLBURN: No. That's okay. But I just wanted to get to the thought that I think the hospital costs

are the hugest. Let me tell you what my patients do when they can't pay. They don't. They don't pay. And that's what I would think your patients probably do. They don't pay. And sometimes they call us and say, "I'm sorry we can't pay." And honestly, I have never sent a bill to a collector in my 31 years of practice. And my dad is an 84-year-old physician. He doesn't send them either. So, I just think that the patients -- if they can't pay, they shouldn't pay.

DR. SHIVERS: I think that realistically that this--

ASSEMBLYMAN COLBURN: I know they don't feel good about that, but they shouldn't.

DR. SHIVERS: But this is what does happen. In my practice, I'm the same as Harold's. If a patient comes to me as a needy patient, I do not charge that patient. If a patient is in the hospital and is incurring these large costs, I will call the consultants as well and say that this patient has very limited means. And as a family physician, part of my chore is to be this patient's advocate. So, I can call and the people will drop the fees. They'll accept what insurance pays. And most physicians, where there's a need, will accept that. The problem is that at the hospital level, at the nursing home level, these people are not necessarily willing to accept. And this is a big burden. This is where the big dollars are. Not in the physicians' fees.

ASSEMBLYMAN OTLOWSKI: Doctor, I think--

ASSEMBLYMAN COLBURN: I think I just broke one of my own rules. I really didn't intend to give my own opinions here today. So, I apologise to all of you for that.

ASSEMBLYMAN OTLOWSKI: Doctor, just to the point that the Chairman interjected here, which I think is a very valid point and as a matter of fact, important to this discussion, he pointed out that the higher costs come with hospital care, nursing home care, and there's no question that that's correct. The disturbing thing I think to all of us is the fact

that medical costs are escalating very, very rapidly. And what is happening is the fact that these very people that you talk about that have wealth or have savings, these very, very people are concerned about that being wiped out inside of two or three months. Great sums of money can be wiped out quickly with catastrophic illness.

You said, of course, that this is the responsibility of society to come up with an answer for that and it's not the physician's burden alone. However, the physician is a part of that. You're here advocating and opposing this bill, and yet I don't see any clear-cut recommendations or solutions for some of the problems that exist, and for some of the problems that people fear, and some of the problems that people have to live with. I'm not saying -- and I don't mean to say -- that the physician and the physician alone should be carrying this load or carrying this burden, but what I think what we're looking for here, I think we're going to be looking for some answers here, and I haven't heard the answers yet.

DR. SHIVERS: I'm not sure the answers have been coming. I think there are many options out there that are happening. Number one, the passage of this bill will not have any impact on the problem that you just stated, because you are dealing with tying licensure to physicians' acceptance of Medicare assignment. The major problem in the cost are not with physicians' fees in general. Certainly, speaking from the family physician point of view, talking about increase in costs, the net income of family physicians has actually gone down in the last five years by 9.8% when compared to the CPI. Our fees have not gone up, even keeping with the CPI. But that's from the family physicians' point of view.

But this bill does not approach the cost of a Medicare person's cost of going to a nursing home, which is one of the biggest wipe out features, or the cost of someone having major surgery and being in the hospital for six or eight weeks, or

going on dialysis. These are the major health care costs which are the ones that actually people live in fear of. They do not live in fear of coming to the family physician's office. And oftentimes, part of our task is to help them find alternate care that's less expensive, and to provide home health care rather than nursing home care which is one of the alternatives that's not showing up.

ASSEMBLYMAN OTLOWSKI: Doctor, your argument then is that the Medicare and Medicaid system is not fair to the physician at this point? That's the thrust of your argument?

DR. SHIVERS: That is the thrust of this.

ASSEMBLYMAN OTLOWSKI: Thank you.

ASSEMBLYMAN COLBURN: Thanks, Dr. Shivers.

W I L L I A M F E I R S T E I N: (speaks from audience) Dr. Colburn, may I say something?

ASSEMBLYMAN COLBURN: Well, you really shouldn't, but go ahead.

MR. FEIRSTEIN: I have an appointment.

ASSEMBLYMAN COLBURN: Are you on the list?

MR. FEIRSTEIN: Yes.

ASSEMBLYMAN COLBURN: What's your name?

MR. FEIRSTEIN: Feirstein.

ASSEMBLYMAN COLBURN: Where are you listed here?

MR. FEIRSTEIN: On the second page.

ASSEMBLYMAN COLBURN: Well, if you have a quick one--

MR. FEIRSTEIN: Yes. At 12:15 I have to get a stethoscope (inaudible) in liquid.

ASSEMBLYMAN COLBURN: I can sympathize with that.

MR. FEIRSTEIN: Now it cost me $160 for that. The doctor expects to be paid immediately.

ASSEMBLYMAN COLBURN: Really? On the spot?

MR. FEIRSTEIN: Yes, on the spot.

ASSEMBLYMAN COLBURN: Okay, we don't do that.

MR. FEIRSTEIN: (continues to speak from audience) What I'm trying to bring out is this (inaudible). Assemblyman Otlowski have been discussing the (inaudible)--

ASSEMBLYMAN COLBURN: That's a problem.

MR. FEIRSTEIN: True. Burlington may be charging less money, but you people do not know the charges that have been incurred by patients in Ocean County. I will explain that when I am up there to speak. Thank you very much.

ASSEMBLYMAN COLBURN: Okay. Thanks, Dr. Shivers.

DR. SHIVERS: Okay.

ASSEMBLYMAN COLBURN: I have asked several times that we try to find somebody from the American Association of Retired Persons and we were in touch with them. I don't know whether we ever got anybody from that group. Is anybody here representing them?

MR. HOOPER: (speaks from audience) I am not representing them, but I am a secretary on the State Legislative Committee.

ASSEMBLYMAN COLBURN: Of that group-- So you have already spoken. Okay. I guess there's nobody here. I promised to get Assemblyman Doyle out of here by 12:30 and I expect to meet that obligation. Cecilia Zalkind and Shirley Geismar from the Association for Children of New Jersey.

C E C I L I A Z A L K I N D: Thank you Assemblyman Colburn and members of the Committee for the opportunity to testify before you this afternoon. I'm Cecilia Zalkind and this is Shirley Geismar, who's our health expert on our staff, who had a great role in developing our testimony today.

We represent the Association of the Children of New Jersey which is a statewide child advocacy group. We're a nonprofit member based organization dedicated to improving the policies and programs that affect children in the State. A lot of our efforts are geared towards children and families who are living in poverty.

Before I begin my testimony, I would just like to make two comments. One is because we're a child advocacy organization, our comments today are focused on children who are Medicaid recipients. We do, however, participate in some of the other organizations that have already appeared before you. We are members of the New Jersey Health Care Coalition, and have worked in the past with the Federation of Senior Citizens, particularly on the Medically Needy Program, and we share and support some of the concerns and issues that they and others will raise later today.

Secondly, within the context of your Committee notice, we are neither recipients nor providers of health care under Medicaid. However, we feel we represent a constituency partly from our membership, and also from our research and publications which have focused on this issue in the past, particularly the "Through the Safety Net" report in which we reported on the effect of the 1981 Federal budget cuts, and a more recent report that did a survey on Head Start families -- 1200 Head Start families living in Newark. The access to health care for these families was a serious and important issue of that report.

Access to health care is what we focus on particularly in evaluating health programs for poor children and their families. In our testimony today, I would like to concentrate on the providers of service, and discuss our concerns regarding the availability of participating doctors, the low Medicaid reimbursement levels, and the impact of these particular problems on the Medicaid patient. I've submitted written testimony to you which I will summarize in the interest of time.

Our main concern is that fewer and fewer physicians are participating in the Medicaid program. As you've heard earlier this morning we believe strongly that this is due in large part to low reimbursement rates. For a number of years, medical groups around the State have reported that fewer and fewer physicians participate in the Medicaid program.

Statistics for this were published in "The New Jersey Pediatrician" in 1982. In a survey that they did of their readers, they found that half of the doctors responding indicated that they consciously limit their Medicaid practices. The most common way is to refuse new Medicaid while they continue to serve old patients already under their care. Additionally, 22% of the doctors responding said that they would decrease the percentage of Medicaid patients in their practices in the following year.

Also in 1982, ACNJ conducted its own survey of pediatricians and family practitioners in this State, and we found that out of 469 respondents, 65% had less than 10% of their patients-load enrolled in the Medicaid program. So it's our belief, supported by some research, that doctors do not accept Medicaid patients.

Our report, "Through the Safety Net" and our Head Start report as well as reports from the Governor's Committee on Children Services Planning, have further documented these problems. Now in each of these studies and surveys the low provider participation rate was linked to the inadequacy of Medicaid reimbursement. In our 1982 survey, about 45% of the physicians contacted indicated that an increase of the fee schedule would be the most effective measure to increase the number of providers. This, by far, led the list of other recommendations.

These issues were also affirmed more positively by a poll taken by the "The New Jersey Pediatrician." In their poll, almost 75% of those doctors responding said that they would consider increasing Medicaid participation if reasonable fees were provided.

Now in an attempt to look at what are reasonable fees, in 1986 we talked to a pediatrician who has worked in Middlesex County. This is a doctor with a large Medicaid practice. In assessing his fees, compared to other pediatricians in the

State, his private fees seemed to be on the statewide average. In getting some information from him, he gave us the following data. Some of this you have already heard this morning so I'll go over it very briefly.

For initial office visit, Medicaid will pay $22. An average visit for a child is $30. However, that's an annual visit. If that doctor sees that child again during the year, the Medicaid reimbursement rate drops to $9. The doctor's private fee remains at around $30, and $30 is an average fee statewide, but Medicaid will reimburse $9.

A urine analysis or blood test that the pediatrician requires of the child, costs the average private patient $10. Medicaid reimburses $1.20. A throat culture, again, costs $10, Medicaid pays three dollars. In looking at hospital costs of newborns, the care of a healthy newborn in the hospital which entails daily visits to the child and mother as long as they are in the hospital which is now about three days, costs the private patient $150. Our pediatrician reported that Medicaid reimburses him $33 for the same service for a Medicaid patient.

For care of a sick child in the hospital entailing perhaps longer hospital care, the private fee that the doctor charges is $50. Medicaid reimburses $22 for the first day and nini dollars thereafter.

These are but a few examples of what we feel are significant differentials between private fees and Medicaid reimbursement in just a few types of pediatric services. Clearly, these differences -- in many cases amounting to reimbursements of 80% or 90% less -- are a serious disincentive to provider participation. Examples such as these, illustrate the necessity to give providers fees that adequately cover materials and office expenses, and provide them with a small incentive to continue participation in the program.

Now taking this issue of low reimbursement further, we believe that this is tied very strongly and has a serious

impact on the poor families' access to medical care. In rural and some suburban counties, it's been reported to us that it's exceedingly difficult to find a doctor when needed. Very often preventive or ongoing care must be ignored as a result. In large urban centers, such as Essex County where we are based, patients use costly hospital emergency rooms because there is no one available. Once again, preventive or ongoing care is often ignored.

In both instances, whether in a county with few health resources or one with hospital centers that are both utilized, we believe that the program is ill served. In the first instance, the patient has haphazard, crisis oriented, perhaps lower quality care; in the second, there is little continuity and follow-up. So that even though it may be given in an up-to-date medical institution or hospital, the care might lack optimum quality and effectiveness.

Fiscally, we believe the program itself also suffers. As you've already heard this morning, the sums that are paid to the emergency rooms are not inconsiderable. Again, either the patient is getting preventive or follow-up care that could help prevent the emergence of acute health problems in the future. It was interesting that Commissioner Altman commented this morning that poor families tend to be sicker. Our response was if there was an opportunity for the preventive ongoing health care, would the costly care at the end, when the health problems become so severe, be necessary?

We feel that New Jersey has made considerable initiatives in the last several years to improve the quality of health care for its citizens. The passage of the Medically Needy Program was one that we long supported and we're very happy and pleased to see it approved. We are monitoring it to see how exactly it's implemented. We've supported currently pending initiatives to provide better health care to pregnant women and children. Yet, we must question how effective such

programs will ever be if there are not a sufficient number of providers who are willing to participate in these programs?

Similarly for many years, we've strongly supported the EPSDT Program. This is the Early Periodic Screening, Diagnostic and Treatment Program that's geared to low income children primarily receiving AFDC support. This program is an attempt to provide preventive screening services to identify problems early on, before they affect the child seriously and become a costly program. The success of this program has been well documented. ACNJ, along with other groups have strongly supported EPSDT, but we must question, how can we encourage expansion of the program to more eligible children when the reimbursement system penalizes doctors financially for those children they see more than once a year?

Finally, there have been some efforts -- and we'd like to acknowledge them -- to increase provider participation in the State. For example there's now a personal physician plan and an HMO in Cumberland County which have been added to the roster of Medicaid services. However, we believe that unless proven otherwise, until the fee structure of the Medicaid program is reformed, these innovations will only be cosmetic or of limited regional importance. The fundamental underlying problem to us is the economic disincentive that's inherent in the fee schedule which inhibits the participation of providers.

Now this morning, I've stressed our concern about reimbursement and how that affects access to health care. I'd like to raise very briefly, one other issue that we feel is important. And one is to take a look at the quality of services that many children are receiving. There really has been no evaluation of what those services are and how good they are. Are children who are receiving medical care through Medicaid receiving the same type of medical care that children who can afford a private physician or can afford a private physician's fee, receiving?

We would urge that there be some look or some attempt to evaluate the effectiveness of the Medicaid program as it concerns the young under its care.

In summary, I'd like to thank you for the opportunity to express our concerns to you today. We believe strongly that the decreasing number of providers willing to participate in Medicaid is due in large part to inadequate reimbursement. Consequently, as I have said, the lack of available providers has a serious impact on the poor's access to health care, both in finding a provider, and obtaining a full range of medical services. We believe that if we're committed to providing adequate health care to our most dependent citizens, our children, then we must first address this most basic problem. Thank you.

ASSEMBLYMAN COLBURN: Thank you. Mr. Frelinghuysen or Mr. Otlowski? (negative response) Thanks very much. Is Assemblyman Singer back yet? (positive response). John Paul, in order to get you a place to sit down, why don't you sit up next to him. Would that be all right with you? (positive response) There's a chair there.

A S S E M B L Y M A N R O B E R T W. S I N G E R: Is this called a merger or something? Thank you Mr. Chairman. Please forgive me for being a little bit late. Unfortunately my vote was required--

ASSEMBLYMAN COLBURN: They can't hear you. This thing is for the reporter.

ASSEMBLYMAN SINGER: Forgive me. Unfortunately I had to vote on my Environmental Committee just prior to this.

I would first like to thank the Assemblyman and the rest of the Committee for the foresight in having this Medicare/Medicaid hearing. I understand that this is the first hearing of its kind to investigate the performance and the impact of this program from all perspectives, and that's quite important.

It is an all encompassing issue that directly affects so many of our lives. I represent Ocean County which is perhaps the fastest growing population of senior citizens in the State of New Jersey. There are over 100,000 seniors in Ocean County and the number is growing daily. Given that perspective, I am sure you can easily understand my eagerness to examine the Medicaid and especially the Medicare issue.

Today one in eight New Jerseyans are 65 years or older. Ocean County alone has 22% of the State's elderly population. That is almost double the percentage of seniors in 12 other counties. Ocean's high percentage is a characteristic of other seashore communities, such as Atlantic and Cape May, which over the years have become the final residences of many of our senior citizens of this State.

I represent Lavallette which has over 540 seniors. Mantoloking has over 25% senior residents. Seaside Park has over 428 of a population of only 1700 residents. Point Pleasant has approximately 20% of its population of senior citizens. These figures are highly significant. For instance, I am the Mayor of Lakewood which has over 10,000 of a population of approximately 40,000 people.

As a public official, I continually battle with the problem of how best to serve my constituents. Seniors represent a large percentage of my constituents, and I'm especially concerned in ensuring that their needs are met.

Accordingly, to the statistics published in a most recent report by the Department of Community Affairs entitled "Aging in New Jersey: 65 and Over," over 35% of those residents 65 and older have annual incomes of over $20,000. Five percent of those mentioned have incomes of over $40,000. The emphasis, however, should be placed on those residents in the remaining 65% with incomes of over -- excuse me -- under $20,000. I would also make reference to my bill, A-3395, which in essence

addresses this problem I think which is an important problem to realize the--

ASSEMBLYMAN COLBURN: Assemblyman Singer, you do understand that we're not here on a public hearing on specific bills. This is just to figure out what Medicare and Medicaid are doing as they currently exist. I just wanted to remind you. It's okay to refer to a bill as other people have, but not in any great detail.

ASSEMBLYMAN SINGER: Thank you Mr. Chairman.

ASSEMBLYMAN COLBURN: Thank you.

ASSEMBLYMAN SINGER: Almost 28% have incomes less than $10,000, 15% of incomes of $5000 to $7500, 19% of incomes below $5000, and 5% of less than $2500. This is disgraceful. It greatly illustrates the need for the State to provide relief for the residents' needs.

Among all the competing necessities which the elderly must have such as housing, transportation, other professional services, the greatest need for seniors today is quality health care. It has been reported that over 80% of older people have at least one chronic condition, such as hypertension, heart conditions, crippling arthritis, cancer, or strokes. This figure is especially frightening when you realize that health care costs have risen three times faster than the cost of living in the last 20 years. A significant part of this increase reflects a tremendous gain in medical technology.

Medicare, since its inception in 1965, has traditionally had low reimbursement for services. For example, Medicare reimburses home health care for only 5% of the State's most needy. The reimbursement for 1982 was only $931 which did not cover the expenses incurred for treating even the mildest of cases. I strongly suspect that this has not changed.

This becomes more important as shorter hospital stays send patients home in need of great amounts of care. One out of every four seniors in New Jersey was hospitalized for acute

care in special hospitals last year. This demand for hospital care increases every day. Hospital services represent the largest personal health care expenditure for those 65 years and older.

Medicare represents the highest payer of all health care expenditures for seniors. Last year it paid over 50% of all expenditures. Hospital reimbursements by Medicare and Medicaid, Blue Cross/Blue Shield, and other payers under the DRG system -- this system in its attempt to contain cost has merited many criticisms regarding the deliver of quality care. I must add to that, that in my own district, numerous people have come to see me concerned about DRG and how it affects them and the lack of understanding of DRGs in many cases.

I understand your public hearings in June focused on many allegations such as increased readmissions to hospitals, increased same day surgeries, and the cutting of auxiliary services.

I commend you and the Committee for your efforts. I strongly urge, however, that the powers be investigate in these allegations and make necessary corrections, because they greatly affect the quality of care that is issued to the seniors. I am very concerned over the quality of care. I think eventually the equitable reimbursement to Medicare and Medicaid providers will ensure that the elderly of this State are receiving the best possible care available.

In solving the problems of my elderly constituents, I may say that it should be done in the fastest possible manner. It is important that we not damage the high quality of health care that is provided in this State.

I am also highly concerned that senior citizens know what benefits are available to them so that maybe they are better able to take advantage of these programs. It is not uncommon for my office to receive a call from a senior citizen asking why they have been denied a particular benefit or who they could call to get information.

Again, I think that in many cases when seniors go into the hospital, especially concerning DRGs and things of that sort, they really don't have a full understanding. Someone has explained it to them at a time when they can least understand, or in an emergency situation. Again, I am concerned about their understanding and am concerned about the quality of health care received.

I thank you for letting me share some of my thoughts with you. Again, in some lobbying effort, I again urge you to hopefully hear my bill 3305 which I think addresses totally the issue of that 65%, the most in need seniors, the ones we're concerned about, especially in the health care situation.

ASSEMBLYMAN COLBURN: Thank you. Mr. Otlowski?

ASSEMBLYMAN OTLOWSKI: No.

ASSEMBLYMAN COLBURN: Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: No.

ASSEMBLYMAN COLBURN: Again, thanks Bob. You're on, John Paul.

A S S E M B L Y M A N J O H N P A U L D O Y L E: Mr. Chairman, members of the Committee, thank you very much too for this opportunity. I'm particularly pleased that some small or perhaps not so small degree of my bill which I will not mention too specifically-- (laughter) Suffic it to say that as heartening as those yellow diamonds are behind me, I didn't cause them, but I appreciate them.

I hope to, in a procedural manner -- in addition to my gratitude for this hearing in response to whatever incentives -- you would look at the size of this room and the number of standing room only people that are here and suggest to you that a second hearing in the not-too-distant future in a larger better air conditioned room -- allowing those people who could not get on the speakers' list-- I know from my own county, both representatives of the medical community and the senior citizen community-- And I don't mean to state them as

adversaries. Both sought to get on the limited list and could not. I hope that either today or in the very near future they will have that opportunity.

Mr. Chairman, as I understand it, the purpose of this hearing is to see whether, in fact, there is a problem. That problem has been suggested as being the following: Are we in this State providing adequate medical services for New Jersey's older Americans? To put it another way, has the two decade-old promise of Medicare been met? That is, that older Americans, regardless of their ability to pay, will be able to obtain needed appropriate medical services. A third way of phrasing it very bluntly is, is Medicaid working?

Mr. Chairman, based upon the facts that I'm about to give you, I think the answer is clearly, "No." It is no secret that the benefit structure of Medicare is unbalanced. According to recent reports, three out of every four Medicare dollars are spent on hospital care and only two cents of every dollars is used to buy skilled nursing facility care. In addition, the program does not pay for such services as self administered prescription drugs, extended care facilities, and routine physician or preventative care, all of which are vital components of the health care of the elderly.

Due to the fact that Medicare coverage is geared towards the most expensive and highly inflated services in the medical arena, the responsibility to fill in the gaps has been shifted to beneficiaries and states. Yearly costs of Medicare have risen approximately 16% to 18%. In 1984 the average out-of-pocket medical expenses for Medicare recipients was $1575. We'll just stop on that figure. Just over $30 a week has to come out the senior citizens' pocket regardless of their ability to pay. And as is often the case, we all realize they can't pay that amount.

ASSEMBLYMAN COLBURN: What year was that?

ASSEMBLYMAN DOYLE: 1984.

ASSEMBLYMAN COLBURN: 1984.

ASSEMBLYMAN DOYLE: This meant that medical coverage consumed as great a percentage of annual income as before Medicare existed. Simply put, we're not getting any better; the problem is growing. As a result, State and Medicaid programs are having to finance at least half of all long-term care that is given to the aged and disabled. The problems and the structure of the Medicare system are threatening to bankrupt the very individuals that it was designed to help. Medicare covers less than half of the elderly medical expenses. One third of the remaining costs have to come out of their own pockets.

Let me point out again, going back to 1984, Medicare recipients paid approximately $17 billion nationwide out of their own pockets for medical services. It is not surprising to find that the rise in Medicare's outlay has not been caused by the increasing age of the population, nor an increase in the use of medical services. The prime factor has, in fact, been the increased cost of medical care. At least half of the group in Part B expenditures has been directly linked to inflation and physicians' fees. At last report, medical costs had been rising at twice the rate of general inflation.

I think these facts strongly suggest, Mr. Chairman and members of the Committee, that there is a problem. I would like to think that we believe that for every societal problem, we have the willingness, the desire, and the capacity to fashion a legislative solution. What then is that answer? Without mentioning the specifics of my legislation, suffice to say that that stands, perhaps as some might see it on one end of the spectrum as a solution -- the mandatory exception of assignment along with the co-pay as full payment of the medical bill. Let me point out though that the California legislation as well as some congressional suggestions about assignment for every medical service including every visit and every possible health care expense are even a wider-ranging solution than are mine.

On the opposite end of those mandatory solutions there have been the suggestions generally from the medical community that the existing voluntary system suffices as a solution. In that regard, I have read statements and documents, and I can appreciate where they are coming from. One fact that is given by the medical community is that nationwide only 28% of the doctors will accept assignment in every case, but in fact 68% of the claims paid are paid by way of assignment.

Those wide differences suggest -- I think rightly as the medical community would say it does -- that a number of doctors on an individual basis, knowing their particular patients are willing and prepared to accept assignment. This, they suggest, would say that the present voluntary system would be kept and should be kept. I'm further aware that in our State there are any number of annecdotal incidents such as you suggested, Mr. Chairman, and has been suggested to me by many doctors, that out of humanitarian and personal feelings, and feelings for their profession and the needs of their profession to care for people first, that they will willingly accept lesser or reduce the amounts as full payment.

I am further aware that there has been a continuing and ongoing effort by the State Medical Association and constituent agencies, including in my own county, to meet on a voluntary basis with senior citizens' groups to try to resolve on an amicable, voluntary basis the medical needs of those that are most needy. However, notwithstanding these voluntary efforts, these annecdotal instances, and these percentages, the fact remains that they do not rise to meet what is our duty as a society as exemplified by the Medicare law and that is to provide universally -- not just for those people who are willing to ask for it -- but universally the health needs of all citizens regardless of their ability to pay. The fact of the matter is senior citizens of this generation of this time raised in a depression, having fought wars, rightly are proud

and have a right to be proud and not to accept what they would conceive to well be charity.

Now I know that there are other issues raised by the medical profession, specifically that in accepting assignments they are being welded into a payment schedule that is discrimanatory, unfair, and out-of-date with modern economic realities of their profession. I don't disagree. The assignment schedule is unfairly low. I wish that it were higher. I wish that something was done nationwide about that. But the fact that we can't change that, should not hamper or restrain us from meeting a New Jersey need to provide for the medical needs of our senior citizens.

I am also aware of other comments that have been made, including at this microphone today that the average medical income in this country which is now, I believe, $103,000, that the annual increased medical income has barely met the cost of living. I'm aware too that there is a genuine concern in the medical community that looking down the road that there will be 20,000 doctors more than are needed by our society in the year 2000. I'm further aware that they are concerned about the effective medical malpractice rates in certain situations and our tort law. All of these though -- go as they may to the individual needs of the medical practitioner -- do not rise to the level of our societal concern about providing health care for all of our citizens.

In looking then at a solution that you must fashion or begin to fashion, I think it's appropriate to look at what other solutions have been sought in other states. Clearly there is a precedent in the State of Massachusetts. I am aware that the medical community has said that that is only one state out of 50. I'm aware that they are still appealing that law. I'm aware that that law only went into effect last year and there has been limited time to assay the evidence under it. But I am also aware as I know you are, Massachusetts is like us -- a northern industrialized state.

Massachusetts, like us, has population of mid single millions range. I am aware as I know you are aware that the population of Massachusetts has the same kind of variations as to minorities, age, and income as those in New Jersey's population. I am suggesting therefore, that that, if you will, laboratory for our experiment, is an appropriate one. I am further aware that within that one year, there has not been the mass exodus of medical practitioners from that state as had been suggested by the opponents of the law.

I am also aware that there is an increased number of physicians that are willing to accept assignment and I think that needs to be taken into account in wondering whether the kind of solution that was attempted in Massachusetts and the one that I had suggested in 2511 would work any distress in New Jersey. I don't think it would.

In looking at a solution too, I am aware that there will be those who will suggest that some sorts of needs test, however that be done or in whatever other formula it be accepted from, be used. That might well seem to be the thrust of the earlier bill mentioned by my colleague from the 10th District, Assemblyman Singer.

I don't wish to disagree with any legislative proposal. I only mean to suggest to you facts that I have seen and for you to consider them in arriving at a solution. In Washington State a needs test was applied to legislation that earlier had none. Let me quote from the American Society of Internal Medicine's focus on state health legislation: "The bill was defeated, however, because the Washington State Medical Association was able to attach a means test provision to the proposal." I would hope that a means test would be -- if it were to be employed, and I don't suggest that it should be -- I just caution the Committee to realize that that might be a diversionary tactic, to impede the support for the bill,

and to produce a bill that will be neither acceptable to either of the competing interests involved in this arena.

Let me conclude, because I strongly believe, though I am not suppose to comment on legislation, let me say with respect to 2511, I have heard, read, and received a lot of information. The bill basically has three parts to it: One, the findings that there is a problem. I think there is. Two, the suggestions for a solution, and that is the acceptance of assignment as full payment along with the co-pay. Until I hear a better solution for a problem that cries out for solution, I will continue to accept that solution as the best one so far. Thirdly, the bill like all bills that contain -- and must do -- has a penal provision. I am aware that that penal provision has exacerbated the difficulties between the medical community and the political community. I think that that penal provision may well be deemed to be too harsh and a monetary penalty would better serve the purposes of all concerned.

But let me now address myself to the overwhelming and overall problem of senior citizens and medical care. We have all heard that due to the DRG system, patients, particularly senior citizens, are being released quicker and sicker. We have been told that no coverage is available for home health care that is so desperately needed. Skilled nursing care coverage seems to be a thing of the past.

Where, in fact, are the elderly of this State suppose to turn in times of sickness? I would like to believe that we have not become a society so obsessed with youth and health that we would turn a deaf ear to the needs of our growing senior citizen population. We need to find solutions now before the elderly of this State become so financially insolvent that they cannot afford everyday medical care, let alone hospital care.

We are creating a group of individuals that are so fearful of losing their life savings that they are remaining at

home too sick to care for themselves rather than seeking medical attention. Let me just digress, because you can have all of the statistics in the world, you can have all of the information, you can have all of the studies, you can look at all of the legislation and none of that will test, measure, or count, the very human feelings that I have heard from senior citizens as the sponsor of A-2511 and which Mr. Otlowski rightly refers; that senior citizen who comes in and says, "I'm afraid I can't afford it, so I won't go for it. I can't do it. I'm worried." Something has to be done about that all too real prevalent human feeling in the senior community.

I urge your Committee to take a serious look at the problem and other alternative solutions to meet the crisis we now have. Just by the fact that you are holding this hearing, I know that you are aware of the injustices. Let us now move very quickly for solutions. Thank you Mr. Chairman.

ASSEMBLYMAN COLBURN: Thank you Mr. Doyle. Mr. Otlowski?

ASSEMBLYMAN OTLOWSKI: No, thank you.

ASSEMBLYMAN COLBURN: Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: No.

ASSEMBLYMAN DOYLE: Thank you for your kindness in rearranging the schedule.

ASSEMBLYMAN COLBURN: I'm glad we made it. We have two more people to testify before we take about an hour break for lunch. The first one is Dr. Sachs, the President of the Union County Medical Society. Are you still here Dr. Sachs? (positive response) I think I know Dr. Sachs. And the final speaker will be Mr. Evanoff -- this is of the morning session -- from the New Jersey Health Care Coalition. So, if we could all have your attention now for Dr. Sachs.

R. G R E G O R Y S A C H S, M.D.: Mr. Chairman, I didn't prepare a statement because I was interested in hearing the discussions up to this point, and try to address some of those

points and add a few that hadn't been mentioned. I do think the three things to keep in mind are that there are three major components of the health care bill that any potential consumer faces: the hospital component, the physician component, and the extended care component, whether it's nursing home or home care.

In general, the hospital component of this bill represents approximately 60% of a person's bill, for physicians approximately 20%, pharmacy and other medications are 20%, and the others fill in down the line. There is a problem in this State just like there is a problem in all states in providing health care at a reasonable price and with reasonable availability to all individuals in all locations out of all means. In terms of the--

ASSEMBLYMAN COLBURN: Excuse me, maybe we should take a couple of minutes and let people free up some seats for those who have been standing. Everybody has been very patient. I think we may even have a longer afternoon than we have in the morning. But we do want to hear all of this. And I want to thank everyone for coming because we've had a great turnout.

Yesterday, a lady came in to my medical office who is near me. She's an obstetrician. She said, "Harold, how many doctors do you want to come to the hearing tomorrow?" And I said none. (laughter) Because I said that we're going to have plenty of everybody. We've had a lot of people on both sides. To me, the numbers aren't as important as the facts that we're getting.

And we'll probably hear the same bits of-- If we had hearings all over New Jersey, I bet you we would hear pretty much the same things all over. So, I don't know whether we want to have a whole slew of hearings. I'm not much one for -- they call them around here -- dog and pony shows. It's called that in the political trade. When we go all around the State -- and I've never done this yet -- they call it dog and pony shows.

It's supposed to attract a lot of media attention and publicity. Well, I'm a different kind of person than that. I'm interested in the facts and don't want to hear them too many times. Just try to get it down here and try to solve these problems as best we can. Thanks for waiting a minute. Yes, sir?

DR. SACHS: So I think some of the obvious problems which were mentioned are: one in the Medicaid business, the subject which the lady from Essex County referred to-- There's no question that by trying to establish a consistent doctor/patient relationship, you can both avoid more serious illness downstream, and avoid unnecessary hospitalizations. Anything that we can do to foster that is much desirable for society as well as for the individuals. All of us recognize that the fees that the physicians are paid for outpatient visits, especially in primary care in Medicaid, are so disproportionately low for their expenses that by allowing them to stay at that level, we've created a great disincentive for physicians to play that role for patients.

On the broader subject, I think that some of the points made are true. That the factors that concern most patients -- and I'm sure that 50% of my patient base is Medicare, many of whom I've taken care of for many years, so you get very familiar with their concerns -- are the whole idea of, how about if I face a catastrophic illness? What is that going to represent? Where can we in society find a way to cover for that possibility? As you know, Dr. Bowen, who is the new Secretary of HHS, is trying to address that at the Washington level, but we should also be trying to address it at the New Jersey level.

I think we have two fortunate things that are going for us when you try to look for resources to tap into to try to help those of lesser means. One is that we are a very wealthy State. We are certainly, on a per capita basis, the second or third wealthiest state in the country. So therefore, if there

are states which have the means to try to help their less fortunate members, whether they fit under Medicare or Medicaid, we should certainly have it in the form of general revenues.

On a more specific level, in terms of the health care basket, we also have an unusual situation in that the hospital costs which are by far the largest component of the health care dollar in New Jersey, are lower than any state in New England or the Mid-Atlantic states. They are lower than Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island, New York, Pennsylvania, Delaware, Maryland, and West Virginia.

So again, if you only limited your perception to those people are paying into the health care revenue basket, obviously substantially fewer dollars are coming out and therefore substantially fewer dollars are going into our State versus other states. I can't believe that between these two sources of potential income there can't be enough money found to protect our less fortunate citizens from catastrophic illnesses.

When you come down to the more specific point of dealing with outpatient physician charges in Union County, we have several mechanisms which we believe have dealt very well with this problem over the years. One is that we have a judicial committee which patients/consumers who are unhappy either with the quality of care that they receive from a doctor or with the cost of care which was stated by the doctor can appeal to. And on the average, after these appeals are heard, we only have two to three per year which we pass on to the State Board of Medical Examiners because the doctor has not been able to come to a satisfactory agreement with the individual.

The second is that we've had for many years a very good relationship with the Senior Citizens Council in Union County. The Senior Citizens Council in Union County themselves have helped create a means test which they supervise and which

they testified to the Union County Medical Society -- individuals who they feel are deserving of accepting assignment under Medicare. And then physicians in Union County, and we have several hundred now who are participating in this program, and will accept assignment for those individuals on the word of the Senior Citizens Council.

Yes, it would be lovely to accept assignment for every patient who is over the age of 65. But the realities are too, that there's a large patient voting block who are not over 65 and who are not doctors. If some 29-year old individual, who has three children and is living on a very limited income realizes that his boss, who is still working at 69 and has much more income, is paying less to see the doctor than he is, he's going to resent it. And we can't do anything in our society which is divisive among generations.

So, I would say factors that I believe are-- I do believe that there are adequate funds in the State of New Jersey -- in our wealthy State with our very low cost hospital system, to take care of our less fortunate means-- I do believe that at least in Union County that we have a great satisfactory way of establishing those senior citizens who are deserving of a means test in a way in which they can deal with their own organization, rather than having to deal with the physician. And as a new member of the Board of Trustees of the State Medical Society, I will certainly do everything in my power to make that be a statewide program.

ASSEMBLYMAN COLBURN: Thank you. Mr. Otlowski?

ASSEMBLYMAN OTLOWSKI: Doctor, of course, you're talking about massive appropriations. You are aware of that. To cover the subject in the manner that you are advocating--

DR. SACHS: Catastrophic health insurance? Senator (sic) Bowen estimates that it doesn't represent more than 10% or 12% of the total health care package. He doesn't think, according to his calculations with--

ASSEMBLYMAN OTLOWSKI: In dollars and cents, the program that you're advocating, you know, the general approach that you are advocating-- What do you figure that would cost?

DR. SACHS: I don't know the facts for the State of New Jersey. I can only talk about the type of percentages which the Rand Institute quotes to Senator (sic) Bowen.

ASSEMBLYMAN COLBURN: Is Dr. Bowen the Commissioner of--

DR. SACHS: Yeah, I should say too -- Secretary Bowen, right.

ASSEMBLYMAN COLBURN: Yeah. He is the Commissioner or Secretary or something.

ASSEMBLYMAN OTLOWSKI: There are no figures that you have available?

DR. SACHS: Not specifically for the State of New Jersey that I know of. No.

ASSEMBLYMAN COLBURN: Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: Yes, Mr. Chairman. I think our colleague, Assemblyman Otlowski, is somebody who is basically asking for a future tax increase. I say that facetiously--

ASSEMBLYMAN COLBURN: I'm glad that's facetiously.

ASSEMBLYMAN FRELINGHUYSEN: --but of course that's, what in fact, we may be talking about. I'd like to recognize the fact that a number of your members have taken the liberty of contacting me. During a short perid of time early in this year, my office was put out of commission by a number of calls from your membership. I'm glad to see that democracy works and that we finally did find time to acknowledge all those calls and letters.

But I think one of the important things about this hearing -- your testimony as well as the other men and women who have come forward -- is that we can hope that there is some cross pollenization of ideas; that for those of you who perhaps missed the testimony, you will take the opportunity to

read one another's testimony and compare them. Some solutions have, in fact, been suggested including obviously, raising revenues and perhaps raising taxes. But also looking at what, in fact, in the overall formula is a Federal obligation, and what, in fact, is being put on the State of New Jersey by the Federal government not fulfilling its obligations.

DR. SACHS: That is a problem because we have the second oldest population in the country and therefore we'll have a higher percentage of senior citizens in any state except Florida.

ASSEMBLYMAN FRELINGHUYSEN: Thank you very much for your testimony.

ASSEMBLYMAN COLBURN: Thank you. Mr. Evanoff. Last but not least for the morning.

A L E V A N O F F: Chairman Colburn and members of the Assembly Health and Resources Committee, the New Jersey Health Care Coalition consists of unions, senior citizen organizations, children and disabled organizations, and persons interested in accessible, affordable, high quality health care.

On behalf of the coalition, I'd like to thank you for the opportunity to appear before you today to testify basically on the mandatory Medicare assignment legislation. Although I realize that this is a committee hearing on various questions on Medicare and Medicaid--

ASSEMBLYMAN COLBURN: You may have an opportunity to testify on specific bills, I'm sure you will, at a later time.

MR. EVANOFF: Yes, and we'll be there. We see this piece of legislation as one of the most important pieces of social legislation before the Legislature this year. We see it as affecting over three quarters of a million seniors and disabled residents of this State. A-2511, or the mandatory assignment bill, would require medical providers who treat Medicare Part B patients to charge no more than the reasonable fee approved by Medicare. This bill in no way compels a health provider to treat Medicare patients, but states that once

treated, the fee to be charged is that set by the Federal Health Care Financing Administration -- HCFA. The bill does not in any way question the quality of care provided by doctors and other providers.

Doctors have been responding at conferences and in letters to the press as if this bill would be a fatal blow to health care and they claim that doctors would leave their profession because of this legislation. It reminds many of us of the statements made back in 1965 prior to the passage of Medicare. Everyone, including doctors and all of the various health providers, who now admit that not only is Medicare a fine piece of social and health legislation, but it is a financial boon to the physicians. As to doctors leaving the State, to our knowledge not a single doctor has left Massachusetts where similar legislation was passed. It's true that it hasn't been in effect too long, but there is no record of anyone leaving.

Twenty years ago, the United States government assured its senior citizens and future seniors that they would receive medical care in hospitals under Part A of the Medicare Program. The government also structured a plan called Part B of Medicare that required seniors to pay for insurance, and I'd like to underline insurance, for Medicare provided by doctors. Seniors were required to pay three dollars per month for Medicare Part B. Medicare was to pay 80% of the doctor's bill and seniors would pay 20%. This was the Federal government's commitment to seniors and later to the disabled, that our country would provide them with access to high quality health care.

The monthly fee is now $15.50 per month, and in 1987 is $17.50 per month. Members of the 99th Congress gave recognition to this commitment when they rejected the Administration's move to change the calculations of Medicare Part B payment. The Administration asked for the 1987 payment to be $24.50 per month but Congress upheld the original method

of calculation and the 1965 commitment and increased the payment to only $17.50 per month.

The richest country on earth made this commitment to its seniors, future seniors -- a commitment not being honored, and the New Jersey legislators who introduced A-2511 deserve credit for their action. This legislation is modeled after the mandatory assignment law which was passed last November in Massachusetts and recently upheld in the courts of that state. The purpose is to alleviate the elderly and disabled for some of the extremely burdensome out-of-pocket health care costs which are now preventing many of them from seeking medical attention when they truly need it.

Medicare patients now are paying more out-of-pocket for health care than they were before Medicare was enacted, and that point was made a number of times today. A major reason for this phenomenon is the escalation in physicians' fees. Nationally, according to HCFA only 25% of the doctors have agreed to accept the Medicare rates as their fees. In New Jersey only 20% of our doctors accept assignment for all their Medicare patients. The remaining 80% are charging up to three times the Medicare rate for many, if not all, of their patients.

Seniors who live on Social Security payments which average only $482 per month or $5784 per year cannot shoulder the burden of these costs. As to the myth, and I believe it's the worst myth that's been propagated throughout this country of rich seniors because I'd become a millionaire if you compare me to Mr. Paley of NBC or ABC or whatever station that he owns-- But I'm not a millionaire.

The average yearly income for seniors in New Jersey is only $14,695. Doctors who earn an average of $110,000 per year can better afford to take the Medicare rates as their fees. We cannot depend on voluntary action by the medical profession to bring the fees down to an affordable level. Nor should seniors

or disabled persons have to plead with their doctors to reduce their bills. The seniors believe that they have the promise of their government to be taken care of. Attaching any form of means test to this bill will change the insurance program of payment to a welfare program and that is the first thing that the powers in Washington will look to cut. Seniors need Medicare Part B and mandatory assignment.

We in the New Jersey Health Care Coalition recognize the difficulty that physicians may have with Medicare and we have offered to work with the medical profession for a revision of the formula for a reasonable charge if it is warranted. Today there is no motivation for any doctor or their association to work to correct any injustice in the Medicare reasonable charge as long as the doctor or other providers can pass the difference on to the Medicare patient. The bill that was introduced, A-2511, would give the push to the medical associations to work with other organizations in this State to correct what's wrong.

As an example of the costs seniors face today, when I suffered a recent heart attack, Medicare paid $3500 to cover physicians' services, excluding hospital costs, over a six month period. However, the doctors' fees were $5400 and I had to pay $1900 or 35% of the total. That would be compared to approximately $800 that I would have to pay if Medicare fees were accepted. This is in addition to paying a $75 Medicare deductible yearly, and $15.50 per month for Medicare part B coverage. This kind of gross overcharge by physicians is, unfortunately, the norm instead of the exception.

Mandatory assignment is not a question of money alone. It is a life and death question for many seniors. When a senior is faced with a costly visit to the doctor or money to put food on the table, unless there is an emergency, the senior will up for food, putting off going to see the doctor until it is too late and some serious problems

develop. Then there's that fear that most of us have of an emergency room visit. That is the human side.

Financially, the cost to the senior at the point of entering the hospital is a disaster. The cost to society is also a financial burden. Treatment by a physician at the office is much cheaper than of the ill at the hospital. As an example, in my own case, while the doctors' bills amounted to $5400, the hospital stay amounted to $40,000 for 19 days.

We are urging the approval of mandatory assignment which would provide quality health care when it can do the most good. And I'd like to say that I'll be back when this bill is up for discussion. I'd like to thank you for the opportunity to be able to present some of our views and the views of the New Jersey Health Coalition and look forward to continuing to work with this Committee to help make New Jersey a healthier place for all of its residents. Thank you.

ASSEMBLYMAN COLBURN: Thanks a lot.

MR. EVANOFF: I have here, Mr. Chairman, and I don't think I ought to present them now because we'll present them at the time when we really deal with the bill-- I've got thousands of signatures that have been collected in the various senior centers.

ASSEMBLYMAN COLBURN: Probably then, but you're welcome to turn them in for filing to David Price who will not do anything un-torrid to them.

MR. EVANOFF: Right. I will turn them over to you -- letters in particular. Thank you.

ASSEMBLYMAN COLBURN: Mr. Evanoff, just a second. Do you have any questions?

ASSEMBLYMAN FRELINGHUYSEN: No.

ASSEMBLYMAN COLBURN: Mr. Otlowski?

ASSEMBLYMAN OTLOWSKI: No.

ASSEMBLYMAN COLBURN: Okay. We're going to adjourn now for about an hour. We have a long afternoon.

(RECESS)

AFTER RECESS:

ASSEMBLYMAN COLBURN: We will begin the next session. I am taking one man out of order in deference to the fact that he has an appointment later this afternoon in Ocean County. Mr. Feirstein, will you come up here now and tell us what you would like to? And Mr. Hayden, I guess you are with him?

G E O R G E A. H A Y D E N: Yeah. I didn't want to walk home. (laughter)

MR. FEIRSTEIN: First I'd like to apologize a for creaky voice. On top of everything else, I have a cold.

ASSEMBLYMAN COLBURN: I'd give you a prescription, but--

MR. FEIRSTEIN: Thank you. Let me get into action. As a representative of the New Jersey Health Care Coalition and as a member of the New Jersey Federation of Senior Citizens, I am here this morning, or this afternoon, to implore this Committee to realize the facts of the present health care situation in the State of New Jersey.

The Health Care Coalition is a vehicle for organizing the senior citizens of this State to work together to fight the constant attacks on all health care programs as well as to help senior citizens on health policies in our State. For some time now, under the present Administration in Washington, all health costs have risen at a tremendous rate to all health agencies.

We have become a nation of armaments rather than a nation of domestic tranquility. It can be commonly called "guns over butter," and health care has suffered as a result. Let us therefore digest some of the facts that today confront

senior citizens and the persons who will very shortly become senior citizens.

Each day as we grow older, we the present senior citizens lose some of our strength and are therefore prospective patients for doctors and perhaps possible patients in a hospital. In 1981, the first day in any hospital cost $180. During 1986, the cost had risen to $492, and now starting January 1, 1987, the cost of the first day in the hospital will rise to $520, and this is only after much debate in the Congress, who at first decided that the cost of the first day in the hospital shall be $576.

We the senior citizens of this State and other states in the nation realize that the doctors' expenses have also gone up. Our insurance has gone up at home, on our cars, and all other living expenses as well. While I do not condemn our national government for declaring time and again that they have inflation in hand and therefore the COLA -- the cost of living -- must be kept down. Nevertheless, the people, particularly the women shoppers -- our wives, and others -- know that certainly something is wrong when they find that the prices of all commodities have gone up. Where does that leave the senior citizen who is in the center of this controversy?

Yes, we have grown older, living longer, but for some time we wondered if it is worth being alive and attempting to make ends meet and struggle to pay our bills, especially so when as a large group we must visit the doctors continuously to remain alive.

The great state of Massachusetts has shown us the way. We seniors do not prefer social medicine, even though only our nation and the Union of South Africa are the only two large industrialized nations on this earth who do not take care of its citizens in this manner. Home health care denial of services to senior citizens is a shocking situation. Some time ago, I investigated the plight of many seniors in Ocean

County and the results outraged me. With approximately 100,000 senior citizens in the Toms River and Lakewood areas, I found only two doctors who accepted assignments. Then I heard from my good friend, Representative Claude Pepper of Florida, who informed me of the situation in Massachusetts. I was told by this 86-year-young man to wait for details from him, pertaining to bill number 217 in Massachusetts and how it was faring in that state. I received letter after letter from Representative Pepper with the necessary details of this bill.

It had been debated in the Assembly and passed by a great majority and then sent on to the upper house of the Senate. Here too, the bill was debated, discussed thoroughly and finally passed by a great majority and on to the Governor for his signature or veto. But Governor Dukakis was ready for the bill and affixed his signature to it, and announced the date for his signature sometime in December, 1985. I flew to Boston and was astounded by the scene which I saw there. Thousands upon thousands of senior citizens had descended upon Boston to see the actual signing of this bill. The police, realizing that the people were not vandals, not terrorists, but just plain Americans who had come from all areas of Massachusetts to witness this, had no problems to confront with--

The signature, however, would make the bill effective 60 days later, namely February 16, 1986. It was then that the AMA -- the American Medical Association -- of Massachusetts went into action appealing to the Massachusetts State Supreme Court for a decision. In record time the decision was handed down upholding the law and declaring the law constitutional.

Gentlemen, many other states in the Union are now deliberating this very same law. I am certain that the same results will prevail. Yet, New Jersey, with its vast senior citizen population is lagging behind. Why? Are we not citizens who have given our all in depressions and in wars to

our government? At a recent meeting with a number of doctors, it was one of the doctors who declared that at the present rate that Medicare would go bankrupt. He was right in some respects. I have with me a number of bills from Medicare, one which infuriated me as it will you. I will explain its contents.

A man's wife was dying of cancer. The doctor had given her up and she was unable to recover. The husband was told to sit by her bed and await her demise. In walked a total stranger, who said he was a doctor who when asked by the husband who he was, was told that he had been sent in to check on the patient. He'd come in every half hour that same day until the patient died. This doctor sent a bill to Medicare for $208 with a request that the money be sent to him directly. Medicare paid and then sent notification to the husband that the bill had been paid. The husband was furious, but the money had already been paid.

On another occasion, I was in the hospital just five weeks ago. My cardiologist walked out of the room and met a friend, an oncologist in the hall. An oncologist is a doctor who treats cancer patients. Both doctors discussed while they were in the men's room, my case. My doctor informed me he only asked the other doctor two questions. Yet this oncologist never visited me, never came back to my room, but when I was discharged, the oncologist sent me a bill for $125 for consultation. Yes, besides a poor heart, I have cancer. (crying) Perhaps death is a good manner to escape. These greedy doctors who have no compassion appear to have only the need for greed. How many senior citizens have taken their own lives to escape these devils?

Assembly Bill 2511 must pass and must become the law of the State of New Jersey to permit senior citizens to live and die with dignity and not be hounded by attorneys who are constantly threatening to sue, egged on by the doctors, who

have no mercy nor leniency. I have in my files many more such cases of unwarranted bills sent to patients for hundreds of dollars for a one-day stay in the hospital. I could go on and on, but I am certain that you lawmakers must realize that we are human beings too and that there is a breaking point for many seniors who can no longer take it -- being hounded by attorneys and doctors. We would very much like to live to see our grandchildren grow up before we meet our maker.

Gentlemen, I implore you to pass this bill to the Assembly floor and permit the lawmakers to know and realize that their parents and grandparents may have some money, but most has gone to doctors to keep us alive. Thank you very much gentlemen.

ASSEMBLYMAN COLBURN: Thank you. Mr. Otlowski?

ASSEMBLYMAN OTLOWSKI: No.

ASSEMBLYMAN COLBURN: Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: No.

ASSEMBLYMAN COLBURN: Do you have anything to say too, Mr. Hayden?

MR. HAYDEN: Yes. I have a small brochure there. And mostly my (inaudible) submitted to you will be the history of what went on in Massachusetts.

ASSEMBLYMAN COLBURN: Oh, okay.

MR. HAYDEN: Thank you. To the Assembly Health and Human Resources Committee: Today we face the State of New Jersey with a mandatory assignment. The seniors must have affordable health care, thus the physicians must accept Medicare assignment. And any senior with the red, white, and blue card, A & B is to be considered for assignment.

The bill does not prohibit the the Federal Medicare statute or conflict with the Federal Medicare program. The facts are, the purpose of Medicare statute is to provide adequate medical care at affordable cost to the elderly and disabled. There is nothing in the Federal Medicare statute to

prohibit the states from regulating doctor's fees for Medicare patients, and since (the legislation is consistent with the intent of the Federal law, the State) is free to act, the facts are that doctors have misused the insurance factor of value to the point where Medicare and Medicaid cannot balance out. Seniors on a fixed income cannot get medical care that is affordable.

I have an example here. Now the laser is a most important -- medical history for treating patients. This example I have here--

ASSEMBLYMAN COLBURN: Is this for cataracts?

MR. HAYDEN: This was for urology.

ASSEMBLYMAN COLBURN: Oh, okay.

MR. HAYDEN: The laser operations took five days from the time the person went into the hospital and left the hospital. Now in that five days, the part of the doctor's bill was $2655. Office visits were $50 each -- $250. Hospital services -- $455. The anesthesia -- $365. Now this total was $3725 for a minor operation. Medicare submitted $900. That leaves a balance of $2825.

If the patient has Blue Cross and Blue Shield, very little of this balance will be paid, thus the hospital has filed Medicare, Blue Cross and Blue Shield for hospital services, so it cannot pay the patient's for the balance. Many patients are paying five dollars a month or what they can afford, or face the doctor's collection agency for the balance. This is a sample of an overcharge and the laser is a 20-minute operation, rather than hours of operation with cutting, blood work, and stitching. It's a quick operation.

Many doctors send their patients to a second doctor for a second opinion. This doctor is a specialist. The fee is $200 for that report to doctor number one. This a great overcharge to the patient. Doctors do not take an interest in care for the elders in nursing homes. There must be better and

more accurate care for the older people. Thus, I'm going to cite an instance here in Bergen County. A nursing home with 90 violations was never noticed. Patients were starving and uncleaned. After all, when doctors go into these places, they see what's going on, but they did nothing. And the home was put on charges. In fact, the owner was prosecuted by the Federal law not by the State law because he had brought people from the Philippines into the home who couldn't speak English and tried to use them as workers.

The American Medical Association vs. Margaret Heckler, our Secretary of Health and Human Services. This national committee preserves Social Security and Medicare. Well after all, she only made a suggestion: "Doctors, please take assignment for 15 months." It went with a deaf ear. Some did; some didn't. So what happened, the American Medical Association took the case to Indiana South -- Civil action, 1-p.86-1317 C -- filed United States Supreme Court, Indiana South Division, September 21, 4:50 p.m. in 1984.

The case was found in favor of the Secretary of Health and Human Services. The Assembly is duty bound to give affordable health care to the seniors. In closing, I wish I could stay with you and go through more of answering your questions. I go into nursing homes; I go into hospitals. I help the sick. What I have heard, this past couple of months, is a disgrace for America to say that we take care of our sick.

So, I want to know if you can possibly pass this bill with all of the restrictions and give us good affordable health care. Now this was a poster that was sent out, but it doesn't mean much. (holds up poster) Sure, doctors' bills are up. We all know it. This one doctor, I took his ad, he wants assignment. So, we're not at zero in doctors refusing assignment. We have a lot of doctors on assignment, but we have to make it all assignment.

Just to show you, here's a doctor that says, "65 and older." He wants assignment. But he has a little bit on the bottom, that if you can't pay the balance after the assignment

figures are in, he will work out a plan, whatever you can afford. So, he's on the way to getting patients and holding them.

ASSEMBLYMAN COLBURN: He's a podiatrist.

MR. HAYDEN: Yes. And then I have another one -- the Medical Society of New Jersey. All right, they don't like DRG maybe, or HMO or PRO or what. We need a law to coordinate. We're not after the doctors' hides or make them poor people. We seniors just want something we can go on with an affordable care. And if we can get that, we'll all be happy. That's going to be your duty and it's a hard job. Thank you.

ASSEMBLYMAN COLBURN: Thanks. Mr. Otlowski?

ASSEMBLYMAN OTLOWSKI: No.

ASSEMBLYMAN COLBURN: Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: No.

ASSEMBLYMAN COLBURN: Okay. Thanks, gentlemen.

MR. HAYDEN: You're welcome.

MR. EVANOFF: Thank you very much.

ASSEMBLYMAN COLBURN: Now, we have Doris Nash is the Public Affairs Director for Cancer Care, Inc. I just would appreciate knowing -- maybe I'll find out from this -- what your organization is? I can't say I'm familiar with it.

D O R I S B. N A S H: Well, I hope you're going to hear much more about us. I was going to gloss over that portion of it, Dr. Colburn, but--

ASSEMBLYMAN COLBURN: I just wasn't sure who you were.

MS. NASH: We're a social agency over 40-years-of-age and our main office has always been in New York City. But we always did serve that section of New Jersey that was in a 50-mile radius of New York. About four years we opened our first New Jersey office in Emerson. We just moved to Millburn. We also have an office in Ridgewood and a part-time office in New Brunswick. We offer counseling, and help two cancer patients and their families, group and individual

counseling. We help with planning for the care of the patient, particularly with the idea to help the patient remain at home. And we give financial assistance to eligible families to help them with home care plans and for transportation to and from doctors' offices. That in a nutshell is us. We also have an advocacy program on staff to our public affairs committee and we try to speak up about things on perhaps the catastrophically ill whenever we can. In New Jersey, ever since we opened our offices in--

ASSEMBLYMAN COLBURN: Excuse me. Can you hear back there? (negative response) Yeah. We have a problem. That darn thing doesn't help because it's just a recorder. So, you might want to-- It doesn't help a bit. It only records.

MS. NASH: All right. I'll scream like the waitress in the coffee shop--

ASSEMBLYMAN COLBURN: I'm sorry. Everybody please be as quiet as you can.

MS. NASH: --and I do have other copies of the testimony to distribute, if you'd like them.

ASSEMBLYMAN COLBURN: The only person permited to talk other than the speaker is the baby in the back. (laughter) The rest of you, please don't converse.

MS. NASH: I just wanted to point out that ever since we established a physical presence in New Jersey, we have had more and more clients and more and more calls upon our resources for financial assistance to many of these clients. Last year we disbursed over $276,000 to 336 needy New Jersey patients. That figure was $200,976 the year before. During the first four months of this year -- our fiscal year starts July 1 -- we disbursed $61,849 to 323 patients. I want to point out that at this point that we've had to reduce the maximum amount of weekly disbursements to patients from $75 to $60 a week because of decreased resources on our part, and we raise all of our own money ourselves. And in deciding to

reduce the amounts of grants, we were basing this decision on our wanting to not turn away any eligible needy patients who would need our financial help.

That would go on to the real core of our testimony which is the Medicare and Medicaid services in New Jersey. When we first offered testimony years ago on the Medical Needy bill, we estimated that approximately 23% of the patients that we were serving in New Jersey had incomes as low as $600 a month. We have since estimated this figure to be about one third of the disbursement families, which we serve.

So, we can expect that these low income cancer patients would soon be eligible for the Medically Needy or the CCPED programs, but we've been finding that now there is the added frustration that these programs are not as available or helpful as has been anticipated.

I'd like to throw in here that another factor that is offered to us too is that so many of the patients we are helping financially are patients who might be spending down to that Medicaid eligible level, are in such last stages of the illness that there are times were our workers feel that it just doesn't pay to bother the family to urge them to even make application for the Medically Needy Program, because what you have to go through is so difficult and what you are living through already is so difficult.

But, I'll give you an example of a man who has fallen through a load of cracks in the system. He's a 41-year-old postman with liver cancer and with metastasis to the bone. He has a wife and three children, aged 7, 10, and 13. He is considered disabled and receives about $525 a month from an employment related disability benefit. And by the way, this is not disability pronounced by the Social Security system, because he is not eligible for Social Security. He's lucky enough to have health insurance coverage which gives him everything but a home health aide or homemaker care.

He's not eligible for SSI because the worth of his car put him over the assets level, which means he would have to sell his car and get a, you know, a bad car or something and he didn't do it. His children are in the Medically Needy Program. We've helped with some home health care, mainly to give some rest to his wife.

Now that his condition has worsened, he needs skilled nursing care at home. He can expect some reimbursement from his health insurance, however, since he is so poor now, he can't pay the deductibles, or the coinsurance. So, we are going to pay for that and the home health care will be provided by a certified home health agency. He has received no government assistance whatsoever. God forbid his wife should get ill during this time, which is quite likely.

Now another patient is a 71-year-old with cancer of the endometrium with metastasis to the right breast. She gets Social Security of $650 a month. The social worker at our Millburn office said that she had been accepted by the CCPED program, but she refused it since she would have to cost-share to such an extent that she would have been left with only $350 a month to live on while her rent is actually $340 a month. So, we're hoping.

It appears that New Jersey's Medically Needy Program has been set up in such a way as to confound those who apply and to impede acceptance to the program. Those administering the Medically Needy Program acknowledge that the number of those who have indeed become eligible is far less than had been anticipated. They number only 2603 for the first four months of the program. The fact that the income eligibility levels for the program are so low, immediately springs to mind as one reason for the very low enrollment. And I might add here that New York's eligibility for Medically Needy is $409 a month for one person and $600 a month for two people. A solution to this could be found by taking advantage of a provision in the

recently enacted Budget Reconciliation Law which allows states to extend Medicaid coverage to the elderly and disabled with incomes up to the Federal poverty level. This could allow for a more generous program.

Other possible reasons for the ineffectiveness of the program are that it sets a coverage for a six-month period requiring people to keep six months worth of records of their medical expenses, which is a pretty difficult to do when you are also struggling for the reason for this in the first place -- the illness. Patients also lose interest in applying when they realize that Medically Needy coverage doesn't include emergency room services, inpatient services, or nursing home care. Apparently, New Jersey is the only State to offer only ambulatory services to the Medically Needy. We're heartened that the legislators have already spoken to the Commissioner about this program and he, as he said today, is very interested in seeing what could be done to rectify this situation.

But another serious problem we'd like to bring to your attention, is related to the cutbacks that have been occurring in Medicare's home health care services. They've been accomplished not via the legislative process, but via a reinterpretation of the Medicare statute's language regarding home health care, as well as other regulatory changes. Now, clipped to this testimony that is presented to you is testimony that we presented to Senator Bradley last spring when he had a hearing on this issue. So, I urge that you read that testimony because it does describe what's happened to home care in New Jersey -- Medicare covered home care -- as perceived by Cancer Care social workers.

The cutbacks have also seriously affected many Medicare certified home health agencies which have experienced extreme financial problems because of denials of Medicare coverage after home health services were supplied. There are

now many home health agencies struggling with severe financial problems and quite a few have already folded. And I could add here that the venerable Visiting Nursing Service in New York City has recently had to let go 250 members of their personnel.

Now some gains for home health care were achieved in the Federal Budget Reconciliation package and Senator Bradley deserves thanks for his role in this. These gains were mostly of a technical nature, but there is one that is very relevant to the purpose of today's hearing, We refer to that provision which allows providers to represent and/or assist Medicare patients in their appeals of reimbursement denials.

It shouldn't take much imagination to appreciate how hard it could be for an elderly patient to fight city hall, so to speak, by taking on the fiscal intermediary for Medicare and the Health Care Financing Administration. Allow participation in this process by the actual provider of the services in not only rational, but it's also humane.

We wish, therefore, to take special note of certain New Jersey legislative proposals which would offer even more assistance to Medicare patients who feel they have been denied benefits to which they have been entitled. We are referring to S-2484 which passed in the Senate and is now before the Assembly Senior Citizens Committee, as is A-3140. Both proposals appropriate monies for legal assistance for Medicare patients when they want to appeal their denials.

They're interesting bills and give serious recognition to the problems with Medicare which we have been describing. Whether or not the New Jersey Legislature feels the State can afford such a program remains to be seen, but at the least the Legislature should put Medicare and the Department of Health and Human Services on notice of its disapproval of the dismantling of Medicare's home health benefits.

We hope that this testimony will be helpful and we'd be pleased to answer questions.

ASSEMBLYMAN COLBURN: Thank you. Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: No.

ASSEMBLYMAN COLBURN: Mr. Otlowski?

ASSEMBLYMAN OTLOWSKI: No.

ASSEMBLYMAN COLBURN: I do want to say that a few things that you said really did ring a bell with me. I remember somebody in my own office -- that I hadn't accepted assignment. But they got such a little bit from Medicare that it was really ridiculous. And I wasn't allowed to question the thing because I, you know, hadn't accepted assignment. So now at least we can go to bat for people and help them out, which certainly makes sense.

MS. NASH: I'm sure John Paul Marosy can speak on that issue because he represents the actual providers of the home health services.

ASSEMBLYMAN COLBURN: Thanks a lot.

MS. NASH: You're welcome.

ASSEMBLYMAN COLBURN: Let's see. Dr. Robinson, President-elect of the Essex County Medical Society. One thing I wanted to ask was what your specialty is? I forgot to do that.

D R. H E R M A N M. R O B I N S O N: I'm a radiologist.

ASSEMBLYMAN COLBURN: You're a radiologist. Okay.

DR. ROBINSON: I have copies of my statement. Good afternoon. Dr. Colburn and members of the Committee, I thank you for the opportunity to speak before you.

As President-elect of Essex County Medical Society and President of the Radiology Society of New Jersey, I oppose Bill A-2511 as being unfairly discriminatory toward physicians and unnecessary as a remedy for a problem which in truth affects a minority of senior citizens.

ASSEMBLYMAN COLBURN: One thing I have to remind you as I have others. The annoucement of the meeting very clearly stated that we weren't here to discuss specific bills. I did

let others talk about that, but still I would like to remind you. What we're really here to do is to try to figure out how Medicare and Medicaid are working presently and then the Committee is going to go over, not only what we hear today, but other facts that come in and other suggestions, and then we're going to try to come up with reasonable help to people who need help. And to discuss a specific bill was really not the purpose. Did you see the notice of the meeting?

DR. ROBINSON: We were not so informed that--

ASSEMBLYMAN COLBURN: Well, let me give you the copy of the notice. Dave, (referring to aide) do you still have it? I asked for it before. I think this gentleman, whose name at the moment I have lost-- He was doing the same thing and I sort of let him get away with it. But I would like you to read that. You might consider coming back when the bill comes up rather than now.

DR. ROBINSON: Then perhaps I could use a bit of time to mention something that we as physicians--

ASSEMBLYMAN COLBURN: Tell us how Medicare and Medicaid are working and if you have suggestions on--

DR. ROBINSON: Quite poorly.

ASSEMBLYMAN COLBURN: Well, okay. I think a lot of people agree with you. If you have suggestions about how the situation could be improved, especially by the State Legislature, we'd appreciate that. But really, to discuss the specific bills was not the purpose of this hearing and was not stated in the thing.

DR. ROBINSON: Well, what I can state that might be helpful to you is that we find that the mechanism used by Prudential in approving examinations for which patients are reimbursed or physicians are reimbursed if he accepts assignments, very often are faulty. Although there is a clear deliniation of numbers which attest to the type of examination

performed, time and time again ourselves when we accepted assignment throughout the year some years ago with Medicare and our patients tell us now when we-- We only accept assignment where there's an indication that the monies which the patient receives back for a given study varies where the study has not varied -- where the designation of the study has not varied.

We have spoken to Pru -- Prudential -- about this and we're given a figure: "Well, we handle so many claims and only one percent error is made--" which I find extremely hard to believe, because the number of errors that come across our desk by patients complaining that they haven't received what they thought they would get back as a reimbursement, or we haven't received -- is far in excess of one percent-- Yet we have no method to verify, indeed, what the error rate is or how it can be rectified. We're told by Pru when we want to question whether the Medicare program is reimbursing a patient correctly for a procedure performed in radiology, that this has been reviewed by a radiologist whom they have on their committee. And yet when we ask, "Well who is this radiologist? We need a dialogue." We're told that we can't be told that because anonymity must be protected.

We find this a very difficult position to be in medicine where we cannot meet with and discuss the fees allowed for all office or hospital procedures because Prudential feels they must keep those people who advise them on correctness of fees at arm's length from us and will not allow us to have dialogue with them. So we have to depend upon Pru as being Big Brother to work on our behalf when in fact, they are the ones that appear to have the problems we're trying to get corrected.

ASSEMBLYMAN COLBURN: Since your testimony has now become kind of informal, let me stop you right there. Does any of this have to do with the difference in the profiles that different physicians have? I mean it's possible for one radiologist to have a different profile? I don't know.

DR. ROBINSON: It may very well be in some cases. But in the same office, you should have one profile. And we find vast discrepancies.

ASSEMBLYMAN COLBURN: Right. See, in the same office, I didn't know if you have a young physician just coming out of his training. Could his profile be different from the ones that are already there?

DR. ROBINSON: No. The profile would only be under our office name under our group, and we don't have that in our office.

ASSEMBLYMAN COLBURN: Okay. So, that's not a problem?

DR. ROBINSON: No. But we've had vast differences, as much as 25% and 30% difference in what has been allowed.

ASSEMBLYMAN COLBURN: Do you use the same diagnosis or code number?

DR. ROBINSON: Absolutely. In fact, in some cases we've been told to revert back to an old diagnosis number which incorrectly states the quality of the study and that it is, for instance, for those who are familiar with radiology you can perform a study of the colon with barium molone (phonetic spelling) a study of the colon with barium followed by air contrast, which is more involved, but most of us feel it's probably a better study. And the cost of performing the study is more with the barium with air contrast. It's a more exacting study which requires more expensive equipment.

And at times, we were reimbursed on the basis of the old barium study and when we questioned it, we've been told, "Why don't you just use the old number and we'll get you up?" I mean, there's no logic. We're working through the intermediate area - the head of Pru, Dr. Gardum (phonetic spelling) who does his best. But we have at no time and ability to sit through professional medical staff to see if we can rectify problems. There are many patients who do not come

to us and do not fight with Pru if an incorrect reimbursement has been made, and we have no way of knowing it except, incidentally, when we see them on our next visit. So that has been a problem.

ASSEMBLYMAN COLBURN: So, there's a better need for the ability to talk with the intermediate area?

DR. ROBINSON: The professional staff. Absolutely. We have no ability to meet with the so-called experts who advise Pru on the proper reimbursement schedule to be used for any given study.

ASSEMBLYMAN COLBURN: Well, I had something that came to me yesterday afternoon from the Private Ambulance Transporting Association, or whatever you call it. They also said that they are having an awful time with the physical intermediate area -- that they send in legitimate bills and they have to re submit them two or three times, and you know, that gets to be a costly thing on both sides, not only in the office, but in theirs. So, it was interesting that you brought that up.

DR. ROBINSON: There's another matter I'd like to touch on if I can for a moment. I couldn't help but hear the testimony given by the senior citizen and I sympathize greatly with him, and I realize the problems of senior citizens to that degree. I can state that the Medical Society of New Jersey, which I'm on the Board of Trustees, has proposed a possibility that might help patients who have a financial difficulty. We all know that patients are embarrassed and very often they may not reveal to personnel in an office or to a physician that they have financial need.

There certainly is financial need for a minority, but certainly a significant minority of senior citizens. We would like to help out and try to make it less embarrassing for them in order to give them the need (sic) they rightfully deserve. We thought that perhaps some method such as the PAA system

which stands for Pharmaceutical Assistance for the Aged which is available to senior citizens of this State-- It's a method by which a senior citizen can have a reduced cost for the pharmacological agents they use, because they have financial need. Well, if a system such as that or any other system which the Legislature can set up which will help us to identify senior citizens who have financial needs, then I feel certain that most physicians in this State would recognize it, the senior citizen won't be demeaned, and we would certainly give a financial consideration and in cases like that, I'm certain that most physicians would accept assignment in cases like that. I think that would be helpful to senior citizens.

ASSEMBLYMAN COLBURN: That is the subject of a bill that has been introduced. So, you know that's in the hopper along with the others.

DR. ROBINSON: Well, with that I don't have any extemporaneous remarks to make.

ASSEMBLYMAN COLBURN: Listen, I appreciate you coming. I long thought that the physician should participate in these discussions even though they had a hard time getting here. But I appreciate you coming and thanks very much.

DR. ROBINSON: You're welcome.

ASSEMBLYMAN COLBURN: Oh, excuse me. Rodney, do you have a question?

ASSEMBLYMAN FRELINGHUYSEN: With the Chair's permission, the Chair has been generous in recognizing verbal and written contents. Since the gentleman is kind enough to represent this particular medical society, would it be all right if it was attached as an addendum to the record?

ASSEMBLYMAN COLBURN: Oh, sure.

ASSEMBLYMAN FRELINGHUYSEN: As we're looking over the materials, it might be worthwhile having the written testimony as well.

DR. ROBINSON: Thank you very much.

ASSEMBLYMAN COLBURN: Thanks again. Well, Dr. Primich -- you're an OB/GYN. You've testified before us before.

D R. F R A N K J. P R I M I C H: Yes, sir. I trust that I no longer need an introduction to the members of this Committee. However, in the hope that this testimony may someday be found in the archives by some inquiring historian, let me identify myself. My name is Frank John Primich, M.D. I've been a physician for over 40 years. More than 30 of those years have been spent in rendering personalized fee for service medical care to the patients in New Jersey. My fees have always been reasonable and my concerns for my patients' physical, emotional, and economic well-being have always been paramount. For many of those years, I extended the same quality of care, since I knew no other, to those unable to pay. Then along came Medicare and Medicaid.

For those of you who majored in arithmetic in college, I'd better account for the missing ten years. Five were spent in post-graduate and specialty training at no or low pay. Fifty dollars per month, even in that era was far below the poverty level, but my potential to pay back made me a good credit risk. Four of the years were split between two tours of duty in the U.S. Army Medical Corps, at the request of Uncle Sam where I learned enough about the way the government can screw things up to put me on guard.

Part of the tenth year, 1948, was spent in a coal mining town in southwestern West Virginia. That's as far out of the United States as you can get without crossing one of its borders. There I learned about prepaid health care, union kickbacks, and political patronage.

During my entire career, I have spent a goodly portion of my 20-hour days reading, observing, and eventually writing and lecturing on the subject of health care provision. Perhaps, this time around, someone will understand and appreciate my analysis of the problem and my suggested solutions.

First, we must identify the problems separately since Medicare and Medicaid are, for the time being, rather different. Medicaid, along with the ever growing programs of aid to this and that, which as apparently culminated with aid to AIDS, requires funding of massive proportions. The inadequate funding available has been misdirected and squandered on the bulging bureaucracy which is supposedly administering the programs.

Medicaid grossly underpays physicians for their services, especially in an office setting. Physicians' unavailability or outright refusal to see patients under these circumstances result in emergency room visits at four to five times the cost. Patients, encumbered by out-of-pocket expenses are inclined to overutilize any available services. This point has been made repeatedly before this Committee and elsewhere with no remedial action.

Medicaid mills certainly exist. What else would you expect from that tiny segment of health care professional who realize that crime pays very well in this country with a minimal threat of meaningful prosecution? Medicaid milking is a new term I'd like to introduce. It is used by those morally marginal providers who correct the payment inequities by adding essentially unnecessary additions, tests, or visits to pad the bill. Gatekeepers, paid to the do as little as possible, are inclined to do nothing.

Six months ago, when we were here to publicly hear about problems concerning uncompensated care, I offered to tell you about my proposed two-class system. As you will recall, I intend that we not operate under a three-class system, composed of the rich, the poor, and the rest of us. My system was analogous to baseball, only in the competition between American and National Leagues. I had purposely chosen "American" and "National" because of the connotations I attribute to the two words. American conjures up all those things that make me

proud to be an American. National, on the other hand, rings in my mind as symbolic of governmental intervention, as in national health insurance.

Under my proposal, the National program would be funded by taxation. Since the powers that be have determined that health care costs should not exceed 10% of the Gross National Product, my estimate is that half the people would be Nationals and 5% of the GNP would be their allowance.

The system would utilized Army, Navy, VA, State, county, and city hospitals, clinics, dispensaries, etc. It would be staffed by health care providers who would be paid at an agreed upon wage. The system would render care to anyone judged to be a ward of the State, and -- get this -- anyone employed by the government -- and really get this one -- including all elected officials.

Meanwhile, the American system would operate as it always has, using existing hospitals, doctors' offices, and so forth. It would be financed on a fee for service basis by direct payment, or through high deductible private health care insurance. Credit or blame could be simply allotted on the basis of success or failure. No more cost shifting. No more blame shifting. We will have saved the scapegoat.

The National system would run itself into the ground, but at least we would have documented proof of the fallacy of central planning, and an end to the myth of something for nothing. Meanwhile the American system would be able to maintain the high standards we all desire, continue the astonishing progress that has made American health care the best in the world, and still have the compassion and wherewithal to care for those who fall through the National's holey safety net.

Medicare is a somewhat, though not entirely, different issue. The "Now Generation" and their Alzheimering elders never knew or have long forgotten the forging of Medicare. It was to have been a supplemental health care

insurance fund. It was to have cost a paultry few billion dollars a year. As with Social Security, promises and expectations far exceeded any potential fulfillment. Individual responsibility was abandoned, and Big Brother was expected to cover all costs. Now that people are living longer -- our fault of course -- costs are on the rise. Newer and better diagnostic and therapeutic technology adds further to the those costs.

Medicare was not proposed as a welfare program. It was an ominous step in that direction to those of us who recognized the threat. No one ever conceived of it as a welfare program for the rich. While there are far too many hardship cases among out senior citizens, it is sheer idiocy to mandate cut rate medical bills for aging millionares. That is exactly what legislation enacted in Massachusetts and proposed here is designed to do. This unholy mess began with short-sightedness, and now we have the blind leading the blind in quest of solutions.

The best solution available to the Medicare situation is the one I refer to as the health care banking IRA. There is increasing talk about this in Washington, but as yet no action. Progress is always slow when they deal with a good idea. The only quick actions seem to occur with bad ideas. Apparently, they realize that if bad legislation isn't enacted in a hurry, the public will discover the flaws before it's too late.

I'd like to hope that you are all familiar with the concept of the health care banking IRA. It would take too much time to explain too, so to any of you who are unfamiliar with the proposal, I offer to send a copy of the essential provisions and mechanisms for implementation. I have left copies for the members of your Committee.

In conclusion, let me repeat that Medicaid and Medicare were poorly conceived and poorly administered, and are now in deep trouble. It is time to rethink the whole idea,

and seek feasible solutions. Current attempts to blame and squeeze the providers of health care will do little more than destroy the foundation of our reasonably successful non-system and irreparably impair its future.

The steadily growing numbers of senior citizens -- poor and near-poor -- has made them collectively the largest political constituency in the land. Politicians, in campaigning for election, promise more and more. Those for whom we once felt great compassion and concern appear to now be calling the tune. It seems as if the tail is wagging the dog. All I'm really asking, is that in your frustration, you don't bite me. (laughter) Thank you.

ASSEMBLYMAN COLBURN: Thank you. We can always count on you for colorful testimony. Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: What would the record be without a testimony?

ASSEMBLYMAN COLBURN: Is Mr. Otlowski going to come back?

DR. PRIMICH: George is the one who keeps asking me for solution. Fortunately I gave him a copy of this. I think he went to the john to read it so it wouldn't upset him. (laughter)

ASSEMBLYMAN COLBURN: Okay. Thank a lot. Dr. Roemer, President-elect of the New Jersey Dental Association. And Dr. Kristeller will be taking Mr. Ellenberger's next position.

D R. J A C K R O E M E R: Would you like me to distribute the copies?

ASSEMBLYMAN COLBURN: Yeah. We'd appreciate it.

DR. ROEMER: It's a tough act to follow.

ASSEMBLYMAN COLBURN: You're right.

DR. ROEMER: Mr. Chairman and members of the Committee, thank you for this opportunity to address you today on New Jersey's Medicaid program.

A am Jack Roemer, D.D.S. In addition to serving as President-elect of the 5000 member New Jersey Dental Association, I maintain a general dental practice in Princeton, New Jersey.

This Association is firmly committed to the belief not just in words, but in action, that dental care should be available to all, regardless of income. According to the statistics provided by the Medicaid program, over 3000 dentists in this State have recognized their societal and professional obligation to treat Medicaid patients. It should also be noted that just last year NJDA played a key role in the enactment of the Medically Needy legislation which extended basic health care to an additional 200,000 poor, elderly, and handicapped individuals. NJDA proudly stands by our record of commitment to this State and all its citizens.

Programs such as Medicaid were supposed to bridge the gap between the financially compromised individual's ability to pay, and ensuring the individual's access to proper health care. Unfortunately, I must report that the reality has fallen short of the promise. NJDA is concerned that even with 3000 treating dentists, the Medicaid eligible are not receiving adequate dental treatment because of a program that has failed to realistically keep up with the economics of our times.

ASSEMBLYMAN COLBURN: Excuse me. How many dentist are there in New Jersey?

DR. ROEMER: Approximately 6700.

ASSEMBLYMAN COLBURN: Sixty-seven hundred in and out of your organization?

DR. ROEMER: Yes.

ASSEMBLYMAN COLBURN: Some of them are not members, I guess?

DR. ROEMER: Some of them are not members. Approximately 1500 to 1700 are not members.

ASSEMBLYMAN COLBURN: Okay, thank you. Excuse me.

DR. ROEMER: Since the inception of the Medicaid program in New Jersey, Dental Medicaid reimbursement to dentists has increased approximately 23%. During this same period inflation has increased over 225%. As Commissioner Altman mentioned, I can assure you that an increase of only 23% does not cover the continually escalating cost of equipment, utilities, rent, and trained staff. The past two years alone have seen malpractice premiums for dentists in New Jersey skyrocket nearly 600%.

It has never been our expectation that Medicaid fees could, or even should, match the fee schedule of private health insurance. However, NJDA believes that the State does have an obligation to provide the necessary funds for yearly adjustments in Medicaid providers' fees. Just to illustrate how far behind Medicaid fees have fallen, it should be noted that prior to a small increase in 1984, the last major increase in Medicaid's dental fee schedule occurred in 1973.

A second issue which merely exacerbates the problem of low fees and further reduces a practitioner's enthusiasm for treating new Medicaid patients, is that Medicaid patients frequently break appointments at the last minute, or worse, they just don't show. Because the Medicaid fee schedule is approximately 25% or less than the average practitioner's normal fee schedule, the loss by treating a Medicaid recipient must be subsidized by the private practice patient. When Medicaid patients break appointments, it is extremely difficult for the private practitioner to adjust his office schedule to adapt to this last minute open chair time. Many of a the large Medicaid providers must double and triple book appointments in order to cover these broken appointments.

Additional complaints echoed by dental providers center on administrative and bureaucratic problems in the Medicaid program. Constantly we hear of dentists who submit x-rays to Medicaid only to be informed they were lost or

misplaced. Medicaid then requires the dentist to resubmit the x-rays -- a double cost that further eats into the provider's meager fee.

Predeterminations, where Medicaid determines the necessity of a procedure, can be a painfully long drawn out procedure for both the provider and the patient. There's always the litany of provider complaints that center on phone calls and mail that goes unanswered. To underscore these arguments, I would like to share with you an experience NJDA recently had trying to deal with the Medicaid program. Several months ago, NJDA attempted to work with the Medicaid program, at their request, to seek a modest 10% across-the-board fee increase for all providers. Yet at every step along the way we met resistance. Requests for information were ignored and phone calls went unanswered. Quite frankly, I was suprised at this response, given that the issue in question was clearly one of mutual interest and concern.

It is these types of problems and experiences that merely reinforce the impression that the Medicaid program has become an unwieldy bureaucracy that is unresponsive and ponderously slow. NJDA believes that the present system could erode the interest and willingness of even the most well intentioned and altruistic provider, to participate.

In sharing our concerns and difficulties with you, NJDA hopes that the ultimate goal of an efficient and effective Medicaid health care delivery system will be realized. Thank you for giving us the opportunity to testify.

ASSEMBLYMAN COLBURN: Thank you. Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: Just for a matter of interest, through you Mr. Chairman. Who do you write to or who do you contact in terms of the Medicaid program? I know there's a big bureaucracy outside. (inaudible)-- Mr. Russo.

ASSEMBLYMAN COLBURN: Mr. Russo?

DR. ROEMER: Yeah, Mr. Russo.

ASSEMBLYMAN FRELINGHUYSEN: Do you mean to say to say that this was his reaction? This is the reaction to one of our State operations?

DR. ROEMER: Yes, sir.

ASSEMBLYMAN FRELINGHUYSEN: All right. I just wanted if we could name for the name for the record. Mr. Russo. Thank you.

ASSEMBLYMAN COLBURN: I was going to ask you this part on page three. Does this say that the Medicaid fee schedule is 25% below the average fee or is it--

DR. ROEMER: No. It's 25% of the average fee.

ASSEMBLYMAN COLBURN: Of it. Okay, 25-- Well if you read this thing, I don't know how clear that is. "Because the Medicaid fee schedule is approximately 25% or less," -- 25% or less. Oh, okay. So, it's of the total fee.

DR. ROEMER: Yes, it's of the total.

ASSEMBLYMAN COLBURN: Okay. Thanks a lot.

DR. ROEMER: Thank you.

ASSEMBLYMAN COLBURN: Dr. Kristeller? There you are. What's your field of practice?

D R. R A L P H K R I S T E L L E R: Internal medicine.

ASSEMBLYMAN COLBURN: Internal medicine. Okay.

DR. KRISTELLER: Mr. Chairman, Committee members, thank you for this opportunity. I am Ralph Kristeller, a board certified internist who has been in solo practice in Millburn for over twenty years. I am a member of the Medical Society of New Jersey, and a year and a half ago was appointed Chairman of this newly announced Task Force Coalition with Senior Citizens. The Task Force was designed because, and I quote, "the Medical Society of New Jersey, which represents 10,000 of New Jersey's 12,000 physicians, has become increasingly concerned with the gradual deterioration in the quality of the health care delivery system, particularly as it relates to the elderly.

"Consequently, the Medical Society has formed a task force of physicians to meet and establish dialogue with senior citizens. These meetings are to have a dual purpose:

"1) to create a forum which will afford an opportunity for the elderly to express their concerns about the delivery of health care, and

"2) to create an understanding of how current and proposed regulations will impact the delivery of health care.

"Physicians in their role as patient advocates of quality health care, together with the strong political influence of senior citizens, can stem the tide of government interference in the delivery of quality health care."

One result of this task force endeavor is the Senior Citizen Medical Courtesy Program. This program has been formulated jointly by the Union County Medical Society and the Senior Citizen Council of Union County. The purpose of the program is to provide access to private medical care by the elderly who might otherwise forego seeking medical assistance for financial reasons. The details are attached as an addendum to this testimony.

Briefly stated, eligible senior citizens are identified by the Senior Citizen Council. The Council notifies the county medical society, which provides an access card and a list of volunteer physicians to the patient. The volunteer physicians agree to accept assignment billing only for the required deductibles and co-pay. Furthermore, if a patient is presently receiving care from a private physician and meets the eligibility requirements, the Society, at the patient's request, will notify that private physician and request that he also accept assignment as above. This is a pilot program which is rapidly spreading to other counties because of Medical Society leadership.

The best testimony that I can supply to this concerned body with regard to the impact of present programs on the

delivery of health care comes from an excerpt from a brief speech I had the opportunity to deliver before the AMA Hospital Medical Staff Section at its national annual meeting this past June.

And I quote, "Physicians have been the chief architects and principal guardians of the finest health care system in the world for one purpose, the benefit of patients. We are now blamed because quality care for all cannot be delivered at the price people want to pay. This promise was made by government in spite of our advice that the situation could get out of hand.

"The ease which our government makes promises and then breaks its commitment to its people is causing a crisis in credibility. The practice which first affected the medical professions is now being felt by students, farmers, military personnel, veterans, investors, municipal governments, and perhaps most tragic, senior citizens.

"In 1966, the United States government promised its citizens that at age 65 they would receive almost full and unlimited medical coverage. Now 20 years later, their care is suddenly rationed at an age when they cannot possibly adjust.

"If our government, admitting it made a miscalculation, tells my 20-year-old children there will be limits to government support, I can understand they, unlike the elderly, can live within those circumstances. Professionals cannot tolerate this practice of broken commitments.

"A second current practice that professionals actively oppose is the substitution of schemes for policy. Schemes are used to achieve self-interest goals. In medicine we have certificates of need, DRG, capitation, etc. One follows the collapse of its predecessor.

"Professionals demand policy based on prudence, wisdom, and insight. We physicians work out new methods in the

laboratory. They are then used for general application only after thorough investigation for efficacy, safety, and cost effectiveness. We expect the same from government.

"We are the last of the professionals. War is too important to leave to the generals -- so we lost Korea and Vietnam. Teaching is too important to leave to the teachers -- so Johnny can't read. Law enforcement is too important to leave to the policemen -- so we have mayhem in the streets.

"Medicine is too important to leave to physicians -- so the government forces us to replace the art of healing with its cookbook standards. It has all but eradicated funds for the science of medicine, and it hampers the business of medicine by freezing our fees. We are the only segment of the economy where this applies. There are politicians and entrepreneurs who have a vested interest in the erosion of professionalism. With professionals eliminated, they are free to continue to devise schemes for their own self-interest.

"In a world that has gone astray, as exemplified by easily broken commitments, schemes masquerading as policy, and the erosion of the professionalism, it is imperative that we, the medical profession, keep our heads."

At one of our recent meeting with senior citizens, I was told that, "Government never admits to making a mistake -- that's politics." I replied, "Yes, that is until you say no more." And there was silence in the room.

It is clear to me that all of us here today should be here for one purpose: To demand that our government meet its commitments to this people; to demand that our government admit it made a mistake, and devise real policy for the next generation; to demand real policy based on wisdom, prudence, and insight; and to demand that professionalism be maintained as the cornerstone of the patient/physician relationship.

I thank you for your kind attention. I have three remarks to add to this based on testimony that I have been

listening to throughout the day. The first is that I would recommend that the term "catastrophic" or "catastrophic care" not to be used. It means different things to different people in my dialogue with senior citizens. It also means something different to the dictionary. I think we should be talking about the cost of acute care and the cost of long-term care as a better terminology to avoid misunderstandings.

The second remark that I would like to make is the word "solutions" has been raised here: "We're looking for solutions." I wasn't prepared for solutions, as you can tell by my formal testimony. And I'm not sure solutions exist or we wouldn't have been here all day. But I do think we are looking for a road map and I do think that does exist.

I would like to submit for your review, although I don't have a copy presently, because I wasn't prepared for that, is "Report MM" from the board of trustees of the AMA which was produced last June. And the subject is "Proposal for Financing Health Care of the Elderly." This is a 22-page report which was adopted. In this report the board of trustees describes the continuing problems with the Medicare program and presents a new approach developed by the Council on Medical Service and Council on Legislation for Financing Health Care for the Elderly. This report took about two years in the making. It did encompass real professionals in the field and we will be glad to get a copy for you to see, but I do think that it presents a new approach and a road map toward the solutions that you may be seeking.

The last comment that I have to make is, it has been said that governments and societies always do the right thing after everything else has been tried. I think this Committee is proving that that may not be true.

ASSEMBLYMAN COLBURN: Thanks a lot. You're quite right that in the announcement of the meeting, we really didn't ask for solutions. It's not so bad that we have been given a

few, but one group wanted to come in and describe a whole new setup for national health insurance and I told them that this was not the appropriate place, because of course, we're not going to act on that here, although there's a bill in for us to endorse national health insurance.

But we really wanted to learn how all of you felt about how things are working in both programs. And then from that, we're hoping to add other information and come to some-- You know, I don't talk of solutions up here much either. I try to figure out what the best thing is to do. And a road map is also a good idea. Thanks a lot. Rod, do you have anything?

ASSEMBLYMAN FRELINGHUYSEN: He made reference to a 22-page document.

ASSEMBLYMAN COLBURN: Yeah. He's going to give us a copy of that. Just give it to Dave and he'll see that both camps, you might say, get a copy of that.

DR. KRISTELLER: There's an expression that says, "A problem well expressed is a problem half solved."

ASSEMBLYMAN COLBURN: Okay. Thanks a lot. Now, Evelyn Ehrhart and Joanne Seel. Are you all set? Go ahead.

J O A N N E S E E L: Okay. My name is Joanne Seel, and I am here on behalf of my son, Max Nagy, who is Medically Needy and is presently receiving Medicaid. Max, his father, and I live in Bordentown Township, Burlington County. I mention this because our county offices for medical assistance is the county seat, Mt. Holly which is 23 miles away from our home.

My son Max, now one year old, was born October 2, 1985, a full-term baby weighing seven pounds. He was born with three complex congenital malformations. The first one: his heart is located on the right side of his chest instead of the left side with a hypoplastic right pulmonary artery -- hypoplastic right lung, leaving Max with only one functioning lung. Because of his multicystic kidneys, he is left with only one-third of his right kidney functioning.

On the day of his birth, Max was taken from St. Francis Hospital in Trenton to Hahnemann Hospital in Philadelphia to go into Pediatrics Intensive Care. He was there for 10 days under diagnostic examination and treatment of Dr. Eshagh Eshaghpour, Director, Division of Pediatric Cardiology at Hahnemann Hospital. He was called as a consultant for Max. Max continues to be under his care and the care of two other doctors, one for the lung condition and one for his kidney problem. Max also has a local pediatrician in Columbus, New Jersey. He sees him for his regular checkups and emergency care that is needed. He takes daily medication which is paid for through Medicaid.

Max is being provided Medicaid assistance through the Division of Youth and Family Services. Because Max is being treated by doctors at Hahnemann Hospital in Philadelphia, I also must go to Dr. Conrad Bell to secure a letter of approval for out-of-state funds.

It took six months and the aid of a pubic defender attorney to prove we were financially eligible for welfare Medicaid. We had to prove and verify our income, our assets, with letters from the medical doctors to verify Max's condition as proof. In the spring when we became financially ineligible for welfare Medicaid, it was suggested we turn to DYFS. I applied to DYFS in late spring of 1986. DYFS said we could be covered by them for Medicaid because we could not financially afford medical insurance or provide for coverage in any other way. It was explained this way: the financial burden upon us would neglect the entire family, so in a way, it would be child abuse. I was also told by DYFS not to become dependent on Medicaid through them -- this is only a temporary means.

Currently, I am attempting to have Max covered by Social Security. A public defender, Ms. Amy Mack, has entered our first appeal to our first application. We have been denied our first application based upon the judgment by their doctors, that Max is not sick enough.

Frequently we have to reestablish eligibility for assistance every three months for Medicaid through DYFS. The same must be reestablished to secure funds to cross state lines, even though the letter from Dr. Bell's office covered a whole year. When the bills are not paid on time, both the labs and hospitals harass me by phone calls and letters, even though the information has been given to them or sent confirming payments are coming to them.

It took six months and a pubic defender attorney to prove that we are financially eligible for Medicaid for Max through the welfare Medicaid -- repeatedly spending a great deal of time running around securing papers with proper signatures on these documents seeing one person in this office, then another in another office. Traveling place to place has caused an extra financial expense on the family to gather all the papers necessary for eligibility. Physical stress is placed upon myself and Max for every trip to attend to these matters. Oh, wait a minute.

ASSEMBLYMAN COLBURN: Children's Special Services.

MS. SEEL: Yeah. Children's Special Services only suggested applying for Social Security, but never advocated for Max. In late spring, I applied for Social Security for medical coverage. This first application was denied on the judgment of their doctors, not Max's, and stated, "Max is not sick enough." With the help of the public defender attorney, we are asking for an appeal. At this point in time, we do not know if we must go to court for subsequent appeals.

I always have the fright that I won't have a properly dated Medicaid card available for any emergency trip for Hahnemann or the doctors. I carry the fear of being denied help for temporary assistance from DYFS at any time. The DYFS social worker assigned was unaware of procedure to secure assistance of out-of-state funds -- contacting Dr. Bell across the hallway in the same building. It seems no one has th efull picture of all agencies or functions related to the process.

When Max's social worker leaves the position at DYFS without notice to me, I feel the lack of continuity and lose confidence. It is like starting all over again, this is, telling my story one more time. Although I have been in the DYFS program for almost a year, they have not advocated for Social Security or any other source or means of medical coverage for Max.

I do not know how to find the right channel to enter to secure maximum medical coverage with less hassle for all involved. Who has this responsibility and who should advocate? This is what's happening to me. I do not like the stigma of implied neglected child in order to get medical coverage.

I am emotionally spent and physically spent just caring for Max on a day-to-day basis. I am total caretaker for Max. He cannot be left in a day-care center. He must be protected against possible infections. Therefore, I can't be employed outside my home.

From the list of 14 items under the title "Problems in the System," from my point of view, each puts a strong stress on me and those stresses total up -- plus the day-to-day care of my child, I feel my body and mind are simply done in. I feel isolated from humanity and not being able to have enough time or energy to advocate for a better way to help my son's situation of health and well-being. I feel my whole family has been affected by this stressful time in our lives, Max in particular, because he recognizes and reacts to my anxieties, anger, and insecurity. These anxieties come from struggling with the system, financial burdens, and the nature of his illnesses.

These are the kinds of things that I see as helping me and Max: To find a dependable advocate to help me find the correct agency where I can get maximum and hassle free medical coverage for Max -- to be relieved of this particular stress

would be most helpful; prompt payment of Max's medical bills. When late, I receive the telephone calls and the duplicate copy of bills reminding me that I must pay or contact Medicaid to ask, why the delay?

Although, grateful for at least having some kind of medical coverage, I would like to get out of the DYFS program so as to remove the implied stigma that I neglect my child -- also to remove the uncertainty of having only temporary coverage. If asking for an advocate is too much to ask, could we as recipients of Medicaid/Medicare at least be informed directly by letter as to what programs are available now and in the future? We need knowledge in order to ask the questions.

Review the status of our case and find out where we best fit into the system. Rather than a struggle between the system and me, I would like to have the system work as a partnership to give Max the best medical coverage.

Preparation before taking Max for his appointments to the hospital in Philadelphia: First the doctors at the hospital in Philadelphia will not make the appointments unless they know Max has been re-approved for Medicaid for out-of-state coverage. They must see the letter of approval. Through DYFS I must reapply every three months to get the Medicaid card. Within these three months I could have several visits to Hahnemann and the card would be valid.

I must get a signed letter from Max's local New Jersey pediatrician requesting that Max see the Hahnemann doctors. The next step is to make appointment with the social worker at DYFS in the Mt. Holly office to get Medicaid card. Next step is to cross the hallway in the same building to Dr. Conrad Bell's office to hand in the New Jersey pediatrician's letter in order to receive the letter of approval for out-of-state funds. Then I must wait for arrival by mail or drive back to Mt. Holly the next day to pick up the letter of approval for out-of-state funds to take with me to Hahnemann Hospital in time for the appointments.

Some of the good things that I have encountered in the system: that I have had this opportunity to be heard today, that I am able to have the team of doctors of my choice to attend to Max's physical conditions, and that I have appreciated the Visiting Nurse Program. From one year ago I have had one nurse visit my home on a very consistent basis. She is always available by telephone when I have the need of her. I have some of the documents with me.

ASSEMBLYMAN COLBURN: Thank you. I read them. Well we asked how it was working and you sure told us. I think that was the good thing to do. How did you find out about the hearing? Was it through something in the press, or through the agency, or what?

E V E L Y N E H R H A R T: The Office of Governmental Ministry. They sent out a letter. My husband is a minister. It crossed his desk, and I said there's the answer to the prayer.

ASSEMBLYMAN COLBURN: Well, it's a beginning anyhow.

MS. EHRHART: Right, well at least for her today. It was very effective.

ASSEMBLYMAN COLBURN: Yeah, interesting. Of course you're in my county, you know, not to mention my district. Wow, that's really interesting. One thing about Medicaid is it apparently has allowed for people to go, as you say, to the specialist of their choice, whereas in some other arrangements, you really can't.

I was interested that Mr. Doyle referred to my annecdote about what we do in our office with people who don't pay their bills. And annecdotes, I think, are very useful. They're really looked down on. In the medical literature, every time you look at the "New England Journal," they're talking about somebody's annecdotal evidence about something. But, sometimes an annecdote leads you to-- I remember when I was in the-- Who said they practiced in West Virginia? Oh,

that was Dr. Primich. Well, I was down there myself in southwestern West Virginia. I was going to ask him if he was in Bottom Creek or Welch, because I was in Bottom Creek.

Anyhow, when I was down there, ACTH was new and I gave a patient an injection of adrenocorticotropic hormone. He had a tremendous diarecessus (phonetic spelling). He was swollen, because he had heart failure. He got rid of all of this fluid on a brief basis. The next thing I know, about six months later they reported it in the medical journal. I don't think it had been reported at that time. So, annecdotes are important.

We had a hearing on DRGs up here and I thought some of the best testimony we got was from a nurse, who told us how she felt it was affecting her patients. You know, you hear all the people who figure out these systems, but by golly, it's the person who has to use the system that can really tell us. And I think often in the Legislature, we pass a law, and we don't know really how that thing is going to be implemented; we don't know how the regulations are going to be written; we don't know how they are going to work out; and we move on to more things.

I personally think that when a government program fails, the government doesn't admit it. But they are inclined to go on. They say, "Well, we just didn't do enough, so now we've got to do more," and louse it up more, and there we are. So, I know that a lot of the people that provide services and a lot of people who receive them probably feel the same way, because I'll tell you, it's really confusing.

I was interested that you did say that you were able to get these three months approvals, but the problem is that there's nothing permanent. You can't be sure of what's going to happen.

MS. SEEL: No. The supervisor at DYFS offered me to try to apply for the Medically Needy Program, not realizing that this doesn't cover out-of-state.

ASSEMBLYMAN COLBURN: Medically Needy does not.

MS. SEEL: He was the supervisor and he himself didn't even realize what this program covered, and he should have been the one.

ASSEMBLYMAN COLBURN: Okay. Believe me, it's a complicated program. The fellows who passed it, and I did vote for it, didn't know that either.

MS. SEEL: Right. And in his case--

ASSEMBLYMAN COLBURN: That's worse. I thought that when we were passing it, that we were simply superimposing on the existing Medicaid program more people. That's what I really thought. Now I'm finding out that that isn't what we really did. You know, that's our fault for not understanding, and yet it was a process that was going on long before I got here -- long before I got here. Well, thanks a lot. I think for you, in particular, you want to call our legislative office when you have trouble, because we're there in your district. Mr. Wheeler will get hold of you in a second.

MS. SEEL: Okay.

ASSEMBLYMAN COLBURN: 267-3612 is our legislative office. Medically Needy doesn't cover hospital services either.

MS. SEEL: Right.

ASSEMBLYMAN COLBURN: I'll give you the phone number and also Bill Naulty's, our staff person who is on vacation right now. Thanks a lot.

MS. SEEL: Okay. Thank you.

ASSEMBLYMAN COLBURN: Do you have any questions? I'm sorry.

ASSEMBLYMAN FRELINGHUYSEN: I think we ought to note how well behaved the child is. (laughter - referring to Maxwell "Max" Nagy) He's asleep right now. And I think it's worth noting that I think sometimes, especially with this Committee with Mr. Otlowski, Mr. Deverin, Dr. Colburn, Mr. Felice, and I, that we deal with those that aren't even born, as well as those

that are beginning, and those that are perhaps -- I use the term kindly -- ending life. Your visit here, I think, adds perspective and value to our deliberations. Thank you.

ASSEMBLYMAN COLBURN: I might also tell you that I think all the members of this Committee, excluding me, now I'm not going to-- But we have a good Committee and a good staff. Thanks for coming.

MS. EHRHART: Thank you.

MS. SEEL: Thank you for listening.

ASSEMBLYMAN COLBURN: Mr. Ellenberger? You gave up your spot.

A R T H U R R. E L L E N B E R G E R: Dr. Colburn, Committee members, I'm here to represent a physician who is unable to be here tonight. He's an inner city physician, a pediatrician who has practiced in Newark for the past 25 years. He had asked me to bring his presentation for him. He said, quote: "I'm appearing before you on behalf of the poor inner city and poor rural children who are denied access to comprehensive, continuing health care because inadequate Medicaid physician reimbursement has decimated the number of physicians available to provide care to this under served population. I am also representing rural and inner city physicians who are committed to providing care to Medicaid children, but who can no longer afford to subsidize their Medicaid patients whose care costs the physician more than he is reimbursed by the Medicaid program.

"In all urban communities and in many rural areas, the health of poor children continues to deteriorate, resulting in increased morbidity and mortality. Medical care to poor children is increasingly being provided in hospital emergency rooms where care is expensive, episodic, discontinuous, and focused on the immediate medical problem. Emergency rooms do not provide immunizations, do not screen for lead poisoning, do not investigate psycho-social disability, and cannot manage

chronic, multiple health problems. caused by anemia, malnutrition, negligence, lead poisoning, and birth defects, all of which are prevalent among poor children.

"Twenty years ago, Medicaid was created to bring poor children, who had historically been denied access to health care, into the mainstream of medical care. There is no question that Medicaid initially resulted in major improvements to health care; consequently a reduction in morbidity and mortality of poor children.

"In 1978, because of their concern about cost-effectiveness, the Division of Medical Assistance and Health Services began a study of reimbursement of ambulatory services provided in physicians' offices and hospital emergency rooms resulting in the reduction of cost of emergency room care. Physicians are still being reimbursed nine dollars for an office visit while emergency rooms are reimbursed between $60 and $90 for the same service.

In spite of the obvious cost-effectiveness for providing primary care in physicians' office rather than in a hospital emergency room which was confirmed by the 1978 study, no change has been made in physician reimbursement although physicians' costs have escalated every year, and malpractice insurance costs have increased from 20% to 100%. Meanwhile, in 1982, New Jersey Medicaid applied for a Federal demonstration project called the Medicaid Personal Physician or MP Plan. The MP Plan would reimburse physicians on a capitation basis with the expectation that capitation would contain costs.

"Medicaid enrollees were given the choice of continuing the fee for service system which permitted the enrollee to obtain care whenever and wherever they choose, or to elect the MP Plan which would restrict them to one primary care provider. When patients in my office were offered those options, they almost unanimously refused to sign up for the MP Plan. This is the reason, I assume, that only 5300 recipients

have been enrolled. Meanwhile, for the past 10 years, the practicing physician has been frozen into a reimbursement rate which does not cover the cost of an office visit by a Medicaid patient.

"As a direct result more physicians have been forced out of the system which reimbursed care at nine dollars when the actual cost to physicians providing that care is approximately $14. The resulting lack of available, comprehensive, continuing care by office based physicians has created a large pool of un-immunized and unprotected children in New Jersey. The major measles epidemic that occurred in New Jersey this year should be a warning to us all.

"Even more frightening is the potential epidemic threatened by the increasing number of children under three years who are incompletely immunized against the deadly disease, whooping cough. A major pertussis epidemic will put in jeopardy the health and well-being of all young children in New Jersey. This penny-wise, pound-foolish policy of under reimbursement of office based, primary care physicians has many (inaudible) ramifications, in addition to potential epidemics due to lack of preventive services. For example, the emergency room cannot provide lead screening for poor children. It is well-known that only 1% to 20% of the children at risk for lead poisoning are screened by clinics and private physicians.

"It is also documented by the New Jersey State Department of Health that 220,000 children in New Jersey are at risk for brain damage due to lead poisoning. Most of these children are poor and are living in urban areas. Lead poisoning causes learning disabilities and disruptive behavior in school which forces these children into high cost special education.

"Because of disruptions in learning caused by lead poisoning and other preventable or correctable medical disorders, affected students drop out of school in large numbers. Most of them are unemployed or unemployable. Studies

show that this large learning disabled, unemployed dropout population has the highest percentage of drug abusers and makes up the highest percentage of the prison population.

"The ramifications of the lack of access of poor children to comprehensive continuing health are complex and far-reaching. Lack of access not only causes death and disability among the poor, but the deleterious effects reach into every area of society. Access will continue to decrease unless those physicians currently providing services are adequately reimbursed and new physicians recruited with a reimbursement system that covers the cost of comprehensive care.

"This Committee has an awesome responsibility because your decisions will influence the future of this State and the nation. The United States today may be the first society in history where children are worse off than adults. In 1970, 16% of children less than 14-years-of-age lived in poverty. By 1982, 23% of children lived in poverty.

"According to statistics from the New Jersey Department of Health, more than 205,000 New Jersey households with children are headed by a single adult and 88% are headed by a female with no husband present. An estimated 400,000 children in New Jersey are raised in single parent households, 60% of which are below poverty levels.

"Children should be our most precious resource since they are the future of our State and our country. Our society has recognized its responsibility for the care of older Americans by committing 30% of the Federal budget to programs for the elderly. At the same time, society has failed to recognize the needs of children when it commits less than 5% of the Federal budget to programs for children.

"I hope that you will heed the appeal in behalf of health care for Medicaid children in New Jersey by providing adequate reimbursement to physicians who are willing to provide such care, thereby increasing access to comprehensive,

continuing health care for Medicaid children. Respectfully yours, John W. Alexander."

ASSEMBLYMAN COLBURN: Thank you. Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: I think partially germane to the gentleman's comments this morning was the Senate Appropriations Committee approval of a bill that was released and co-sponsored by all the members of this Committee, creating an Office of Prevention of Mental Retardation and Developmental Disabilities. Part of what of you are talking about today is the issue of prevention, and of course you're talking about the physicians getting their proper reimbursement. What we were talking about in that legislation is, of course, unifying what is the scattered approach that we have within the State bureaucracy -- addressing problems of prevention. For those of you -- you sir, and other people -- I commend that legislation to your attention that they will be going to the Governor shortly -- approved by both the Assembly and Senate, hopefully the Senate in the near future.

ASSEMBLYMAN COLBURN: Thanks. I guess we all hope the bill will work -- the legislation will work. There was a fellow from Newark, a physician, who kept speaking for years in the Medical Society about preserving--

MR. ELLENBERGER: Dr. Chase.

ASSEMBLYMAN COLBURN: Dr. Chase. Is he still around?

MR. ELLENBERGER: No. He died from a heart attack two years ago.

ASSEMBLYMAN COLBURN: That's too bad, because he was really into the Medical Society, always talking about the problems of keeping physicians in Newark and how Medicaid was actually driving them out under its policies. They managed to do that.

MR. ELLENBERGER: (speaks away from mike) Between me and Dr. Alexander (inaudible) half the clinics down there.

ASSEMBLYMAN COLBURN: Yeah, I remember Dr. Alexander

also. Okay, thanks a lot. Dr. Chase -- how about that. Let's see, Mr. Alfieri, Executive Committee, New Jersey Association for the Prevention and Treatment of Substance Abuse. Good afternoon.

D A N I E L A L F I E R I: Good afternoon. It's noteworthy that this hearing is being held during Drug Awareness Week in the State of New Jersey and also that we are in the midst of an epidemic with the continued increase of heroin use, the upswing in the use of cocaine and crack, and the ever alarming increase of other abused drugs by indigent persons who may or may not qualify for Medicaid or Medicare.

The State and your Committee ought to be commended for this action in changing the Medicaid legislation around two years ago to include coverage for the disease of drug addiction for recipients of Medicaid. This action has resulted in a substantial number of needy people receiving treatment for their illness, both young and old. And I can directly speak to that in our treatment program. You may think that the disease of drug addiction only afflicts the young or the youth of our area. We might say that we have people who are in treatment and who are well into their sixties, as well as young adults and middle aged people. And I think we are all aware of that. This action has resulted in a substantial number of needy persons receiving treatment for their illness, both young and old. However, we see an increased need to expand these services to include those clients who require treatment but fall through the safety net which Medicaid and Medicare provide.

Now what I would like to do is just offer three suggestions today in which we feel that Medicaid might help out in expanding the services or in providing the treatment for those in need -- drug addiction or alcoholism. One of the suggestions is, anything to do with drug addiction and alcoholism -- the repayment for that, is currently going through the Department of Health and we would like to see that

go through the Department of Human Services with all of the other Medicaid reimbursements. This will allow for these services to be treated as any other medical problem.

Number two: What we would like to see is to expand the coverage of certain treatment services to include residential care in State licensed freestanding treatment programs. At the present time, any State licensed freestanding residential drug treatment facility is not eligible for persons who require inpatient services. They are either treated on an outpatient basis or they must be referred to a hospital setting at an extremely high cost for their services, and in many cases, under another diagnosis.

However, since residential treatment is not covered, many referrals are inappropriately made which are covered by Medicaid and Medicare. So, we'd like to see something be done in regards to payments for residents in inpatient drug treatment programs.

The other area that we're offering some suggestions is to revise the coverage for the disease of drug addiction. New Jersey, about seven or eights years ago, entered into a pilot project with Medicaid and we were able to demonstrate over about a five-year-period that it was cost beneficial, and that it was important that those people involved with drugs who are on Medicaid be provided these services. That had proven effective, and as a result of that, of course, the legislation was changed to include those on a regular basis.

However during that five-year-period, no new services were offered and we only used the services that were currently available under the Medicaid legislation at that time. The Division of Narcotics and Drug Abuse Control has since developed a series of services with specific definitions specifically for substance abuse treatment services. And we would like to see these services be included under the Medicaid covered services.

These services should only be reimbursed if provided in a State licensed treatment facility by certified providers. We feel that in that way, we can continue to offer a good quality of care and be able to provide for the needs of the people in our communities.

With the inclusion of these recommendations, those indigents who are afflicted with the diseases of drug addiction and alcoholism surely will be the benefactors. Thank you for your time and consideration of these recommendations.

ASSEMBLYMAN COLBURN: Thank you. Any questions? (negative response) John (referring to aide), I think he too might want to turn some of his information over to Walter Kern's committee on the drug problem. Why don't we take his testimony and send a copy over to them? That's what we'll do. Here's an overall Assembly committee that's considering all the legislation having anything to do with drug abuse, and before any of it goes out of an Assembly committee, that committee is going to sort of pass judgment on it. Okay?

MR. ALFIERI: Thank you.

ASSEMBLYMAN COLBURN: Thank you. Let's see. Dennis Hett, Executive Director, New Jersey Association of Nonprofit Homes for the Aging, Inc.

D E N N I S R. H E T T: I have some testimony and some supportive documents. Okay, thank you for this opportunity. Again, my name is Dennis Hett, I am the Executive Director of New Jersey Association of Nonprofit Homes for the Aging, which represents 120 church related and voluntary and fraternal facilities for the aging across this State. We have about two-thirds of our members who are Medicaid providers, and I have six points to make that I will simply summarize for you since I've provided you with written testimony and support information.

My first point is that we do not believe that the audit system, as it now stands, is effective. As it now

stands, the audit team comes to the nursing home and spends several months there pouring over every piece of paper that they can possibly ask for. The result is often a very small amount due the State. We do not believe that this is an effective use of either the taxpayers' money or the facility's time, because it simply does not give the kind of return that it ought to.

We recommend that shorter way to be found -- one, that allows the audit team to pass over those things that look in order and concentrate on those areas in which there appears to be a problem. Thus, they would be able to cover more homes and uncover the real problems rather than penalizing the homes by staying for so long. So, we believe that the audit system needs looking at.

Our second point is that the current nursing home reimbursement system does not even pay the home to meet minimum standards. I have a supporting document that was issued in 1983 by the Commissioner of Human Services. It was a report on a study concerning the feasibility of consolidation the two existing levels of intermediate care under the Medicaid program. That is the big supportive document that I have there. The most important element of that is on page three, in which it states that the formula by which Medicaid judges staffing and determines how much they're going to pay, needs to be increased by 12%. This is empirically demonstrated in that document.

No action has been taken in the ensuing three years, and at the same time a Medicaid Reimbursement Study Commission has been authorized by this Legislature. We recommend both that the study be implemented and that the Commission be convened to deal with these issues. As it now stands, the population of nursing home users is growing older and sicker. We are faced with increasing problems of being able to meet their need to do such things as give regular baths and the

like. You've heard other problems expressed from other nursing homes, and we believe that this needs to be addressed.

Our next point is that Medicaid is not coordinated with the rest of the regulatory system. As you know, the Department of Health licenses nursing homes and inspects them. The Ombudsman program has the power to pop in and cite homes if there has been a complaint. But in the regulation writing process, those departments do not often consult with Medicaid, before taking action. The result is often impossible programs. The best example that I can cite and perhaps the most blatant example is a nurses aide certification program, that the Department of Health mandated at least five years ago. Medicaid said that it was a nice program, but they could not pay for it.

The Department of Health went on and mandated the program. We had to protest a program that we had supported initially, because there was nothing to pay for it. As a result, the Department of Health was forced to grandfather the program and phase it in over a seven-year period which has made that program less than meaningful. It has not resulted in a rapid increase in skills of nurses aides. That is one example. So we would urge at the minimum that no new programs be enacted or mandated unless there's reimbursement to go along with them. This has to be coordinated very carefully.

Our next point is that the Medicaid system does not generally contain costs. I think that we may have had a graphic example of this in the child Max a couple of witnesses before. The elderly population is growing rapidly, population of those who are over the age 85 is going to double by the end of the century, and they are going to need nursing home care. One in four of that population is in a nursing home at any one time. As a result of this, we have to see that the system is as efficient as possible, so the children who also need services are going to be able to get them.

The reimbursement system, as it now is set up, depends on how much the nursing home spends in order to determine next year's rate. It doesn't say how much the nursing home is going to save or how well is it doing at containing costs, but how much is it spending? This is an inflationary system and we need to find a way to encourage homes and to reward homes for containing costs. So, that would be another of our recommendations.

I'll pass over this one lightly because it's controversial, which is because of the problems that we saw before Medicaid itself encourages discrimination against Medicaid recipients. I know that this has been debated by the Legislature before, and the Legislature has responded with sanctions against homes in this area. But we have not really dealt with the problem of the desincentive to take Medicaid recipients. Again, we hope that that Medicaid Reimbursement Study Commission will begin to address this.

Our final point is again a ticklish one, and that is that another area in need of reform is that of asset divestiture. I say this again, this is annecdotal information. But our attorney tells us that the most frequent request he gets from people is how to preserve their assets from Medicaid, how to avoid spending their assets in a nursing home. He says that this question is asked very frequently and we know that it is on people's minds. Not many people are willing to talk about this, because some think it's in the same realm as the welfare mother with the Cadillac, that it may be just one of those things that when you see it, it's so spectacular that it sticks in your mind.

But we believe that it may be more widespread, especially since it is the policy of western society, not just the United States, to make sure that a person's assets are used before they qualify for medical assistance. So, we believe that this should be looked at. It should be made known to people that they have a responsibility to utilize their assets

first. And perhaps we also need long-term care insurance as a means of preserving those assets -- an indemnity policy that would pay for institutionalization.

Let me then append just one other thing, and that's another way that we might be able to avoid some costs. And I'm sorry that Assemblyman Otlowski isn't here because it involves boarding homes. The residential health care facility which is a Department of Health licensed boarding home, is something that we in the not-for-profit field have operated for many, many years. In fact they predated the modern nursing home. In a good residential health care facility, an older person can be maintained at a higher level of health and independence for a longer period of time than they can in many other settings. By the time a person needs nursing home care in one of our residential health care facilities, they are really ready for it. In other words, they have not been prematurely institutionalized. They have had significant costs avoided, and at lesser costs. We need to adopt a policy that would encourage the use of good residential health care.

SSI, which is the mechanism that pays for the stay in a residential health care facility, only pays $13 a day now, and there is no Federal matching for this. Good residential health care costs $800 to $900 a month. It's cheaper for the State to put someone in the nursing home at the moment because the Federal government pays 50% of the bill under Medicaid. If there were some kind of either Federal matching or State encouragement for SSI in the residential health care facility, I think we could avoid some significant institutionalization and some significant Medicaid costs. We can preserve people's assets longer, get more bang for the buck, and keep them independent longer. Thank you for the opportunity to speak.

ASSEMBLYMAN COLBURN: Thank you. Rod?

ASSEMBLYMAN FRELINGHUYSEN: Yeah. I have a question. You made reference to this consolidation.

MR. HETT: Yes.

ASSEMBLYMAN FRELINGHUYSEN: I wasn't around in 1983. Whatever happened to the proposal?

MR. HETT: The report was made back to the Joint Appropriations Committee and as far as-- Well, it's basically been dropped, except there is a bill that I cannot quote you at the moment, to implement this. I have seen it introduced in the Legislature and it has not moved for some time. I'm sorry I don't know the number of that bill.

ASSEMBLYMAN COLBURN: Maybe John can find it.

ASSEMBLYMAN FRELINGHUYSEN: I think while we've heard some valuable testimony here, Mr. Chairman, this morning and this afternoon, that this particular testimony raises some questions that it might be valuable to have Human Services answer -- its Medicaid Division in particular -- and perhaps respond to some of the points that are raised here. In other words, provide them with this testimony and ask them to respond, not unlike the Appropriations Committee process where somebody will testimony, questions will be asked, and the Department has the responsibility to respond. I think it might be a worthwhile exercise.

I'd like to know whether in fact, the audit system is cost-effective. Certainly you hear instances of duplication, not only in nursing homes, but all over the place. I think the bureaucracy ought to have the opportunity to respond as to whether the reimbursement system does not pay for minimum standards. You and I -- having been freeholders -- I was on the board of a county nursing home. This asset divestiture at the moment is one year. Isn't it?

MR. HETT: No. Three years now. And that's consistent between the Federal and the State at this time.

ASSEMBLYMAN FRELINGHUYSEN: It is? Well, I must say that while it is an emotional issue, I think any of us who have had any relationship at least on some level of government or

whatever individual-- It happens all the time. And I must say that it is extremely bothersome. I think somebody ought to be addressing it even if we are identical to what the Federal requires. In other words, Mr. Chairman, I think that someone in the Department of Human Services might respond to some of points raised here.

ASSEMBLYMAN COLBURN: I agree with you. I think that--

ASSEMBLYMAN FRELINGHUYSEN: Not that other points raised were not important, but I think these are.

ASSEMBLYMAN COLBURN: Well, I think there are quite a few things in here that might be translated into considerable cost savings. One of the things that I was wondering about and Rod mentioned it-- Do you get an audit that's so similar to this Medicaid audit that they should be combined? Do you get anything like that?

MR. HETT: Medicaid-- Well, I'd say all of our homes have an annual certified audit, but the purpose of the Medicaid audit is not to determine whether the home is keeping its books according to generally accepted general accounting procedures, but to make sure that it is adhering to Medicaid regulations.

ASSEMBLYMAN COLBURN: Are there any other State audits? Are there any other audits that would duplicate this?

MR. HETT: No. That is really the only financial audit. I don't think -- now this is off the cuff -- I don't believe we could find any that would suffice for it. I think the process needs to be revamped, so that it provides the auditor the freedom to pursue logical questions and to pursue the big payoffs, the big returns, the abuse rather than sifting through every piece of paper. I think they spend too time on too much detail. That is my point.

ASSEMBLYMAN COLBURN: Okay.

MR. HETT: I might add that though they have made some efforts, they still remain behind in their audits. The

Medicaid audit team remains behind. I ask homes for dates for which they have not been audited yet, and the earliest that I could find thus far is 1981 -- that the audit is still pending. They have made efforts at bringing them up-to-date. I will say that, but there is still a significant backlog.

ASSEMBLYMAN COLBURN: Okay. Thanks a lot.

MR. HETT: Thank you. My pleasure.

ASSEMBLYMAN COLBURN: Mr. Marosy. I presume if you are going to show us a film that you will use your time to show us the film and not read the testimony. Is that right?

J O H N P A U L M A R O S Y: I'll do that. Here's my written testimony. By way of introduction, my name is John Paul Marosy. I am the Executive Director of the Home Health Agency Assembly of New Jersey. We are the people who treat the 85-year-olds in their own homes and try to maintain them at home. That's becoming more and more difficult to do because of the problems that we're having with reimbursement, especially the Medicare program, Mr. Chairman, and that is the focus of the video tape which I'd now like to show.

ASSEMBLYMAN COLBURN: Okay. You know, I get a little confused. Are there other agencies that wouldn't be in your organization that provides services to people in the home?

MR. MAROSY: Yes.

ASSEMBLYMAN COLBURN: Who do you represent, VNAs?

MR. MAROSY: VNAs, certified home health agencies that are located in hospitals, some proprietaries that are not licensed and certified. And then there's a separate organization of 21 nonprofit homemaker/home health aide agencies, one per county. So, ours represents about a total of 70 providers, and we serve about 130,000 New Jerseyans each year.

ASSEMBLYMAN COLBURN: And beyond these two groups, who else provides home health care? Upjohn? Or they're not in any of these organizations, are they?

MR. MAROSY: There are some proprietary providers that are not affiliated with either of the two groups I just mentioned. We don't know what the volume of their business is because they are not licensed by the Department of Health where those statistics are kept.

ASSEMBLYMAN COLBURN: Okay, thank you. I just wanted to get an idea.

MR. MAROSY: This was produced by New Jersey Network. (film is shown)

ASSEMBLYMAN COLBURN: I thought we were going to get the--

MR. MAROSY: Rather than put you through five more minutes, I just want to summarize. There are two more bills before the New Jersey State Legislature which would address the issue of chronic long-term home care. Medicare will pay for the acute care, although Medicare is cutting back on that. We're looking for some relief from the State for these families that are seen by our visiting nurses each week who can afford to pay for their own home care, but don't qualify for existing Medicaid programs.

ASSEMBLYMAN COLBURN: One is the Van Wagner bill and the other is Azzolina's.

MR. MAROSY: Right, S-2132 and A-3177.

ASSEMBLYMAN COLBURN: Thank you. They're before the other committee, but we should certainly-- At least what you're saying to us comes within the purview of the hearing, even though the bills are in someone else's committee.

MR. MAROSY: I realize that, Mr. Chairman.

ASSEMBLYMAN COLBURN: Okay. Is Rodney around? (negative response) Gee, I'm the sole survivor at the moment. Thank's a lot.

MR. MAROSY: You're welcome.

ASSEMBLYMAN COLBURN: Do you have anything to ask?

ASSEMBLYMAN FRELINGHUYSEN: (returns) No.

ASSEMBLYMAN COLBURN: Thank you.

MR. MAROSY: Thank you.

ASSEMBLYMAN COLBURN: Now, we have the hardy ones remaining. Mr. Kessler, from the Prosthetic and Orthotic Society.

J E R O M E S. K E S S L E R: Mr. Chairman, members of the Committee, I am Jerome Kessler, President of the Prosthetic and Orthotic Society of New Jersey. Our certified members are the only accredited practitioners authorized by Medicaid to provide prosthetic and orthotic services to the indigent of New Jersey. We wish to thank you for allowing us to express our concerns. It is our belief that the present Medicaid program, as it relates to prosthetics and orthotics, does a disservice to our handicapped and practitioners.

Under the direction of Mr. Russo, et al, there has been nothing but dissension as to the upgrading of fees, changes in nomenclature, delay of authorization, confusion in increased costs to the program, and the acquiring of services of unqualified personnel. To be specific, since the program's inception there have only been two changes in the fee schedule. They still want to pay substandard prices -- $85 for a $1500 leg. We have refused to make such a leg, and the patient goes without. Is this providing proper service? We have requested Mr. Russo to use the same codes as Medicare. He did after two years of confusion of the crossovers, but he has omitted 200 items. Is this being cost-effective?

I related to Commissioner Albanese that a patient was kept in a hospital for two months at the cost of approximately $20,000 because we could not provide prostheses for her under that schedule -- $200 could have saved $20,000. Just the other day a similar case occurred where the patient had to go home without a brace because of the inadequate fee schedule -- having stayed in the hospital 10 extra days at $3000 instead of $200. Who's going to be responsible if anything goes wrong

because she does not have a brace? It would appear to be penny-wise and pound-foolish.

We have had to resort to fair hearings before the administrative law judges because of the change of decisions under Mr. Russo's directorship. They tell us one thing, but another to Prudential. I personally will be attending my third hearing this year. It costs money to tie up personnel, not only me, but personnel from his staff and Prudential's.

Sirs, a podiatrist does not have the same qualifications as a physician and is not a medical doctor. He does not have the training of one, such as a psyciatrist, a vascular surgeon, or an orthopedist. Yet the program regards his decision as to the complexity of specific special cases such as excessive scar tissue, multiple amputations, and congenital anomalies. He has yet to visit the patient to determine these complexities. He does it strictly by a written report. Would you have your physical conditions determined from a report rather that a proper physical examination? A podiatrist to tell you about a spinal cord injury?

I've testified several times before different committees of both the Assembly and Senate, including the Joint Appropriations Committee requesting adequate funds be appropriated. Senator Pallone has introduced a bill. He did that last year and has reintroduced it this year. And a companion bill has been introduced by Assemblyman Villane, again last year and reintroduced this year for such fee increases. These funds will ensure proper and adequate prosthetic and orthotic services to our handicapped.

Nine months ago, Mr. Russo was charged with the upgrading and classification of the HCPCS codes -- nine months ago. We have seen nothing of his efforts from his office. However, this did result in a study by Prudential. It will allow 80% of what Medicare allows; not the standard fee. This fee is based on the customary fee established three years ago,

and on the 75th percentile, provided you had an experience of three time, otherwise you were cut to the 50th percentile. I realize that this is a lot of double-talk, percentiles, and things like that. But it means roughly that the Medicare fee would be 50% of what the normal fee will be.

We can no longer provide services under the present system. A letter has already been sent to the Governor requesting that since prosthetics and orthotics are a non mandatory service, that they be dropped from the program. Thank you for allowing us to express our concerns. I will be more than happy to answer any questions.

ASSEMBLYMAN COLBURN: Well, I think I can understand your frustration. Rodney?

ASSEMBLYMAN FRELINGHUYSEN: Mr. Kessler and I are familiar with one another from the Appropriations process. You get an A plus for perseverance. I can see why Mr. Russo took a vacation day today. What do you mean on page three that, "nine months ago Mr. Russo was charged--"

MR. KESSLER: Excuse me, sir. I do have a problem with my hearing. So, if you can speak up.

ASSEMBLYMAN FRELINGHUYSEN: Page three, "Mr. Russo was charged with--" Who charged him with what?

MR. KESSLER: I believe it was the Commissioner then, Commissioner Albanese. A letter was sent to the Governor and a chain of command brought it down, and we had a conference between our group, Prudential's, and Mr. Russo and his group. At that meeting, it was set forth that Prudential was to make up a comparison between what Medicaid allows, and what Medicare allows. This was done forthwith. In other words, I would say by the beginning of February it was completed. That's nine months ago from that date. It's over a year since that meeting occurred.

ASSEMBLYMAN COLBURN: Well, you've given me a chance to say something else. Since I'm up here, now I have a chance

to test out some ideas. The first was when, you know, government makes a mistake, it never admits it. It says, "Well, we didn't do enough." And the second one is that the government likes to provide service, but doesn't like to pay for it.

MR. KESSLER: I used to think that was human nature.

ASSEMBLYMAN COLBURN: Maybe, I guess. It's hard to cope with them, isn't it. Thanks a lot.

MR. KESSLER: Thank you.

ASSEMBLYMAN COLBURN: Loreen Pretsfelder of the New Jersey Speech and Hearing Association. You're one of the survivors of this hearing.

L O R E E N P R E T S F E L D E R: We've made it. Thank you very much for listening to my presentation today about an issue that I care a lot about. My name is Loreen Pretsfelder and I am a certified speech-language pathologist, licensed in the State of New Jersey. I also have a master's degree in Audiology. I serve as a rehabilitation coordinator for the Visiting Nurse Association of Trenton. In addition, I regularly provide speech-language pathology services to Medicare and Medicaid patients in a variety of settings including their own homes. Today, I'm speaking on behalf of the New Jersey Speech-Language and Hearing Association, representing close to 1000 speech-language pathologists and audiologists.

As a professional who works with both Medicare and Medicaid patients every day, I am frustrated by the inadequacies of these two systems. The existing programs simply do not meet the needs of the communities that they are attempting to serve. Speech-language pathologists and audiologists treating both Medicare and Medicaid patients typically serve patients who have suffered a stroke, experienced head trauma, undergone surgery for the removal of a larynx or voice box due to cancer, been stricken with a hearing disorder or other long-term debilitating illness such as

multiple sclerosis or Parkinson's disease, and a variety of other disorders.

One of the biggest problems as I see it right now, is the arbitrary denial of services to patients served both in the home care and hospital setting. We practitioners have very unclear guidelines in reference to who is allowed to be treated and for what problems. We often identify a serious need for a service, but unfortunately, we're unsure of whether a given service will be covered until after the patient is treated.

The reviewers who process the claims often provide us with misinformation and appear to be very inconsistent in their review of similar types of claims. Medicare reviews each claim individually. To us, it seems that they deny each claim arbitrarily. We never really know what they want. The person reviewing the claim seems to make a difference in whether a patient gets services denied or not. When I've questioned reviewers themselves as to their qualifications, they've responded that they are not speech-language pathologists or nurses, nor do they have any training in the allied health field. Some in fact, have no more than a high school education.

Let me know bring to your attention some services we provide as speech-language pathologists and audiologists that seem to be misunderstood and undervalued by the Medicare and Medicaid systems. As speech-language pathologists and audiologists, some of the most important services that we provide include dysphagia, which is swallow training -- working with patients who have swallowing problems. For instance, the second woman we say on the tape who has ALS, she will have swallowing problems somewhere down the road. Now, she obviously will not be covered. She will probably end up having very costly medical problems in terms of have a gastric tube put in if she's not treated. But she can be worked on within a home care setting very efficiently on a long-term basis, if

she's treated by the right person, and that would be the speech-language pathologist.

Some of the other most important services that we provide that we've had problems with, are oral rehabilitation and hearing rehabilitation which is training to aid people, especially the elderly, with hearing impairment and just communicating more functionally due to that hearing problem, as well as working with something we call augmentative communication systems, meaning construction and training in use of a language board or some sort of extra board or device to help somebody communicate who can't use their voice.

Unfortunately, under the Medicare/Medicaid system, these systems are either not covered at all or are very, very limited. When we're treating a patient with dysphagia or swallowing problems, there must be another goal or treatment as well, or the services are going to be denied by Medicare -- its blanket. In the hospital setting the speech-language pathologist is the only person qualified to treat swallowing disorders. This crucial treatment or service is not always covered in the home care setting.

Our hands are really tied with regard to also providing services to patients who may be totally unable to communicate due to loss of voice. We're not allowed to work solely on augmentative communication, even if there's no hope of a patient ever speaking again. Medicare basically requires that they see attempts and also progress in verbal communication as well, or we're not allowed to see a patient.

Audiology services are also extremely restricted under the present systems. Medicaid will not reimburse private practitioners at all for audiology in the home setting. They will help, however, pay for some hearing aids if the testing is done in a physician's office or hospital setting. That, of course, means considerable cost to transport the patient to that facility, if they can even be transported.

Medicare on the other hand will not pay for hearing or for any services, if they are related to acquisition of a hearing aid. They pay only for diagnostic audiological services -- for instance, a brain tumor or something like that. There are special tests that can detect those kinds of things.

There are also problems with the system in regard to long-term care of patients with progressive diseases or just post-stroke. We're typically allowed to treat a stroke patient for several months post-onset. Many stroke patients don't make any real speech-language recovery until three or six months after the stroke has occurred. That's when the most pressing need for treatment occurs and we're not allowed to see the patient. In the case of a patient with a progressive disease -- for example, Parkinson's -- the patient needs treatment initially as well as periodically as the disease process progresses and the speech and swallowing abilities deteriorate, and we're not allowed to do that on a long-term basis because long-term care isn't covered. These patients do really well at home when they are seen, but we're not allowed to see them because services will be denied.

I'd also like to bring to your attention, again a problem that's come up in the past -- the Alzheimer's patient. The Alzheimer's patient who's left to live at home or in an institution with no support from the system is a real problem. Basically, when we see diagnosis of Alzheimer's it's like a red flag for a denial. In home care setting, the speech-language pathologist is trained to help the patient and the family to better understand and communicate with the Alzheimer's patient. Alzheimer's patients are much better able to live a quality life longer in the home setting with the support of the speech-language pathologists, and at significantly decreased cost to the system, obviously.

That's just some of the problems that we've encountered. There are many more, obviously. I'm not going to

go into them in length today, but I wanted to make you aware of some of the pressing problems. Thank you very much for allowing us to speak with you. I'll be happy to answer questions that you may have.

ASSEMBLYMAN COLBURN: Can you provide us with one typewritten copy of your testimony, then we can duplicate it for everybody?

MS. PRETSFELDER: No problem.

ASSEMBLYMAN COLBURN: Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: Who makes up your Association membership? How many members do you have?

MS. PRETSFELDER: I believe we have approximately 2500 members -- 2500 speech pathologists practicing in New Jersey, and the Association is about 1000 members. We're all certified speech-language pathologists. We're now licensed by the State of New Jersey. We all have a minimum of a master's degree or equivalent to that, or there have been people grandfathered in under the licensure law. But I think we're well qualified professionals.

ASSEMBLYMAN FRELINGHUYSEN: Yes. The door opened recently, didn't it?

MS. PRETSFELDER: That's right. That's correct.

ASSEMBLYMAN FRELINGHUYSEN: I just have a question. In the beginning part of your comments you made reference to denial by people who don't have any qualifications to make the denial. For the record, who makes those denials and what part of bureaucracy makes those denials?

MS. PRETSFELDER: We're told when we call-- Every time we get a denial coming through our office, I call and I ask, why were we denied? Could you explain the process? Someone gets on the phone and says, you were denied because you were doing this and this. And we speak with them and we ask them--

ASSEMBLYMAN FRELINGHUYSEN: No. What I'm asking is is what office? What bureaucracy?

MS. PRETSFELDER: Prudential is our fiscal intermediary.

ASSEMBLYMAN FRELINGHUYSEN: So, the comments you made earlier in your testimony relate to that particular organization.

MS. PRETSFELDER: That's correct.

ASSEMBLYMAN FRELINGHUYSEN: Thank you, Mr. Chairman.

ASSEMBLYMAN COLBURN: Thanks a lot. Last but not least, Dr. Russano. I think, as far I'm concerned, after the doctor finishes what he has to say, if any of you who are staying around here want to tell any of us who remain anything, well, you are welcome to do it, having endured all this time.

D R. R O B E R T R U S S A N O: My name is Dr. Robert Russano. I'm a practicing dentist in Paterson, New Jersey, and I have been a provider to the Medicaid program in New Jersey since its inception in 1970. I'm here today as a Director of the Urban Dental Coalition, and I represent a group of dentists who practice in the inner cities of New Jersey, who accept patients under the New Jersey Medicaid program. On July 9, our Coalition received the Certificate of Appreciation for providing continuous, caring and quality service to the Medicaid program from Commissioner Altman. We would like to bring certain facts to your attention in respect to the Dental Medicaid program.

As you all know, Governor Kean has recently signed legislation adding some 205,000 eligible patients. The number of dentists who accept Medicaid has decreased by 17% in the past five years from 2983 to 2478, and it's documented by the enclosed letter from Mr. Russo. Of this number, only 156 dentists provided more than $10,000 in services during the past year. This is the largest decrease of all the health providers in the dental field.

Fact number three: It is impossible to find providers in some geographic areas because of the poor fee schedule. And as an annecdote and as an aside, what these patients do -- and

it's been documented as "the $200 extraction" -- they have a toothache, they go to the outpatient or emergency room of a hospital, they're given pain medication, and the State program is billed by the outpatient department of the hospital. They get referred to the dentist. The come back the next day to see the dentist or the dental arm of the hospital. That's another fee. They perhaps have some swelling or some post-operative problems. That's another fee. And they come back to the ER for a fourth time to probably have a suture removed. This is a $200 extraction. The standard Dental Medicaid fee schedule for an extraction is nine dollars.

Dental malpractice rates have increased 500% this year, with a similar increase projected for 1987. We do extract teeth for nine dollars, however, the average is approximately in the $40 range. Similarly, dental supply and laboratory fees have risen dramatically. How can we be expected to restore a tooth with a two surface silver filling, a 30-minute procedure, for a fee of approximately $13? How could we be required to fix a broken denture -- that's an annecdote, you won't find that on there -- to fix a broken denture when the cost to repair the denture is actually more than the reimbursement schedule.

The most recent issue of the "Journal of the New Jersey Dental Association" contained an interview with the current Dental Association President, Dr. Herbert Bressman. His comments regarding Medicaid patients require no explanation. That interview is attached.

We can provide many other examples of gross inequities if you request them. In 1974, the Medicaid reimbursement represented about 55% of the national median dental fee schedule. In the past 12 years we have received a fee increase of 8.3%. We now find that Medicaid reimbursement has fallen significantly below the 50% of the median fee. We feel that it is unconscionable to ask the providers to accept fees at this

level. It is our inescapable conclusion that the situation we will be facing is a substantial increase in patient population coupled with a steady decrease in providers.

In listening to the testimony today and in response to your questions, Dr. Colburn, to most of the speakers, I will say to you that the Dental Medicaid program -- if you can find a provider -- works. Now no one said that today; that the State works, but the dental program works. There is quality of care and there is, from a taxpayer's standpoint, utilization review. There is x-ray preview and review before treatment plans, there is a dental limitation via a microfiche file, and a seven-and-a-half year limitation so the program can't be abused.

There are models that are requested for a completion of orthodontal treatment so that the dental department can see how the othodontal prognosis was. And there's a (inaudible) program, I don't know exactly how it works, but when you extract a tooth or you do something to a tooth, it gets put into a computer. And if an attempt was made to do the same thing on the same tooth on the same provider, the claim bounces. It's automatic.

If you can find a provider, the Dental Medicaid program works. We would like a fee increase to continue to provide the quality of care as well as to increase our base of providers. There are exactly 156 dentists in this State who you could say are regular Medicaid providers. Thank you for your time, gentlemen.

ASSEMBLYMAN COLBURN: Thank you. Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: One hundred and fifty-six, Mr. Chairman?

DR. RUSSANO: One hundred and fifty-six people who provide more than $10,000 in services under the Medicaid program dentally. That means that they are regular providers. There are approximately 2500, providers, some of which who see one, two, or three patients a year. They are providers to the program, but on a limited scale.

ASSEMBLYMAN FRELINGHUYSEN: Do all 21 counties have someone who provides Medicaid?

DR. RUSSANO: Yes. There are services. However, there are services, especially in South Jersey that are extremely limited. Maybe 30, 40, or 50 miles away. These can be documented. Dr. Bell can document specific cases. He's the dental director of the program. He can document specific cases -- names, facts, dates where people have not been able to receive services -- dentures, partials--

ASSEMBLYMAN FRELINGHUYSEN: One other question. What's your recipient mix here? Russo mentions numbers. What's the mix of age? Do you have it?

DR. RUSSANO: I don't have those facts. They are readily available, but I don't have them.

ASSEMBLYMAN FRELINGHUYSEN: And as I remember, there are other dental programs that assist the needy that the State is involved in?

DR. RUSSANO: I don't believe so.

ASSEMBLYMAN COLBURN: Well, the one in Camden. I don't know how big it is. The dental clinic in Camden.

ASSEMBLYMAN FRELINGHUYSEN: Through the appropriations process, we do support other dental programs, certainly for some of those which fall under the responsibility of the Department of Human Services -- that clientele. Thank you very much.

ASSEMBLYMAN COLBURN: Thanks. Is my impression correct, that the Medicaid law says that hospitals shall be reimbursed at their audited cost and that providers like us should be reimbursed enough to keep enough of us in the programs so that there would be services? It looks like the numbers--

DR. RUSSANO: That's correct. So, that's how we get the $200 extraction as I demonstrated. They go to outpatient visits of the hospital. That's how this State is billed in that regard.

ASSEMBLYMAN COLBURN: Okay. Thanks a lot.

DR. RUSSANO: Sure.

ASSEMBLYMAN COLBURN: Does anybody else want to say anything? (positive response)

D R. B E R N A R D M I L L E R:. (speaks from audience) My name is Bernard Miller. I'm a general practitioner for the past 40 years in Highland Park.

ASSEMBLYMAN COLBURN: You've got me by nine years.

DR. MILLER: Well maybe it's 39. Before Medicaid came in, I was a sole practitioner and worked with four other doctors.

ASSEMBLYMAN FRELINGHUYSEN: You have to come up to the microphone.

ASSEMBLYMAN COLBURN: Yeah, I guess it won't record. So, come up and have a seat. And you are from?

DR. MILLER: Highland Park.

ASSEMBLYMAN COLBURN: Highland Park. I guess, you'd better give us a name again.

DR. MILLER: Dr. Bernard Miller. B-E-R-N-A-R-D.

ASSEMBLYMAN COLBURN: Okay.

DR. MILLER: And I've been practicing for about 40 years, and I cover with other doctors, but I'm a solo. Before Medicaid came in, we had a thing called Deboka (phonetic spelling). And we would furnish our services to people who couldn't afford as a deductible item in the book of the eternal (accentuates the E in eternal) revenue collector. (laughter) It seemed to work all right. And as a general practitioner, in my practice, you're not only a medical doctor, you are a psychiatrist, psycologists, a marriage counselor, a priest or minister or whatever you want to have, all in one. And it's still that way today, very much so.

When Medicare first came in, our group-- We said that we would keep it as low as we possibly can. That's $25. When we submit something to Medicare, it comes down to about $14 that you get back. All the other young fellows, the

individuals, who are practicing in the area -- I called one just before I left -- they're charging $30 and $35, and they allow ten minutes for patient. Oh my goodness, nine patients -- if it takes 15, 20, 25 minutes, whatever it takes.

Now, we're talking about if we couldn't be equalized-- When you put this bill through, I can see some of the good things and bad things from it. I think it should be equalized. Where the doctor who put their fee in 10 or 12 years ago when Medicare first came in as $25, and you're getting $14 and the other group nearby that puts it in for $30 I believe, and they get $22 or something back, and the patient pays five, and it comes out to $27. We put in $25.

You don't only act, as I say, as a doctor. Just recently I had a case with incest in the family. The wife calls me, "Come quick, come quick. The State troopers are shooting at my husband." I get there fast. And he's up in the barn, and I told the State troopers to put down their guns so they won't shoot me. So, I went up and got him down, and of course he went to jail. Here's a family with 13 kids. What do you do with them? They have no money. I said, "Give me your phone." And I said, "Mom, can I bring somebody home tonight." Mom saw 13 kids come in. They stayed for a week, stuck in the living room.

But that happens all the time. It has happened more in the past than it does today. And we're not asking for a consideration for that. All we want is what is fair to us now. And they said I think, there's a ruling that you can't increase your charges to Medicare. In other words, when you put your bill through, I think it should be equalized, that doesn't matter. I have to put in just as much time. I had to give up OB. I had about 3300 deliveries and about 550 or 560 sections. I gave up. I had to give up two years ago. Insurance is too great.

ASSEMBLYMAN COLBURN: I think you're referring to something that I really had expected would come out in the hearing. And I think I'm correct in saying that each of us has a separate profile with Medicare. The physicians who went into the program when it started about 20 years ago started with that profile in Baltimore, and the ones who come out recently can have a higher profile. Also, the ones who raised their fees real fast at the start of the program -- because they probably knew what was coming, you know, they had advisors, and accountants, lawyers, and all of that-- But the ones who didn't raise their fees and tried to keep them low for everybody, I think they are the ones who are penalized by the Medicare assignment program. The ones who have the highest assignments under the profiles can afford to accept assignment. But the ones who kept them low, you know, in good conscience, are the ones who are getting hurt.

DR. MILLER: I agree with you 1000%.

ASSEMBLYMAN COLBURN: That's what you're really bringing out under Medicare, right?

DR. MILLER: That's what I'm bringing up.

ASSEMBLYMAN COLBURN: Okay. What about Medicaid? I guess you're feeling the same way.

DR. MILLER: Medicaid -- if we have to, we do it. There's no problem.

ASSEMBLYMAN COLBURN: Yeah, we used to always take care of poor people before.

DR. MILLER: We used to have services in hospitals -- surgical services, medical services, obstetrical services. You gave it to the hospital for nothing.

ASSEMBLYMAN COLBURN: That's right. The clinics or the ward service.

DR. MILLER: For four dollars? Forget it. I mean, it costs you so much to send for the money. It cost you three dollars and some 28 cents to send the bill out.

ASSEMBLYMAN COLBURN: Probably.

DR. MILLER: But, how do you go about and try to -- you seem to know about it, sir -- about raising your profile and that we can be with the others? I think we've giving more services than they can give in 10 minutes.

ASSEMBLYMAN FRELINGHUYSEN: It may be Federal.

ASSEMBLYMAN COLBURN: Unfortunately, it is a Federal question.

DR. MILLER: But, can't we put that thing in your bill? If you do put this thing through that--

ASSEMBLYMAN COLBURN: Well, we could memorialize the Congress to do things and we can ask them to do them, but we can't force the Federal people to do things.

DR. MILLER: Okay. I'm representing maybe 10 of the older men--

ASSEMBLYMAN COLBURN: Well, you're representing a lot of people and a lot of doctors that I know.

DR. MILLER: --and I would like to know how we could go about this?

ASSEMBLYMAN COLBURN: You have to get a hold of your Congressman and your United States Senator.

DR. MILLER: That's the only way to raise your profile?

ASSEMBLYMAN COLBURN: It cannot be done at the State level. Maybe they could put something in a Federal bill which would give an appeals process which would then allow a waiver on some of these profiles, because this is one of the stupid things in the darn legislation.

DR. MILLER: Because otherwise, they're going to force us to stop Medicaid.

ASSEMBLYMAN COLBURN: Well, I think also, it's going to force a lot of doctors to retire.

DR. MILLER: Well, that's one other thing.

ASSEMBLYMAN COLBURN: That's what it's going to do. You know my dad is an 84-year-old GP. I've told a lot of people that. And he tells me that as you get older, the age of

your patients goes up with you. In other words, the age of your practice goes up, and I think I've noticed it in my own.

DR. MILLER: Of course. I think it is too, unless pediatrics--

ASSEMBLYMAN COLBURN: So, we're the ones who are seeing the Medicare folks.

DR. MILLER: Definitely. Make more house calls, too.

ASSEMBLYMAN COLBURN: Yeah. I make them every week or so. I'm a dermatologist.

DR. MILLER: I do too, because of the fact that you have the older people who can't come out, so you're making more house calls.

ASSEMBLYMAN COLBURN: So, we'll do as much as we can on that. But it's a Federal thing about these profiles. I think the profiles when Medicare went into effect, probably made sense. They weren't usual in customary fees. But now they've gotten ridiculous.

DR. MILLER: Wasn't there somebody, one of the vice presidents of Prudential, who was in charge of the Medicare in, I think in parts of New Jersey -- Middlesex County?

ASSEMBLYMAN COLBURN: Yeah, well, they're the intermediary for New Jersey. They are not in every state.

DR. MILLER: But don't they have something to do with that program business?

ASSEMBLYMAN COLBURN: No. It's Federal legislation that establishes it. It's all the physicians in the country have one of these profiles.

DR. MILLER: So, in other words, the only way you can do it is write to your Congressman.

ASSEMBLYMAN COLBURN: Yeah, and tell them about the inequity of the program system. That's as I understand it.

DR. MILLER: What would prevent you -- would prevent me from closing my practice--

ASSEMBLYMAN COLBURN: And starting again?

DR. MILLER: --and starting as a corporation?

ASSEMBLYMAN COLBURN: I don't know. Maybe that's the way to do it. I don't know. I know of a fellow who has an ambulance services who did that. His fees were low, so he changed his corporation and opened up a different one. What do you think of that?

DR. MILLER: People are that way too. I know a woman who had six babies. All the boys had cerebral palsy. I wouldn't charge a lot. The bills go higher and I started again. The husband left and I wouldn't take care of him. Finally, they sold their house. I don't know if you know in the Brunswick area what the houses are now? A house that they paid $9000 then is just sold for $110,000. And I said to her, "Well since you're getting $110,000 and you're buying a condominium in Florida, don't you think you ought to pay part of my bill?" She said, "I'll pay you someday." And I said, "No, now." And because I put a lien on her house, she thought I was horrible. But she never paid me a nickel for 15 years.

ASSEMBLYMAN COLBURN: I'll tell you-- Okay. Well, thanks.

DR. MILLER: Thank you for listening to me.

ASSEMBLYMAN COLBURN: Yeah.

ASSEMBLYMAN FRELINGHUYSEN: You better say we're adjourned for the tape count.

ASSEMBLYMAN COLBURN: Well, I'm just going to ask if anybody-- I want to thank David Price who did a great job in scheduling this session.

ASSEMBLYMAN FRELINGHUYSEN: And how about our recorders down there?

ASSEMBLYMAN COLBURN: The recorders, the poor souls, they're going to have their dinner late. Thanks a lot to you. And now we're going to adjourn this hearing.

(HEARING CONCLUDED)

APPENDIX

NEWS

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
222 SOUTH WARREN STREET
TRENTON, NEW JERSEY 08625

OFFICE OF PUBLIC INFORMATION — PHONE (609) 292-3703

FOR IMMEDIATE RELEASE

November 17, 1986

FOR FURTHER INFORMATION

Charlene Brown

Human Services Commissioner Drew Altman called today for New Jersey to stop the further decline in the number of physicians and other medical professionals who care for Medicaid patients by increasing the fees they are paid under the state's Medicaid program.

"Medicaid has been a tremendously successful program, but its effectiveness is in danger of slipping. This is because our low rates of reimbursement for medical professionals are driving them away from serving Medicaid patients," Altman said in testimony before the Assembly Health and Human Resources Committee.

The state/federal Medicaid program provides medical care to low-income mothers and children, the blind and disabled and the poor elderly. Because of the low rates of physician reimbursement, many of these people have been forced to forego or delay care or to use more costly types of care, such as hospital emergency rooms, the commissioner said.

Medicaid currently pays physicians about $7 for a routine office visit, compared to approximately $35 paid by private patients, he said. Other comparisons between Medicaid fees and private patient fees cited by the commissioner include $7.50 versus $40 for a simple tooth filling and $236 versus $1,600 to $2,000 for obstetrical care.

Department figures indicate that only 1 in 5 physicians currently serve Medicaid patients and the number doing so is continuing to decline.

In contrast, as physician participation decreased, the number of visits to hospital outpatient facilities and emergency rooms has increased in the last four years.

Care in such settings is six times as costly as care provided in a private physician's office and the department estimates it would have saved approximately $6 million in state fiscal year 1986 alone if this shift from private physician care had not taken place, he testified.

"The issue at hand is not physician incomes - physicians will continue to do well," Altman said. "The issue is assuring access to needed care for vulnerable groups, and assuring the most cost-effective use of the Medicaid dollar," he said.

# # #

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COMMISSIONER DREW ALTMAN

NEW JERSEY DEPARTMENT OF HUMAN SERVICES

ASSEMBLY HEALTH & HUMAN RESOURCES COMMITTEE

NOVEMBER 17, 1986

3X

Mr. Chairman, members of the Committee, I want to thank you for inviting me to make a statement today before the Committee on Health and Human Resources concerning the Medicaid program. As Commissioner of Human Services, I have great interest in the issues you will be discussing today.

Mr. Chairman, if time permits, I would be happy to talk with you about the full range of Medicare and Medicaid issues that affect the citizens of New Jersey, in particular, my plans for improving services and reducing costs under the Medicaid program. Reforming Medicaid so that it becomes not just a reimburseme mechanism, but a catalyst in developing a better and less costly health care sy is one of my top priorities.

But today, I want to try and restrict myself to one issue that I believe is of immediate concern - our low rate of reimbursement for physicians and othe practitioners who serve people on Medicaid - and its implications for access to health services and the cost-effectiveness of our Medicaid program.

Let me start by saying that, since its passage in 1965, the Medicaid program has made the critical difference in affording access to health care services for the disadvantaged in our country and in our state. In my view, Medicaid needs to be protected and it needs to be improved. I would not support any measure that would cut back on Medicaid services or see Medicaid patients' access to needed care further eroded.

Perhaps the biggest accomplishment of the Medicaid program is this: In sharp contrast to the pre-Medicaid era, the poor now see a doctor and go to a hospital at least as often as the non-poor in New Jersey and across our country.

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Moreover, despite the fact that the people served by Medicaid are sicker than the general population, Medicaid has served them at the same or at less cost than comparable insurance provided to the general population.

Medicaid, of course, also serves our most vulnerable populations. Despite public preconceptions about who is on Medicaid, the Medicaid program actually serves three groups: 1) low income mothers and children; 2) the blind and the disabled; and 3) poor elderly citizens of our state. Thus, Medicaid is really three programs in one, and each of these programs serves a very needy and vulnerable group.

However, despite this record of success, Medicaid is not without problems. For one, Medicaid never has become a comprehensive health insurance program for all low income people. In fact, today Medicaid covers less than fifty percent of the poor and near-poor.

Of particular relevance to today's hearing, Medicaid's effectiveness in perhaps its most important area - providing primary care and other basic medical services to covered groups - is slipping, and is in danger of slipping further. In large measure, this is because our low rates of reimbursement for physicians and other practitioners are driving them away from serving Medicaid patients. As a result, access to basic services is eroding and Medicaid patients are delaying needed care. Further, when they seek care, they are increasingly relying on much more expensive and sometimes less effective hospital outpatient departments and emergency rooms; sites which are not now well-equipped to serve in the role of personal physicians.

Medicaid reimbursement in New Jersey has been almost stagnant outside of the institutional area for many, many years.

Today, we are paying physicians $7 for a routine office visit, as compared with the approximately $22 from Medicare and the $35 physicians receive from their private patients. We are paying dentists $7.50 for an uncomplicated tooth filling and $9 for an uncomplicated tooth extraction, while they are paid about $40 from their private patients. Further, we are paying obstetricians on $236 for a full package of obstetrical services, which includes prenatal care, delivery and postpartum care. This compares with between $1600 and $2000 for private patients. We are even limiting Medicaid patients to $5 eye glass frame that are unpopular and often substandard.

These rates exist because fees to professional practitioners are not indexed to any consumer price factor or cost of living formula, but rather are negotiated based upon the specific funding levels made available through the annual appropriations process. With overall budget constraints and the press of other state priorities, these rates have remained almost static since the inception of the Medicaid program in New Jersey in 1970. As a result, each yea we fall further and further behind fees paid by other public programs and in th marketplace. This is in contrast to payments to institutional providers, such as hospitals and nursing homes, where fees are routinely increased based upon costs and inflation factors.

What does all this mean? Mr. Chairman, let me be blunt. I am not convinced that physicians in our state will be unable to make an adequate living. To be sure, physicians are being buffeted by multiple changes in our health care system. Nevertheless, I am confident that when things shake out physicians wil continue to do well economically and will continue to be viewed as one of the most respected groups in our society.

My primary concern, with regard to this issue of Medicaid rates, is for preserving access to needed health services for the poor, the elderly, and disabled served by Medicaid, and for assuring that Medicaid gets the best buy for its dollar.

Today, there are sections of our state where a Medicaid-eligible pregnant woman cannot obtain prenatal care because there are no physicians or obstetricians in her area willing to see her at the current low rate of reimbursement. This means that she cannot receive necessary health care, prescription drugs, nutrition counselling, etc., thereby endangering not only her own physical health but that of her unborn baby. Too often these women end up presenting themselves in the emergency room of a hospital on the day they go into labor, having received little or no prenatal care.

The impact of low reimbursement rates is perhaps most graphically seen in the area of obstetrical services, but this is a problem across-the-board in our Medicaid program. In the last six (6) years, the already low number of physicians participating in Medicaid declined further, from 6,888 in state FY'81 to 6,744 in state FY'86. The total number of physician visits has also declined by 20% over that same time period. Thus, while total health care expenditures have gone up, spending for physician services in our Medicaid program has actually gone down -- from $62.6 million in state FY'81 to $52 million in state FY'86. This compares, for example, to a 20 to 25% increase in recent years in payments for physician services under the Medicare program.

This all occurs, ironically, at a time when we have more and more practicing physicians in our state which, one would think, would result in greater physician participation in the Medicaid program, not less. In fact, our rates of reimbursem

are so low that even the increasing competitive demands in the market place on physicians have been inadequate to stimulate more of them to care for Medicaid patients.

Just as important as the impact of our low rates of reimbursement on access to health care, is its impact on cost.

When Medicaid patients cannot get care from a personal physician, they often delay needed care, and then ultimately receive it in a much more expensive hospital setting. Our statistics from the Medicaid program bear this out. In recent years, for example, the number of participating physicians has gone down, while outpatient and emergency room visits have gone up -- from 847,000 in state FY'82 to 938,000 in state FY'86. On the average, care in such settings costs six (6) times as much as care provided in a private physician's office. It is interesting to note that if the increase in patient visits to hospital outpatient departments and emergency rooms in the last four (4) years had not occurred, and if those patients had received care from private physician instead, the Medicaid program would have saved approximately $6 million in last

Over the last month, I have been traveling across the state and meeting with welfare recipients to discuss our welfare reform initiative. All of these young mothers on welfare, of course, are eligible for Medicaid as well. Of the first group of eight welfare recipients I met, two reported that their physicians had recently refused to care for them as a result of low Medicaid rates. In the second group of six, three made the same claim. This is, of course, sad, but not altogether surprising. In fact, in many cases the cost of supplies needed to treat Medicaid patients are actually higher than the Medicaid payment for the total service.

Mr. Chairman, although I plan to diligently promote more cost effective health care delivery systems, such as HMO's and our Medicaid Personal Physician Plan, and look for opportunities to bring prepayment and case-management to other settings such as hospital outpatient departments, it is clear that we will not have enough providers of prepaid services in New Jersey to service the entire Medicaid population. Thus, it is essential that we maintain a viable provider fee structure for our Medicaid service system to provide the necessary care to keep our adults and children healthy.

Therefore, I urge you as a committee to help remedy the situation by 1) recognizing that if current trends persist, the state Medicaid program's objectives will be seriously undermined; and 2) working with us to make Medicaid participation more attractive to health care providers.

Let me just close by saying, then, that from the point of view of one who is committed to preserving and improving access to health services for the disadvantaged, and is committed to a more cost-effective health care system, it is imperative that we take a closer look at our Medicaid fee structure and make the changes that are warranted.

Family Physician and General Practitioners concerns

Re: Legislation Requiring Medicare Assignment for State Licensure.

I. Inappropriate use of License Process to solve social/political issues

A. License designates professional competency.

B. Social implications of Medicare problems are societal and should be shared by all citizens.

II. Recognition that some Medicare recipients need financial assistance.

A. Process required to identify needy Medicare recipients.

1. Establish plan to direct resources to these people.

B. Statistic that 70% of the discretionary wealth in U.S. is held by senior citizens (defined as persons over the age of 55).

1. Not all senior citizens require subsidizations of health care costs.

a) The income of over 50% of the population of persons age 65 and above is sufficient to classify them as middle or high income earners. (DHHS 84-3362).

b) The large majority of persons in the Medicare population can afford supplemental private health insurance in addition to Medicare and even in the combined low income - poverty group 72% are covered by supplemental insurance (54% private health Insurance 18% Medicaid).

III. Impact on the Business of practicing Family Medicine

A. Service provided primarily in out-patient environment, office and/or home.

1. Most cost effective.

B. Care is mostly cognitive
(diagnostic problem analyzing and therapeutic vs technical such as performing procedures).

10X

III. Impact on the Business of practicing Family Medicine (Continued)

C. Medicare Reimbursement.

1. Fee schedule unrealistic, only approximates paying for fixed overhead of the practice on a per visit basis.

a) Illustration

Average office visit fee $25
Average office encounter $28
Overhead (National average for FP) 49%
Average overhead cost per encounter $13.72
Average Medicare allowable fee $14.40 (code 90050-limited services)
Medicare reimbursement for above $11.52
May bill to patient $2.88

Total fee possible under assignment $14.40
Funds available for physician's services $.68
(Medicare allowable - overhead)

2. Practical assumption under legislated assignment

a) Loss of income to Family Physicians imposing severe economic hardship. The larger the Medicare patient population the greater will be the economic impact.

b) Illustration -

- Average earning of Family Physicians $76,000 (1986 Medical Economics Survey amount includes pension contributions).
- Assume 30% of practice income derived from Medicare, therefore, approximately a 30% loss of net earnings.
- Average earning reduced to $53,200

IV. Solutions

A. Investigate mechanism to assist only the needy senior citizens.

B. Revise Medicare Fee Schedules to realistic relative value scale.

C. Obviously, don't pass proposed Legislation.

C. Evaluate Medicaid from same perspective.

201/643-3876

ACNJ

ASSOCIATION FOR CHILDREN OF NEW JERSEY

17 Academy Street, Suite 709
Newark, New Jersey 07102

November 13, 1986

TO: Honorably Harold L. Colburn, Jr., Chairperson
Members, Assembly Health and Human Resources Committee

FROM: Ciro A. Scalera, Executive Director
Cecilia Zalkind, Government Relations Coordinator
Shirley Geismar, Research Coordinator

RE: **TESTIMONY FOR THE PUBLIC HEARING ON THE MEDICAID PROGRAM IN NEW JERSEY**

The Association for Children of New Jersey (ACNJ) is a statewide membership-based, non-profit organization. Our role is to increase the effectiveness and accountability of those systems that impact on the lives of New Jersey's children and families. We are pleased to be here today to give testimony regarding the Medicaid program, since it is a subject with which our organization has been involved for a number of years, and one that is of great importance to the health and well-being of children in our state.

In evaluating health programs for poor children and their families, the degree to which these programs provide ACCESS TO HEALTH CARE is what appears to us to be most important. There are at least three aspects of this concept: 1) Who are the eligible recipients? 2) To what services are they entitled? 3) Who is available to provide these services? In this testimony today we would like to concentrate on the last element - the providers of service - and to discuss our concerns regarding the availability of participating doctors, the low Medicaid reimbursement levels and the impact of these problems on the Medicaid patient.

FEWER AND FEWER PHYSICIANS ARE PARTICIPATING IN THE MEDICAID PROGRAM DUE, IN LARGE PART, TO LOW REIMBURSEMENT RATES.

For a number of years medical groups around the state have been reporting that fewer and fewer physicians are participating in the Medicaid program. Statistics on this phenomenon were published in **The New Jersey Pediatrician** in Spring, 1982. In a survey of their readers, they found that half of those doctors who responded, indicated that they consciously limited their Medicaid practices in a variety of ways, the most common of which was to refuse to accept new Medicaid patients while continuing to serve old ones. Additionally, 22% of those responding said that they would decrease the percentage of Medicaid patients in their practices in the following year.

In 1982, ACNJ surveyed pediatricians and family practitioners in both North and South Jersey and found that, of 469 respondents, 65% had less than 10% of their patient load enrolled in the Medicaid program.

In our report **Through the Safety Net** of 1983, a result of interviews with consumers and social service personnel, we discussed this problem, and this trend has been further reported by the Governor's Committee on Children's Services Planning in publications of 1982 and again in 1985.

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Each of these studies and surveys linked the low provider participation rate to the inadequacy of Medicaid reimbursement. In the 1982 ACNJ survey, about 45% of the physicians contacted indicated that an increase in the fee schedule would be the most effective measure to increase the number of providers. This by far led the list of other recommendations. These responses were affirmed more positively by the pediatricians in the poll taken by The New Jersey Pediatrician. Almost 75% of those respondents said that they would consider increasing their Medicaid participation if "reasonable" fees were provided.

In an attempt to define "reasonable" fees in 1986, we recently talked to pediatrician in central Jersey who charges average fees in order to learn what a private patient of his paid for service as contrasted with reimbursement he receives from Medicaid. He gave us the following information:

* For an initial office visit (i.e., those in which a child has not been seen by the pediatrician for a year), the average non-Medicaid fee is $30 - Medicaid pays $22 - 27% less.

* If the child is a regular patient of the physician and is seen more than once a year, Medicaid pays $9 for each office visit - 70% less than the average $30 fee.

* A urine analysis or blood test costs the average private patient $10 - Medicaid's reimbursement is $1.20 or 88% less.

* A throat culture costs, on the average, $10 - Medicaid pays $3 or 70% less

* Care of a healthy newborn in the hospital, entailing daily visits to the child and consultation with the mother as long as they are confined to the hospital (usually three days), costs the private patient $150 - Medicaid reimburses at the rate of $33 - 78% less).

* For care of a sick child in the hospital, the private fee is $50 for each day's visit by the physician - Medicaid reimburses $22 the first day and $9 thereafter - 56% and 72% less, respectively.

These are but a few examples of significant differentials between private fees and Medicaid reimbursement in a few types of pediatric services. Clearly, these differences, in many cases amounting of reimbursements of 80 or 90 percent less, are a serious disincentive to provider participation. Examples such as these illustrate the necessity to give providers fees that adequately cover materials and office expenses, and provide them with a small incentive to continue participation in the program.

INADEQUATE REIMBURSEMENT LEVELS AND LOW PROVIDER PARTICIPATION RATES SERIOUSLY IMPACT ON ACCESS TO HEALTH CARE FOR POOR FAMILIES

The lack of private physicians available to provide health care for the Medicaid patient has a serious impact on poor families in several ways. In rural and some suburban counties, it is exceedingly difficult to find a doctor when needed, and often preventive or on-going care must be ignored as a result. In large urban centers, patients must use costly hospital Emergency Rooms for treatment of non life-threatening health conditions because there is no one else available. Once again, preventive or ongoing care must be ignored.

In both instances, whether in a county with few health resources or one with many, the program is ill served. In the first instance, the patient has haphazard, crisis-oriented, perhaps lower-quality care; in the second, there is little continuity and follow-up, so that - even though given by up-to-date medical institutions - the care lacks optimum quality and effectiveness.

Fiscally, the program itself also suffers. The sums paid to the Emergency Rooms are not inconsiderable. Moreover, neither patient is getting preventive or follow-up care that could help prevent the emergence of acute health problems in the future. In the end, these problems prove to be very costly to the state and to the patient, in both material and human terms.

THE SUCCESS OF NEW HEALTH INITIATIVES IN THE STATE WILL BE LIMITED BY THESE PROBLEMS

In recent years, New Jersey has been in the forefront of states in providing significant health initiatives for low-income families. The Legislature deserves a great deal of credit for these important initiatives. Enactment of a Medically Needy Program and support for programs providing better health care for pregnant women and young children are all important and essential elements of an adequate health care system for the most needy citizens of our state. Yet we must seriously question how effective such programs will be if there are not a sufficient number of providers who are willing to participate.

Similarly, ACNJ, along with several other groups, has strongly supported expanded outreach for the Early Periodic Screening, Diagnostic and Treatment Program (EPSDT). The success and cost-effectiveness of this program has been well-documented. Yet how can we encourage expansion of the program to more eligible children when the current reimbursement system penalizes doctors financially for those children they see more than once a year?

There have been some efforts to increase provider participation in the state. For example, a Personal Physician Plan and an HMO in Cumberland County have been added to the roster of providers for Medicaid services. These are both attempts to avert expensive Emergency Room reimbursements and to deal in a constructive way with the decreasing participation of providers, particularly physicians. To date, we have not seen any evaluation of these efforts, and therefore are not in a position to state whether or not they have had a positive effect upon access to care. Unless proven otherwise, however, it is our firm belief that until the fee structure of the Medicaid program is reformed, these innovations will only prove cosmetic, or - at the very best - of limited regional importance. The fundamental, underlying problem is the economic disincentive inherent in the fee schedule which inhibits the participation of providers.

FISCAL EFFECTIVENESS MUST ALSO BE MEASURED BY AN EVALUATION OF THE QUALITY OF SERVICES TO POOR CHILDREN AND THEIR FAMILIES

Medicaid is deeply concerned with fiscal matters such as cost containment and the exposure of fraud, from both a patient and provider standpoint. It has not considered such matters as program evaluation and quality control of its community-based, child-focused activities. We do not know if the care received by poor children covered by Medicaid is comparable to that given to children able to afford private medical care. We do not know of any initiative to collect data on the health of the children covered by the program, of their participation, their mortality, and the possible effects upon

them of Medicaid participation. Thus, in addition to a reform of provider fees, we call upon the Medicaid program to evaluate the effectiveness of the services it gives to the young under its care, an age group experiencing the highest poverty rates of the entire population.

In summary, we thank the committee for the opportunity to express our concerns about this serious issue. We believe strongly that the decreasing number of providers willing to participate in the Medicaid program is due in large part to inadequate reimbursement levels. Consequently, the lack of available providers has a serious impact on the poor's access to health care both in finding a provider and in obtaining a full range of medical services. If we are committed to providing adequate health care to our most dependent citizens, then we must first address this most basic problem.

Passed + Signed
December 1985

SENATE . . . . . No. 217

By Mr. D'Amico, a petition (accompanied by bill, Senate, No. 217) of Gerard D'Amico, Jack H. Backman, Frederick E. Berry, Frank J. Manning and John P. Houston for legislation to further regulate the registration of physicians. Health Care.

The Commonwealth of Massachusetts

In the Year One Thousand Nine Hundred and Eighty-five.

AN ACT FURTHER REGULATING THE REGISTRATION OF PHYSICIANS.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

Section 2 of Chapter 112 of the General Laws is hereby amended by inserting after the fifth paragraph the following paragraph: —

The board shall require as a condition of granting or renewing a physician's certificate of registration, that the physician agree not to collect from a beneficiary of health insurance under Title XVIII of the Social Security Act any amount in excess of the reasonable charge for that service as determined by the United States Secretary of Health and Human Services.

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Passed + Signed
November 1984

SENATE . . . . . No. 2243

By Mr. Edward L. Burke, a petition of Edward L. Burke for legislation to further regulate Medex charges. Health Care.

The Commonwealth of Massachusetts

In the Year One Thousand Nine Hundred and Eighty-four.

AN ACT FURTHER REGULATING CERTAIN MEDEX CHARGES.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

Section 6 of said chapter 176B is hereby amended by adding the following subparagraph at the end thereof: (f) A Statement in the case of any subscription certificate providing supplemental coverage to medicare or other governmental programs that no participating physician or other participating provider of health services shall charge to or collect from a subscriber or covered dependent any amount in excess of the maximum allowable compensation determined by the governmental agency administering such program as the basis for the government's payment thereunder to such participating physician or other participating provider of health services.

17x

Chapter 475

THE COMMONWEALTH OF MASSACHUSETTS

In the Year One Thousand Nine Hundred and Eighty-five

AN ACT FURTHER REGULATING THE REGISTRATION OF PHYSICIANS.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

Section 2 of chapter 112 of the General Laws, as appearing in the 1984 Official Edition, is hereby amended by inserting after the fifth paragraph the following paragraph:-

The board shall require as a condition of granting or renewing a physician's certificate of registration, that the physician, who if he agrees to treat a beneficiary of health insurance under Title XVIII of the Social Security Act, shall also agree not to charge to or collect from such beneficiary any amount in excess of the reasonable charge for that service as determined by the United States Secretary of Health and Human Services.

House of Representatives, October 30, 1985.

Passed to be enacted, George Fleming, Speaker.

In Senate, October 30, 1985.

Passed to be enacted, William M. Bulger, President.

November 12, 1985.

Approved,

Governor.

18X

FACT SHEET

AN ACT FURTHER REGULATING THE REGISTRATION OF PHYSICIANS (S.217)

The Problem:

Nearly 200,000 senior citizens and 64,000 disabled persons in Massachusetts continue to pay costly physician overcharges. Elderly residents in the greatest need remain vulnerable. These seniors who are among the poorest seniors in the state remain unprotected from doctors' overcharges. The fees physicians charge them are not set as for Medicaid beneficiaries, nor are balance bills prohibited as for Blue Cross/Blue Shield subscribers. Clearly, the state has an obligation to help these elders and disabled, extending to them the same protection from high medical bills afforded most other Massachusetts residents.

Nearly 80% of Massachusetts 5.4 million residents are protected(as Blue Cross/Blue Shield subscribers and Medicaid recipients) from doctors' overcharges and balance bills. Among those protected are 500,000 of 800,000 Massachusetts elderly citizens. Most of these seniors were only recently helped by the enactment of Chapter 310, "The Ban on Balance Billing of the Elderly," a previous Massachusetts Senior Action Council legislative priority. It only remains to protect those most in need.

What the Legislation Will Do:

Fortunately, the state can protect these poor elderly by preventing doctors from charging senior patients more than the Medicare set fees. Through the Board of Registration in Medicine, the state grants qualified physicians the privilege of practicing medicine in the Commonwealth. The state has the moral and legal responsibility to ensure that physician practice "promotes the public health, welfare and safety." Obviously, allowing the poorest seniors in Massachusetts to pay excessive medical fees violates the public interest and perpetuates a blatantly unfair situation. Physician charges to these low income seniors should not excees fees paid by most Massachusetts citizens.

This bill would stop doctors, as a condition of licensure, from charging elderly patients more than the reasonable fees set by Medicare.

The Gallagher Amendment:

When S. 217 was voted on in the Senate, before the summer recess, it was with an amendment introduced by Senator Edward Kirby (R. Whitman). Senator Kirby's amendment effective negated the intent of the bill, rendering the legislation meaningless. Therefore it is necessary to restore the meaning of S. 217 (extending protection from physician overcharges to those seniors and disabled persons not covered by Medicare supplemental health insurance) before the bill can be voted on.

Representative Thomas Gallagher (D. Boston) will introduce the necessary amendment, restoring the substance of S. 217.

The Legality:

This bill utilizes the Commonwealth power to regulate the practice of medicine for the protection of the public's health. By requiring all doctors not to collect more from Medicare patients than the amount Medicare dtermines is a reasonable fee, doctors are guaranteed a reasonable compensation for their services and the aged and disabled are assured their costs for health services will be affordable. It is crucial for the Commonwealth's elderly and disabled population that their costs for doctors' services be controlled to maintain access to these services for this population.

This legislation is not prohibited by the Federal Medicare statute, nor is it in con-

...LTH CARE CAMPAIGN

1985

Issue- Elimination of Physician Overcharges (Bills) to Seniors

Immediate Objectives-
1) 100% acceptance of Medicare assignment (or Medicare fees) by all Massachusetts doctors
2) Eliminating copayments and deductibles for seniors without supplemental insurance
3) Increasing senior Medicaid enrollment of medically needy (non-SSI poor)
4) Increasing physician acceptance of Medicaid patients.

Strategies-
1) Legislative Campaign:
- Legislative Package (Three Bills)
  * Require doctors to accept Medicare fees through Board of Registra... Licensure
  * Increase the Medicaid eligibility level
  * Require doctors to accept Medicaid patients
- Followup with Blue Shield on implementation of S. 2243

2) Direct Action: (Targets)
- Mass Medical Society
  * Require 100% assignment or acceptance of Medicare fees for membe...
  * Require members to forego deductibles and copayments for seniors without Medigap insurance (or income criteria)
  * Require members to accept Medicaid patients
  (Alternatives: recommend above to members, set up referral servi... publish physician directories)
- Hospitals (Model campaign in Boston)
  * Same demands as for MMS plus:
    Bilingual services
    Senior advocates
    Transportation services
- Board of Registration in Medicine
  * Challenge their opposition to our Legislative Package!

Tactics-
1) Legislative Campaign:
*Winter- enlist key legislative supporters, solicit general support, clarify legal issues, pack committee hearing
*Spring/Summer- hold Lobby Day, pressure key legislators

2) Mass Medical Society:
*Winter- target District (County) societies with demands
*Spring- target State society with demands

3) Hospital:
*Winter- identify hospital, research demands, outreach to members
*Summer- community meeting with hospital
*Summer/Winter- negotiations with hospital

(Other issues which might require organizational attention in 1985 include: the nex... Medex rate hike, growth of "Senior Plans", the emerging impact of Chapter 372. MSA... will have to respond to the rate hike in the spring, and develop an organizational... viewpoint and gameplan for HMO's. It is less clear what 372 might bring regarding... service cutbacks.)

1986 and Beyond

Possible Issue Work-
1) Replication of Boston hospital campaign throughout the sta...
2) Establishing consumer (senior) control of HMO planning pro...
3) Offering HMO programs to MSAC members

Need Sheet for S2243 Ending Balance Billing of Blue Cross Subscribers

Massachusetts Senior Action Council
277 Broadway, Somerville, MA 02145 • Tel. (617) 776-3100

DO YOU PAY DOCTORS OUT OF YOUR OWN POCKET??

Massachusetts Seniors Can Save Millions in Doctor Bills!

Help End "Balance Billing" of the Elderly

To Learn More Read The Following (Carefully!) This Concerns Massachusetts Seniors

HAT'S THE PROBLEM?

A typical senior spends over $1,500 each year on health care. Almost one-third of this goes to doctors. t, many doctors want more. They refuse to accept Medicare's set fees and charge their elderly patients a gher rate. In other words, they refuse Medicare assignment, and charge seniors the "balance of the bill" the difference between Medicare's set fees and the doctor's own charge.

Massachusetts Blue Shield subscribers under the age of 65 have always been protected from this alance billing". A recently enacted law says doctors may only charge Blue Shield subscribers under the e of 65 the rates set by Blue Shield. Unfortunately, elderly Medex (Blue Shield's Medicare supplement) bscribers are **not** covered by this law and are **not** protected. Doctors may ignore Medicare's set rates, and arge the half-million Medex subscribers whatever they choose.

HAT'S THE SOLUTION?

The Massachusetts Senior Action Council worked with Senator Edward Burke (D. Framingham) and presentative Joseph DeNucci (D. Newton) to introduce legislation to protect elderly Medex subscribers m these physician overcharges and to **stop** the "balance billing" of seniors. These bills, S.2243 in the nate and H. 6180 in the House, will be considered by the legislature when they reconvene in late ptember.

HAT DO S.2243 and H.6180 DO?

These bills stop doctors from charging elderly Medex patients the balance, or difference, between what doctor wants, and what Medicare and Medex pay. For Medex III subscribers, Medicare would pay 80% most doctor fees, and Medex the other 20% (after paying the $75 deductible). **No** more could be charged elderly patient.

This law would save seniors millions of dollars a year now lost to physician overcharges.

HAT CAN YOU DO?

Write a letter to your senator or representative at State House, Boston, MA 02133, asking for their support S.2243 or H.6180 (If you don't know their name, call us at (617) 776-3100). Be sure to include the owing points in your letter:

- ** Seniors deserve the same protection from doctor overcharges as everyone else.
- ** Half a million seniors will be saved millions of dollars.
- ** A vote for S.2243 or H.6180 is a vote for the elderly.

(And remember to mention the bill numbers S.2243 and H.6180)

you'd like to do more to help, check off what you can do on the slip below, tear it off, and mail it to the s Senior Action Council.

JOIN THE FIGHT FOR LOWER DOCTOR BILLS!

---

e: _____

ress: _____ Area Code Phone # (.) _____

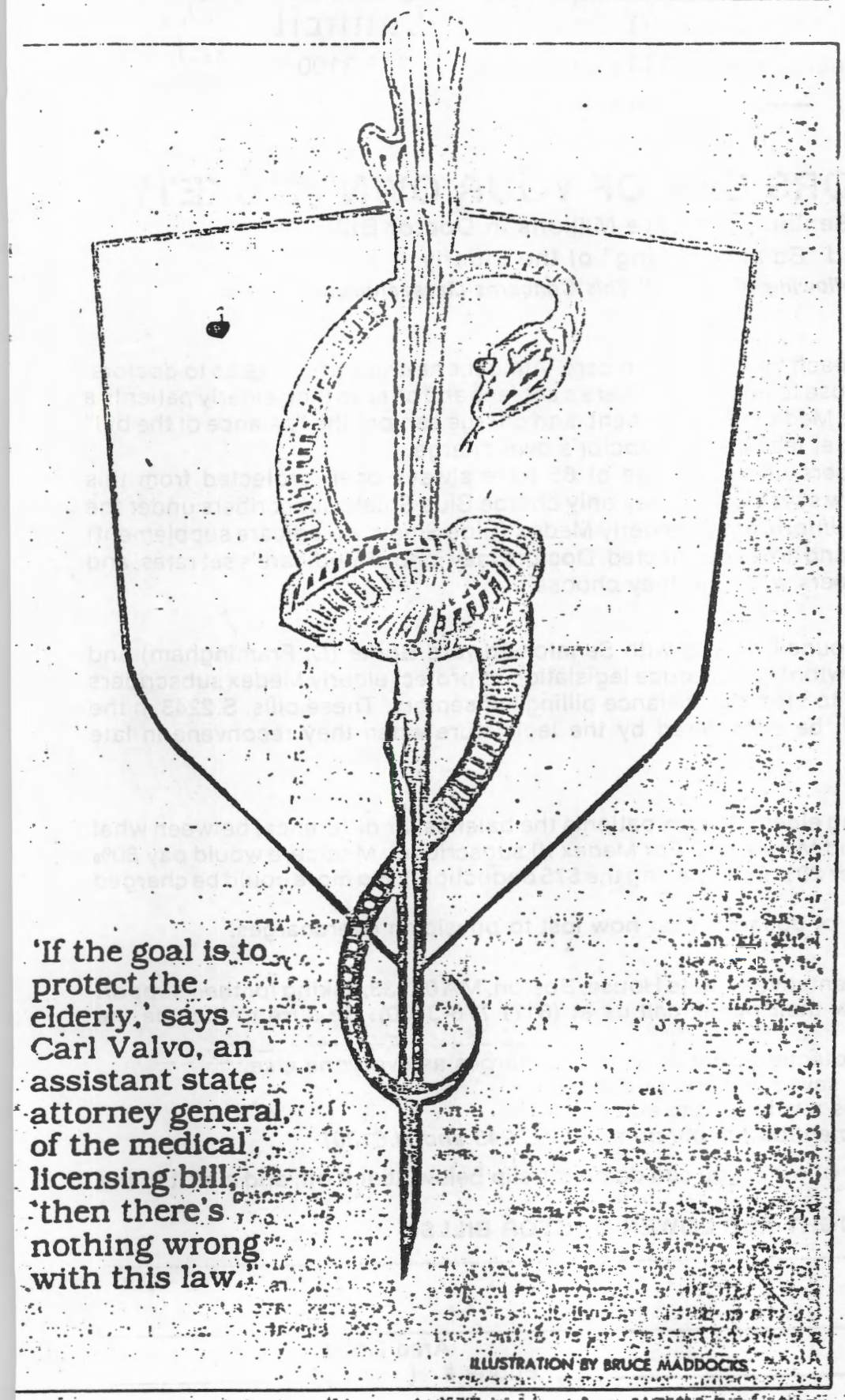
---

nt To Help:

Make Phone Calls ____
Speak to Senior Groups ____
Help Do Mailings ____
Visit the State House With Other Seniors ____
Other Help _____

To Massachusetts Senior Action Council 21X

(CONTINUED FROM OTHER SIDE)



'If the goal is to protect the elderly,' says Carl Valvo, an assistant state attorney general, of the medical licensing bill, 'then there's nothing wrong with this law.'

ILLUSTRATION BY BRUCE MADDOCKS

condition for getting a medical license is obnoxious and inconsistent with the law."

So far, the Board of Registration in Medicine has not said how it plans to certify doctors under the new law, which will take effect in February barring an attempt by the medical community to get a preliminary injunction to stop it.

The state's lawyers, meanwhile, are confident that the law will be upheld. "I don't see the statute as problematic," Valvo says. "I think the courts will agree."

22X

MASSACHUSETTS SENIOR ACTION COUNCIL, INC.

Main Office:
277 Broadway
Somerville, MA. 02145
(617) 776-3100

Boston Office:
90 South Street
Jamaica Plain, MA. 02130
(617) 524-8088

Bristol County Office:
867 State Road
N. Dartmouth, MA. 02747
(617) 673-2964 or 997-2933

Franklin County Office:
French King Highway
Greenfield, MA. 01301

Boston Sunday Globe

ASSACHUSETTS

Licensing law angers doctors

equired Medicare fee pledge called discriminatory, a dangerous precedent

Peter Mancusi
be Staff

As far as most Massachusetts doctors are concerned, a license to practice medicine in the state should be based on professional standards y, with no strings attached.

But that notion was shattered last nth when Gov. Michael S. Dukakis ned into law a bill that requires doc- s – as a condition of licensure – to ree not to charge elderly Medicare pa- nts more than the fees set under the leral program.

The bill marks the first time doctors in y state have had to meet such a re- irement in order to be certified, and it already being challenged in federal urt.

"It's unjust legislation, and I hope the urts interpret it as such," says Dr. onard J. Morse, who was so angered by e law that he resigned his post as chair- an of the state Board of Registration in edicine the day after Dukakis signed e bill. "The fees that a doctor accepts or esn't accept have nothing to do with s ability to practice medicine."

State officials defend the bill, which on unanimous approval in the Legisla- re, on the grounds that it is in keeping ith the spirit of the Medicare program. f the goal is to protect the elderly, then ere's nothing wrong with this law," ys Carl Valvo, an assistant state attor- y general.

ome see unhealthy precedent

While the legal battle will be fought imarily on the question of whether the ll conflicts with provisions of the Medi- re law, a secondary issue is also bound receive close attention: whether an oc- pational license can be used by state overnment as a means to further social ograms.

Lawyers for the two medical groups ing to overturn the law contend that, if is upheld, it could provide a precedent r the state to achieve policy initiatives any of the areas it licenses. Allowing e state to demand conditions that are nrelated to the work a group performs, ey say, would be a significant depar- re from common notions of what a li- nse is.

"I think you could characterize the w law as an attempt to change the na- e of a license," says Thayer Fremont-Smith, one of the lawyers representing the Massachusetts Medical Society, which joined the American Medical Association in filing suit against the state. "It would transform a license from something that qualifies a person for a skill into something the state can dispense with any conditions it chooses."

Besides doctors, the state issues certifications for 27 other professions and trades, ranging from architects, accountants and nurses to plumbers, electricians and barbers. Each occupation is licensed by its own board of registration, which is responsible for reviewing the qualifications of applicants.

"The conditions for granting a license have to be reasonably related to the function covered by the license, Fremont-Smith says. "A license to practice a profession is a right, not a privilege awarded by the state."

But the state's lawyers say that the new law falls within the regulatory scope of the medical profession and that social values are an inherent part of the licensing process. "It's a little specious in 1985 to say the issue of health insurance is completely unrelated to the practice of medicine," Valvo says, noting the rapid increase in medical costs in recent years.

Valvo and others also contend that there is already a basis in state law for placing conditions on a license that have no direct tie to work qualifications. They point, for example, to a three-year-old statute that requires the estimated 500,000 holders of work licenses in Massachusetts to certify that they have paid their state taxes when they renew their registrations.

Other state regulations mandate disciplinary actions, including the loss of a license, against license holders found to have discriminated against a customer or patient, Valvo says.

"That has nothing to do with one's ability to perform a job," he says. "It's a societal value we expect professionals to follow, whether they are doctors or plumbers."

Critics unconvinced by arguments

Such arguments, lawyers for the medical community say, provide little basis for the new condition on medical licenses or for requirements that might be placed on other groups.

"That you comply with a state law that everybody else has to obey is hardly an imposition," says Kirk Johnson, a lawyer for the American Medical Association, which is worried that other states may follow the lead of Massachusetts in requiring doctors to accept Medicare fees as a condition of licensing.

"We don't have any problem with making someone pay their taxes," Johnson adds. "But this law means that the state can point to any licensed person in Massachusetts and require some special condition. I frankly don't think other professions are worried yet about it happening to them, but it can."

Under Medicare, doctors who join the federal program must accept its fees. Medicare pays for 80 percent of a fee; the patient pays the remaining 20 percent. Doctors who do not participate are free to charge Medicare patients above the assigned rates. Since the new law prohibits such "balance billing" in all cases, that option has been ended for doctors in Massachusetts.

According to the Massachusettts Medical Society, the state's doctors already have one of the best records in the country for accepting Medicare fees, and the organization has attacked the law partly on the basis that there is no need for it.

But the statistics can be misleading, according to Stella Frimmel of the 5,000-member Massachusetts Senior Action Council, which proposed the state Medicare law.

"Even if you accept those figures, that still means there are thousands of elderly in the state who have been overcharged by doctors," Frimmel says. The council claims that overcharges in Massachusetts had reached $20 million a year.

Frimmel has no qualms about tying the acceptance of Medicare fees to a doctor's license to practice medicine.

"When a doctor gets a license, he has a commitment by law to maintain the public health," she says. "If they charge fees that are too high, then the elderly are not going to go to the doctors, and they're not going to get proper medical care."

But lawyers for the medical community say the new law denies Massachusetts doctors due process by unreasonably inhibiting their right to practice their profession.

"There's no other state with a statute like this one," says Johnson, the lawyer for the American Medical Association. "If you want to set restrictions on fees, there are other ways to do it. But making fees a

(CONTINUED ON BACK)

The Boston Globe

MONDAY, NOVEMBER 11, 1985

Aged hail Mass. law limiting doctors' fees

By Jean Dietz
Globe Staff

After two years of lobbying, leaders of the Massachusetts Senior Action Council, an advocacy group for the elderly, are hailing passage of legislation that bars Massachusetts physicians from charging their Medicare patients more than the federal program will pay for their care.

The legislation, long opposed by the Massachusetts Medical Society, will make Massachusetts the first state to require doctors, as a condition of their licensure, to accept Medicare fee limitations.

Proponents say the law, which will be signed into law tomorrow by Gov. Dukakis, extends to the state's 700,000 elderly and 65,000 disabled Medicare beneficiaries a ban on so-called "balance-billing" previously extended to subscribers of Blue Cross-Blue Shield.

"The problem of physicians charging more than the Medicare assigned fee is a national disgrace, costing the elderly billions of dollars annually, contends Stella Frimmel of the Senior Action Council. "In Massachusetts, we have been overcharged to the tune of $20 million a year. By barring the practice, we have removed a great financial burden from the elderly."

However, Dr. Barbara Rockett, president of the Massachusetts Medical Society, said in a telephone interview that the advocates' intensive lobbying campaign for the legislation has created "a state of confusion" about the issue among the elderly. "They have been led to think that the law means that that Medicare patients will no longer need to pay a deductible or a co-payment. Both are required by federal law," Rockett said.

Court appeal predicted

Rockett also predicted that the law will be challenged in the courts, since a physician's decision to participate in Medicare is voluntary under federal law. "The state has no right to mandate participation in a voluntary program as a condition of licensing physicians," Rockett added.

The Medicare program pays 80 reasonable fee for doctors' services, leaving 20 percent to be paid by the patient. Many elderly, but not all, buy supplemental insurance from Blue Cross-Blue Shield or private insurance policies to cover the deductible.

If a doctor has agreed to accept the Medicare-set fee as full payment – a process known as accepting "assignment" of the fee – he or she receives the 80 percent payment directly from Medicare. Some physicians, however, insist on the right to charge more than the Medicare fee level for patients who agree to pay the higher fee.

Says most MDs accept fee limit

"The vast majority of physicians do accept assignment and it won't affect them," said Dr. Manuel Lipson, chairman of the Medical society's committee on tax-supported medical care. "But licensure is supposed to be a measure of a doctor's qualifications, not used for economic purposes."

The new law, he said, "interferes with voluntary relationships between doctors and patients. The vast majority of physicians do take a patient's financial status into consideration."

By preventing physicians who now participate in Medicare from charging wealthy persons more on

law will probably lead certain specialists, particularly orthopedic surgeons, gynecologists and neurosurgeons, to withdraw from Medicare participation.

The Senior Action Council, which has 5000 members, has been pushing since 1983 for a state requirement that physicians accept Medicare-assigned fees.

In 1984, following a series of court rulings, legislation was passed prohibiting physicians from balance-billing Blue Cross-Blue Shield subscribers under age 65.

The group immediately drafted a bill to extend the same protection to Blue Cross-Blue Shield subscribers over the age of 65 – the 500,000 elderly who purchase Medex supplemental insurance. That became law in December 1984.

"Unfortunately, this left approximately 200,000 elderly and 65,000 disabled Medicare beneficiaries who could not afford Blue Cross-Blue Shield Medex insurance unprotected from balance-billing," said Manny Weiner, a Senior Action Council member. "Those elderly who could least afford to be balance-billed remained vulnerable."

The bill being signed into law tomorrow was filed by Sen. Gerald D'Amico (D-Waltham) and Thom-

Cancer Care, Inc.

AND THE NATIONAL CANCER CARE FOUNDATION, INC.

WERNER WEINSTOCK
Chairman, Public Affairs Committee

JAN C. CHILDRESS
Vice Chairman, Public Affairs Committee

DORIS B. NASH
Public Affairs Director

November 17, 1986

To: Assemblyman Harold Colburn, Jr. Chairman
Committee on Health & Human Services
New Jersey Assembly

Re: Medicare & Medicaid Problems

I am Doris Nash, Public Affairs Director of Cancer Care, Inc. Our agency not only offers direct services to cancer patients, but also maintains an advocacy program in behalf of cancer patients and the catastrophically ill. Before proceeding with our testimony, we would like to commend Chairman Colburn and members of the committee for your concerns about what New Jersey residents are experiencing in regard to Medicare and Medicaid. Your apprehensions are well justified, and we hope that this hearing will lead to some productive changes.

Cancer Care, Inc. is a not-for-profit social service agency which has been helping cancer patients and their families for over 41 years. We provide individual and group counseling, help with planning for the patient's care, as well as some financial assistance to help eligible families meet the costs of needed home care services or transportation to and from chemo and radiation therapy. Since we deal on a daily basis with the many needs of cancer patients and the financial and emotional problems with which they and their families must cope, we believe that we are particularly equipped to speak to the inadequacies of the Medicare and Medicaid program vis-a-vis catastrophic illness.

While we have traditionally offered services to New Jersey residents who lived within 50 miles of New York City, it was not until we opened offices here several years ago that we began to serve really significant numbers of New Jersey cancer patients. These figures have increased each year.

New York Office
Avenue of the Americas

Long Island Office
20 Crossways Park North, Suite 304

New Jersey Offices
24 Lackawanna Plaza
127 East Ridgewood Avenue

For example, during our 1985-86 fiscal year, we received 2029 requests for help as compared to 1441 during the previous year, and 1272 the year before that. Cancer Care disbursed over $276,000 during '85-'86 to 336 needy New Jersey patients; the amount disbursed during '84-'85 was $200,976, to approximately 250 patients. Each year New Jersey disbursements have taken up larger percentages of the agency's total disbursement budget. This appears to be related to the fact that New York's Medicaid-only program has somewhat more generous eligibility levels, and apparently less cumbersome application procedures.

During the first 4 months of our '86-87 year we have already disbursed $61,849 to 323 patients. It is important to note at this point that we have had to reduce the maximum amount of weekly disbursements to patients from $75 a week to $60 a week. This was necessitated by decreased resources — and we would like to emphasize here that we are completely supported by private donations. Our decision to reduce the amounts of our grants was based on our commitment not to turn away any eligible needy patients.

And now we will focus in our testimony on New Jersey's Medically Needy and the Community Care Program for the Elderly and Disabled, (CCPED), as well as Medicare's home health services.

The year 1984 marked Cancer Care's first public policy statement in New Jersey when we presented testimony in support of the "Medically Needy" legislation, introduced by Assemblyman Deverin and for which he worked so hard. We stated then that we had found that approximately 23% of the patients we were serving in New Jersey had incomes as low as $600 a month or less. We have since estimated that as many as one-third of our disbursement families are in that category. One could expect that such low-income cancer patients would soon be eligible for the Medically Needy or the CCPED programs, but we have been finding that now there is the added frustration that these programs are not as available or helpful as had been anticipated. Let us offer some examples:

One patient, a 41-year old postman, has liver cancer with metastisis to the bone. He has a wife and 3 children, aged 7, 10, and 13. He is considered disabled and receives about $525 a month from an employment-related disability benefit. He also has health insurance coverage which covers everything except home health aide or homemaker care.

He has been declared ineligible for SSI because the worth of his car put him over the assets level. However, his children have been accepted into the Medically Needy program. Cancer Care helped with some home health care to offer a little respite for his wife so that she could devote more of her energies to the children and her household responsibilities.

Now that his condition has worsened, he needs skilled nursing care at home. He can expect some reimbursements from his health insurance; however, Cancer Care will be helping the family pay for the deductible, and 25% of the nursing cost left unreimbursed by the health insurance. But, he has received no government assistance to ease his situation.

Another patient, a 71-year old woman, has cancer of the endometrium with metastisis to the right breast. She receives Social Security benefits of $650 a month. She has been accepted by the CCPED program for home care services, but has had to refuse this since she would have been left with only $350 to cover all her needs after the required cost sharing with the program. Her rent alone is $340 a month and she concluded that she would not have enough money left to live on.

It appears that New Jersey's Medically Needy program has been set up in such a way as to confound those who apply and to impede acceptance to the program. Those administering the Medically Needy program acknowledge that the number of those who have indeed become eligible is far less than had been anticipated. They number only 2603 for the first 4 months of the program. The fact that the income eligibility levels for the program are so low immediately springs to mind as one reason for the very low enrollment. A solution to this could be found by taking advantage of a provision in the recently enacted Budget Reconciliation law which allows states to extend Medicaid coverage to the elderly and disabled with incomes up to the **Federal poverty level.** This could allow for a more generous program.

Other possible reasons for the ineffectiveness of the program are:

1. Coverage for a 6-month period, which requires complicated record-keeping of medical expenses incurred by the patient/family over a lengthy period of time, presents too many problems.

2. Patients lost interest in applying when they realize that the Medically Needy coverage does not include emergency room services, inpatient services, or nursing home care. It has been pointed out that New Jersey is the only state to offer only ambulatory services to the Medically Needy.

All of this needs to be examined very soon in order to rectify the situation. Otherwise the Medically Needy program will be nothing but a hollow victory, an empty promise to the poor and the sick. We hope that you will bring this message to the Governor and the Commissioner of Human Services, and that adequate solutions will be found.

Another very serious problem which we would like to bring to your attention at this time is related to the cutbacks that have been occurring in Medicare's home health services. These cutbacks have been accomplished not via the legislative process but via re-interpretations of the Medicare statute's language regarding home health care, as well as other regulatory changes. This has caused a sharp decrease in the provision of home health services for the elderly, who must require skilled service at home in order to qualify for home care in the first place.

Needless to say, this has seriously affected elderly patients discharged from the hospital "quicker" and "sicker" than has been the norm years ago before the DRG method of reimbursement. We are attaching a copy of testimony on this issue which Cancer Care presented to Senator Bill Bradley last April. It vividly describes how Medicare's home health services have been compromised, and offers many examples of inadequate home health services which elderly New Jersey patients are receiving.

The cutbacks have also seriously affected many Medicare - certified home health agencies which have experienced extreme financial problems because of denials of Medicare coverage after home health services were supplied. There are now many home health agencies struggling with severe financial problems, and quite a few have already folded.

A few gains for home health care were achieved in the federal Budget Reconciliation package, and Senator Bradley deserves thanks for his role in this. These gains were mostly of a technical nature but there is one that is relevant to the purpose of today's hearing. We refer to that provision which allows providers to represent and/or assist Medicare patients in their appeals of reimbursement denials.

It shouldn't take much imagination to appreciate how hard it could be for an elderly patient to "fight City Hall," so to speak, by taking on the fiscal intermediary for Medicare and the Health Care Financing Administration. Allowing participation in this process by the actual provider of the services is not only rational, it is also humane, and that is a very necessary ingredient.

We wish, therefore, to take special note of certain New Jersey legislative proposals which would offer even more assistance to Medicare patients who feel they have been denied benefits to which they should have been entitled. We are referring to S.2484 which passed in the Senate and is now before the Assembly Senior Citizens Committee, as is A.3140. Both proposals appropriate monies for legal assistance for Medicare patients.

These are interesting bills and give serious recognition to the problems with Medicare which we have been describing. Whether or not the New Jersey legislature feels the state can afford such a program remains to be seen, but at the least the legislature should put Medicare and the Department of Health and Human Services on notice of its disapproval of the dismantling of Medicare's home health benefits.

We hope that this testimony will be helpful to you in your deliberations concerning these difficult problems. Also, we would be pleased to answer any questions you may have.

Thank you.

LEGISLATIVE MEMORANDUM

Cancer Care, Inc.

AND THE NATIONAL CANCER FOUNDATION, INC.®

WILLIAM C. PELSTER
Chairman, Public Affairs Committee

WERNER WEINSTOCK
Vice-Chairman, Public Affairs Committee

DORIS B. NASH
Public Affairs Director

April 21, 1986

To: Senator Bill Bradley
U.S. Senate Committee on Aging

Re: The Condition of Medicare's Home Health Care Benefit

We wish first to commend you for holding a hearing on the "dismantling" of Medicare's home health care benefit and its impact on New Jerseyans. This is an extremely urgent issue, one that needs as much exposure as possible.

In lieu of presenting oral testimony, we are submitting this statement about our New Jersey social workers' experience with Medicare's home health benefits. We trust our statement will be given full consideration and will be part of the official record of the hearing.

Cancer Care, Inc. is a voluntary agency - now in its 42nd year - providing comprehensive social services to cancer patients and their families. Individual and group counseling are available for patients and their relatives, as well as bereavement counseling. In addition to helping families plan for the patient's care at home, some financial assistance is available to eligible self-supporting but needy families to help them pay for home care plans and transportation costs to and from chemo and radiation therapies. It is this latter aspect of our services that provides us with so much experience and knowledge of what is happening with Medicare's home health services.

Since opening our office in New Jersey over 2 years ago, the call on our services there has increased dramatically! During our '84-'85 fiscal year, New Jersey patients comprised 14.4% of Cancer Care's total caseload (9,984 patients) and utilized 23.3% ($200,976) of our total disbursement funds of $864,320. Statistics for the first 6 months of our current fiscal year reveal that New Jersey now represents 20% of the total caseload and 28% of the agency's disbursements. The New Jersey office is currently receiving about 190 requests for help each month. It is projected that New Jersey disbursements for the full year will probably amount to $230,000. Our caseload in New Jersey

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1180 Avenue of the Americas
New York, N.Y. 10036 • (212) 221-3300

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

New Jersey Office
466 Old Hook Road, Suite 17
Emerson, N.J. 07630 • (201) 261-2003

is quite indigent, with one-third of our disbursement recipients having incomes under $600 a month. It remains to be seen how many of these very poor patients will be helped by New Jersey's new "Medically Needy" program.

The largest single group of patients receiving financial disbursements from our New Jersey office are those over age 65 and on Medicare. Our disbursements to this group primarily help pay for home care for those ineligible for Medicare's home health services.

But, there are also many situations in which we are called upon to help augment the miniscule amount of home health care a very sick patient is getting via Medicare. We are finding that most of these patients - and all of them are in terminal stages of the illness or very close to it - are receiving home health aide services only 3 times a week, 2 hours per visit, upon discharge from the hospital. It should be emphasized here that these are patients deemed to need a skilled service such as nursing supervision. If they do not need a skilled service, they get nothing. Frequently this initial judgment is made by the discharge planner at the hospital who contacts the home health agency.

This is in sharp contrast to what used to be the norm: 4-hour visits, 4 or 5 times a week. One of our social workers, formerly with a New Jersey hospital as an oncology social worker, states that the more generous number of hours and visits could be depended upon in the past, but that today the picture is very different.

Another observation: Home health agencies are stating in advance just how long they will provide Medicare - reimbursed home health services. Ostensibly they make these predictions based on their experience with how long it usually takes patients with different types of cancer to stabilize sufficiently after discharge from the hospital so that they no longer need a skilled service. Our agency is apprised in advance so as to be ready to pick up with some financial help when the home health aide is withdrawn. These time predictions are definitely shorter than they used to be, although New Jersey's prospective hospital reimbursement system stimulates earlier hospital discharges.

Skilled nurses are no longer offering the kind of hands - on care in the home that they used to in the past. Since the home health aide is not allowed to perform skilled procedures which the nurse used to execute, the nurse teaches family members -- very quickly because time is short -- how to perform skilled procedures. This includes changing surgical dressings and giving intramuscular and subcutaneous injections for pain relief. Family members are also being relied on to flush surgically-placed Broviac and Hickman catheters which are used for chemotherapy and also to change urinary tract catheters and gastrostomy tubes.

In addition, skilled nursing supervision now seems to be limited to a 15-minute visit once a week. One can well wonder if this is indeed supervision. There is barely time to find out how comfortable the patient is, and whether the patient's pain is controlled. All this is happening when patients are being discharged earlier, needing more complicated procedures at home.

30x

Another point raised by our social workers is related to the inadequacy of the 2-hour home health aide visit. What can she really accomplish in such a short time, especially when one must consider that she needs some time to attend to her own personal needs upon arriving at the home? Yes - there may be time to bathe the patient, perhaps prepare lunch, but what else?

We are also frequently called upon by hospices to cooperate with them in regard to Medicare hospice patients who have become "stabilized" and seem to be delaying the dying process. These patients may not be eligible for Medicare's typical home health services but, according to the referring hospice, they need help with home care. The irony of this kind of situation is quite obvious; why should home care be approvable if the patient is actively terminal but not when the patient still needs help but has extended the time of his/her projected demise?

Here is one example: Mrs. E.D. is an 82-year-old widow living with her 52-year old son who has a degenerative muscular disease. She has breast cancer metastatic to the lung with a prognosis of less than 6 months. Despite ongoing deterioration, she has surprised her doctors by surviving as long as she has. She has been on and off Medicare hospice benefits because of stabilizations in her condition.

She really requires 24 hour supervision. Medicare home health coverage was provided following a hospitalization for 2 hours a day, 5 days a week, but this was terminated after 4 weeks. Cancer Care is now helping her pay for 8 hours of help, 5 days a week.

Our New Jersey office is also dealing with many instances when the patient is eligible for Medicare hospice coverage but refuses to accept it because he/she still wants to fight the illness or because of other restrictions imposed by hospice. One such case is that of a 91-year-old man who has prostate cancer with metastases to the lungs and bone. His wife is 82 years old and not able to be of much help.

Medicare did supply a home health aide 2 hours 3 days a week for a short while, but pulled out as soon as it was determined that the patient was terminal and did not need a skilled service. Our social worker said that in the past a patient half as sick as this would have received help 5 times a week, 4 hours each day.

Clearly the experience of our social workers is that the amount of home health services has been cut back severely on an ongoing basis, and there is no longer such as thing as a crisis situation which might have been given special consideration.

The paltry amount of home health services which is currently being doled out is usually completely inadequate to the real need. It is as though it's based on a fixed formula, without any real regard for the patient's/family's circumstances.

Some of our elderly patients are living with children who work and others have very involved children. The fact that they must work does not seem to matter. This kind of approach on the part of Medicare will certainly lead to more instutionalization of parents by children who had tried to avoid it. Would this really be less costly for Medicare? Isn't all of this a short - sighted and punitive device to save money?

Mary K., for example, aged 76, lives with her 78-year-old husband who has diabetes. She has a recurrence of breast cancer with metastases to the lung and bones. She has been given a prognosis of less than 6 months, but the family will not consider hospice.

Her 2 children are actively involved in her care, but both go to work. Medicare terminated the part-time and intermittent home health services she was receiving. Cancer Care is now contributing to her care at home according to a plan worked out with the family.

Although we are not a Medicare-certified home health agency dealing directly with a fiscal intermediary, we hope that we have been able to provide telling evidence of the dismantling of Medicare's home health benefits. Cancer Care is trying to help needy elderly New Jerseyans and New Yorkers when Medicare denies them adequate home health care benefits. To our knowledge, this kind of assistance is unavailable in other areas.

We are extremely worried about the shrinkage of Medicare's home health benefit and what seems to presage the abandoment of homebound Medicare patients. To what extent the voluntary sector can compensate for this degree of cutback in the program is a critical issue. We hope that you will be able to persuade Congress and the Administration of the urgency of this issue.

32x

ESSEX COUNTY MEDICAL SOCIETY

EXECUTIVE OFFICE:
80 Pompton Avenue
Verona, New Jersey 07044
Area Code (201) 239-9392

November 17, 1986

The Honorable Harold L. Colburn, Jr., M.D.
Chairman of the Assembly Health and Human
Resource Committee
State House Annex
CN 068
Trenton, New Jersey 08625

Assemblyman Dr. Colburn and members of the Committee:

As President-Elect of Essex County Medical Society and President of the Radiology Society of New Jersey, I oppose Bill A-2511 as being unfairly discriminatory toward physicians and unnecessary as a remedy for a problem which in truth, affects a minority of senior citizens.

To mandate acceptance of assignment on all Medicare patients regardless of their finances, as a precondition to maintaining a license to practice medicine in New Jersey is grossly unfair. This bill would penalize the only profession which has given more than lip service to helping the senior citizen with marginal financial resources. We voluntarily froze our fees in 1982, and in 1983 Congress continued the freeze until the present. Our fees have been reduced further by Gramm-Rudman law. This is not the essence of our opposition, but let me put this point into perspective.

I am a radiologist. My fees are modest and I always accept assignment when either the referring physician requested or the patient informed us of the need. I signed up to accept

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assignment for all Medicare patients in 1984 with a promise from Congress that I could adjust my fees in 1985 for the cost-of-living. You all know that Congress reneged on that promise. Medicare published a list of participating physicians and more senior citizens came to use my services. I had to hire an additional technologist. Medicare allowed me to collect 75% of 1981 fees, fees which were not high to start with. The end result was a 15% decrease in my gross receipts for the year.

I still accept Medicare assignment where there is a need. Indeed the vast majority of physicians in the State have always and will continue to accept assignment when the need is demonstrated. We are aware from our discussions with our own parents and with senior citizen groups that many people find it demeaning to have to bare financial troubles to physicians or their office personnel. Surely this State and this Country can devise a financial evaluation based upon taxable income and other assets which can define who is in need of having us accept assignment. The senior citizens can merely present a card to the physician's office receptionist indentifying them as one who is in financial need. If financial relief is sought, then a determination of financial need must be made.

Bill A-2511 before you is the result of fear and frustration on the part of some senior citizens. They fear that medical care at a reasonable cost will not be available to them. Although physician fees account for less than 20% of all Medicare costs, we pledge to continue to help them in assuring that adequate medical care will always be available. Senior citizens are frustrated because they think no one is listening to them. Let me assure you that we are listening and will continue the

dialogue. The House of Delegates of the Medical Society of New Jersey led by the immediate Past President, Dr. Ralph Fioretti, has mandated a yearly state-wide senior citizen conference so we can all hear the medical problems of senior citizens and work toward correcting them. We have also set up, county by county, medical committees to seek out senior citizen groups to deal locally with the problems related to health and medical care. Dr. Ralph Kristeller, of Union County, has spearheaded this effort and has been to almost every county in the State meeting with groups of concerned senior citizens. He will continue to do so in the future.

In conclusion, THE STATE BOARD OF MEDICAL EXAMINERS disapproves of this bill. Physicians across the State who now voluntarily accept assignment, disapprove of this bill. Lastly senior citizens, when they have met and discussed their problem with us, admit that a bill which indiscriminately makes mandatory a policy which should be selectively applied to those in need, is unfair and unnecessary.

Respectfully submitted,

Herman M. Robinson, M.D.
President-Elect

HMR/as

35x

By Frank A. Rogers, M.D.

Savings instruments could return responsibility for retirement care to individuals

Health care IRAs – Medicare's redemption?

The problem of health care cost is easy to solve: eliminate government interference. In America, the process of socialization in health care has been incremental—a slice at a time. But lately the slices have been getting thicker. Medicare started 18 years ago at a cost of approximately $1.5 billion. It soon will cost more than $90 billion.

To stem such exponential growth in the future, the federal bureaucracy must bow out of the picture. Government can't afford to and has no business meddling in health care. The question is how to perform the exorcism. The current 99th Congress could remedy this awesome situation by amending the Social Security laws to allow citizens to choose between government taxation of their paychecks and the allocation of the same amount of money to tax-exempt individual retirement accounts (IRAs) for health care.

A system gone bad

Having once again been bailed out of bankruptcy by another major increase in the payroll tax rate (to 2.9 percent from 2.6 percent) and the tax base, Medicare once again lives down its billing as a savings system. It always has been a taxing system. Even worse, it is a tax system in which most of the payers have no interest in or right to the benefits stipulated by law. It matters not whether the recipients of Medicare ever paid a penny of Social Security taxes, they are eligible when they reach their 65th birthday. The tax money is paid out as it is collected. There *are no reserves*. As in Britain, it is a pay-as-you-go system.

Dr. Rogers is a Whittier general surgeon and assistant professor of surgery at Loma Linda University.

The great majority of older people do not need Social Security and Medicare. They are the most affluent members of society. Their homes are largely paid for, and their children are educated and gone. They have savings and other income that younger generations, who are footing the bill for Medicare and other welfare programs, do not have. And their after-tax income is significantly higher than for those under 65 (Nearly one million households receive Medicare despite incomes of $48,000 a year or more).

Paring through natural selection

Removing millions of people, including the more than 254,000 millionaires, from the Medicare program would have a dramatic effect on balancing what has always been a bankrupt-prone, ill-conceived program. But identifying those individuals who genuinely need help requires a "means test," which is unpopular with both politicians and bureaucrats alike. Instead, the Social Security mess can be resolved by returning responsibility to the individual.

All health care schemes, including government welfare programs, that specifically exempt private citizens from making the decisions or for taking any of the responsibility, simply feed the bureaucracy and promote inefficiency.

Reprinted from CALIFORNIA PHYSICIAN, March 1986

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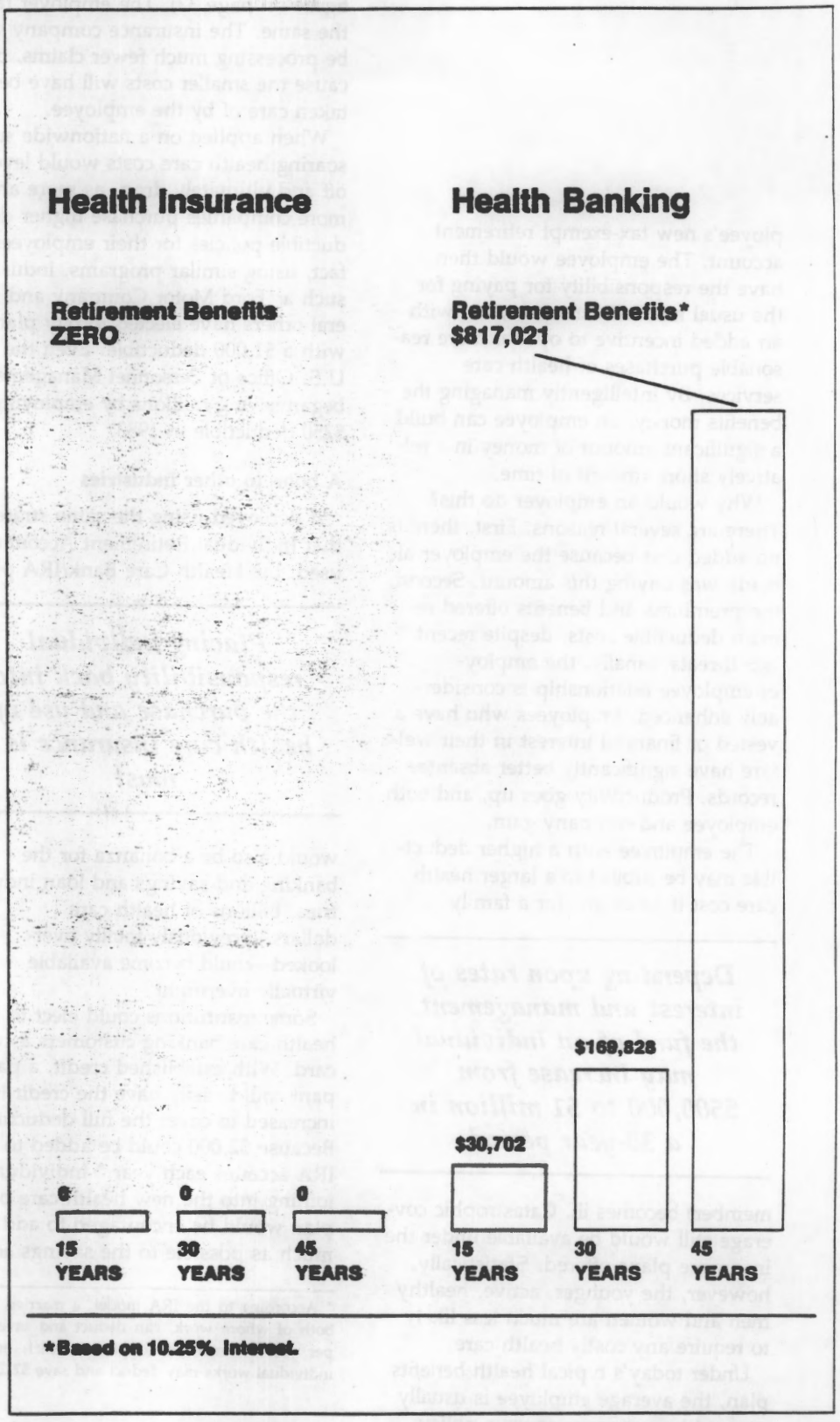
Health care IRAs are simply savings plans that, based on the current Individual Retirement Account plan, encourage individuals to return to high-deductible, low-premium group insurance plans and save money for the employee, the employer, and, ultimately, the public.

The system is sound. Workers would be allowed to establish a special tax-free savings account (similar to an individual retirement account), called a health care savings account. Funds would continue to accumulate tax-free investment returns during retirement years.

Workers would use these funds to purchase private medical insurance and/or pay for health expenses during retirement years. During their working years, employees would be encouraged through other incentives to build their health care savings accounts. For example, an employer might initially set aside a certain amount of money—say, $700—to spend on an employee's

Employees who have a vested or financial interest in their welfare have significantly better absentee records

health coverage, based on the employer's average expenditures per year per employee for health care coverage. The employee is then given a choice between a comprehensive health care package containing a plan with a small premium and a high deductible or a plan with a high premium and a small deductible. The premium for either policy is paid out of the $700, with the remainder going directly to the em-



The above figure represents a comparison of the short- and long-term savings benefits offered by traditional health-benefit packages versus those offered by a health care IRA option. (Source: Wilmington [CA] Savings and Loan)

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ployee's new tax-exempt retirement account. The employee would then have the responsibility for paying for the usual medical care costs, but with an added incentive to opt for more reasonable purchases of health care services. By intelligently managing the benefits money, an employee can build a significant amount of money in a relatively short amount of time.

Why would an employer do this? There are several reasons. First, there is no added cost because the employer already was paying this amount. Second, the premiums and benefits offered remain deductible costs, despite recent IRS threats. Finally, the employer/employee relationship is considerably enhanced. Employees who have a vested or financial interest in their welfare have significantly better absentee records. Productivity goes up, and both employee and company gain.

The employee with a higher deductible may be subject to a larger health care cost if he or she (or a family member) becomes ill. Catastrophic coverage still would be available under the insurance plans offered. Statistically, however, the younger, active, healthy men and women are much less likely to require any costly health care.

Depending upon rates of interest and management, the fund of an individual may increase from $500,000 to $1 million in a 30-year period

Under today's typical health benefits plan, the average employee is usually covered by a more expensive policy than necessary, probably spends some health care dollars unnecessarily, and has zero dollars saved. The employer saves nothing, and the insurance company has a net profit. With health care banking, the employee accumulates substantial savings, with tax-free interest by the end of the year (See figure on page 32). The employer fares the same. The insurance company will be processing much fewer claims, because the smaller costs will have been taken care of by the employee.

When applied on a nationwide scale, soaring health care costs would level off and ultimately drop, as more and more companies purchase higher deductible policies for their employees. In fact, using similar programs, industries such as Ford Motor Company and several others have elected to buy plans with a $1,000 deductible. Even the U.S. Office of Personnel Management began saving millions by employing a $250 deductible in 1983.

A boon to other industries

If deployed using the same strategy that Individual Retirement Accounts used, the Health Care Bank/IRA plan would also be a bonanza for the banking and savings and loan industries. Billions of health care dollars—previously totally overlooked—could become available virtually overnight.

Placing individual responsibility back into the purchase and use of health care insurance is a must

Some institutions could elect to issue health care banking customers a credit card. With established credit, a participant could easily have the credit limit increased to cover the full deductible. Because $2,000 could be added to an IRA account each year,* individuals joining into the new health care bank plan would be encouraged to add as much as possible to the savings account. Employed individuals would do this by applying the amount of money exempted from taxation equal to the number of dependents.

Also, beginning January 1986, employees with established IRAs were allowed to have money credited to their individual accounts monthly through computerized payroll service. This is similar to all business payroll deduction services and is carried out by the bank or institution, which becomes the depository for the IRA funds. The savings are generally compounded daily. Depending upon rates of interest and management, the fund of an individual may increase from $500,000 to more than $1 million over a 30-year period.

Health care banking using IRAs shifts responsibility for health care from tax-supported, government-controlled, welfare medical care to private-savings and private-insurance alternatives. The Medicare system would almost immediately be relieved, but a phase-out period would be required. The idea has caught with some Congressional leaders, in fact. A health bill entitled, the "Health Care Savings Account Act of 1985," is before Congress now, with Representatives Slaughter, Siljander, Dreier, and Crane as sponsors.

While correction of Medicare's other deficiencies would have to be made first, placing individual responsibility back into the purchase and use of health care insurance is a must. Anything thought to be free or already paid for will be over-utilized, whether it be food, air travel, or health care. Proper deductible health care insurance contracts bring back needed responsibility on the part of the insured. The higher the deductible, the less the policy costs. When a savings program that accrues money for the individual is tied to health care insurance, a nearly ideal program is achieved. Health Care Bank/IRAs offer a clear and compelling answer to rising health care costs. CP

* According to the IRA model, a married couple, both of whom work, can deduct and save $4,000 per year. A married couple of which only one individual works may deduct and save $2,250.

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SENIOR CITIZENS MEDICAL COURTESY CARD

The Senior Citizens Council of Union County attest that

_____

is eligible for participation in the Union County Medical Society Senior Citizen Medical Courtesy Program for the period

_____ **to** _____.

Medicare # _____ **Courtesy #** _____

Authorized by _____

Union County Medical Society

REGULATIONS

Volunteer physicians in this program will forego billing for any amount not covered by the patient's insurances except for such deductibles and co-payments as required by Federal Law.

Patients in this program must meet income limitations as set forth in the eligibility requirements.

FOR FURTHER INFORMATION, CONTACT:

UNION COUNTY MEDICAL SOCIETY
347 Lincoln Ave., East
Cranford, N.J. 07016
272-1707

SENIOR CITIZENS COUNCIL OF UNION COUNTY
2165 Morris Avenue
Union, N.J. 07083
964-7555

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UNION COUNTY MEDICAL SOCIETY OF NEW JERSEY

347 LINCOLN AVENUE, EAST - CRANFORD, NEW JERSEY 07016 (201) 272-1707

August 25,1986

Dear Doctor:

Recently, you volunteered to participate in the SENIOR CITIZENS MEDICAL COURTESY PROGRAM sponsored by the Union County Medical Society and the Senior Citizens Council of Union County.

Enclosed is a list of Union County physicians who have signed up. Please check that you are listed appropriately.

Enclosed please find the yellow I.D. which the Society will supply to seniors who are eligible for the program. Make sure your office staff is familiar with the program and its protocol (also enclosed) and will extend this courtesy to those who have the card.

If you or your staff have any questions please call Andrea Maniscalco at the society office (272-1709).

Your society and the Senior Citizens Council applaud your willingness to share in this worthwhile program designed to assist needy seniors.

A.R. Kristeller, M.D.

ARK/atm

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July 14, 1986

PROTOCOL - SENIOR CITIZEN MEDICAL COURTESY PROGRAM

UNION COUNTY MEDICAL SOCIETY - SENIOR CITIZENS COUNCIL OF UNION COUNTY

This program has been formulated jointly by the Union County Medical Society and the Senior Citizens Council of Union County. The purpose of the program is to provide access to private medical care by the elderly who might otherwise forego seeking medical assistance for financial reasons. It is not intended to interfere with any present physician-patient relationship.

Volunteer physicians are those members of the Society who have indicated to the Society office that they wish to participate in the program. The Society makes no guarantee that the physician selected by a patient will accept him as a patient since physicians retain free choice of patients as patients do of physicians.

If a patient who is presently under the care of a private physician member of the Union County Medical Society meets the financial requirements of the Senior Citizens Medical Courtesy as determined by the Senior Citizens Council of Union County, the Medical Society, at the patient's request, will notify that private physician of the patient's financial status and request same be taken into consideration in future financial arrangements with that patient.

If the physician refuses because he has other information which would indicate the status conferred is open to question, that information will be relayed back to the Senior Citizens Council for re-evaluation.

If the physician is unable to accept the patient as a "SCMCP" patient because his present load of reduced rate patients is as high as he can handle, or any other reason deemed appropriate by the physician, the patient will be advised and if he so desires, will be given names of other physicians who might be able to accept him.

* * * *

Senior citizens are eligible who:

1. Are 65 years of age or more.
2. Are residents of Union County.
3. Have an income of no more than $13,250 per year (single); $16,250 (married).
4. Are enrolled in Medicare Part B.
5. Have no more than $35,000 in liquid assets.

Eligibility is determined by filing an application with the Senior Citizens Council of Union County. If the Council has any questions about eligibility, they will refer such applications to the Joint Physicians-Senior Citizens Liaison Committee for approval.

The financial application will contain the following language: "The information supplied by the applicant shall be made available to the physician upon request. The applicant hereby releases the physician from any holding of confidentiality if the physician forwards other financial information regarding the applicant which he deems pertinent to the findings of the Senior Citizens Council in this regard."

Once a patient is approved, the Senior Citizens Council forwards a copy of the application stamped "Approved - Senior Citizens Council of Union County" to the office of the Union County Medical Society. The Society will provide an access card and a list of volunteer physicians to the patient. The patient will initiate contact with the physician on his own.

* * * *

The patient will furnish the physician with all necessary insurance information, i.e., Medicare supplemental insurance and major medical information. The patient will be billed for any deductible or coinsurance as required by law.

Volunteer physicians agree not to bill the patient for any amount above that covered by his insurance and the legally required deductibles and copays.

* * * *

If patients have any complaints about physician service under this program, they shall forward such complaints in writing to:

Union County Medical Society
347 Lincoln Avenue, East
Cranford, NJ 07016
ATT: Judicial Committee

If physicians have any information or questions about a patient's eligibility for the program, they will forward such inquiries to:

Senior Citizens Council of Union County
2165 Morris Avenue
Union, NJ 07083
964-7555

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SENIOR CITIZEN MEDICAL COURTESY PROGRAM

UNION COUNTY MEDICAL SOCIETY - SENIOR CITIZENS COUNCIL OF UNION COUNTY

PLEASE PRINT CLEARLY, ANSWER ALL QUESTIONS

LAST NAME	FIRST NAME	MR.	SEX	DATE OF BIRTH			AGE
1.		MRS. MISS		Mo.	Day	Year	

STREET ADDRESS	CITY	STATE	ZIP	TELEPHONE
2.				

3. Do you own your own home; Yes__ No__ Do you rent: Yes__ No__
Do you live with others (than spouse): Yes___ No ___

Seniors Citizens Housing: Yes No Do you have a car? Yes No

4. Applicant's Social Sec. # _____ P.A.A.D. # _____
Expiration date

My income:

SOURCE	INCOME	
	APPLICANT	SPOUSE
Yearly Social Security Benefits		
Medicare Part B Premium		
Pension Benefits (Public or Private)		
Salary (before payroll deductions)		
Unemployment Benefits		
Interest and Dividends		
Rental Income (Net)		
All others (Please Identify)		
TOTAL ANNUAL INCOME (by column)		

5. IMPORTANT: THE FOLLOWING CERTIFICATION AND AUTHORIZATION MUST BE SIGNED.

I understand that I am responsible for paying the $75.00 Medicare deductible and copays.

I certify that the information above is true and accurate to the best of my knowledge, and is subject to possible verification.

The financial information supplied shall be made available to the physician upon request. I hereby release the physician from any holding of confidentiality if the physician forwards other financial information regarding the applicant which he/she deems pertinent to the findings of the Senior Citizens Council in this regard.

If any question of eligibility arises, this information will be forwarded to the Senior Citizens-Physicians Liaison Committee for decision.

With the foregoing exceptions, the above information will be kept in strict confidential

RETURN TO: SENIOR CITIZENS COUNCIL OF UNION COUNTY
2165 Morris Ave.
Union, NJ 07083
964-7555

_____
Signature of Applicant

_____
Signature of Preparer

SUPPORTING LETTERS AND DOCUMENTS

1. Letter dated February 5, 1986 - Written by Eshagh Eshaghpour, M. D.

2. Letter dated May 30, 1986 - Written by Conrad E. Bell, D.O.
Medicaid District Office

LIKOFF CARDIOVASCULAR INSTITUTE
of Hahnemann University

Eshagh Eshaghpour, M.D., F.R.C.P. (C), F.A.C.C.
Director, Division of Pediatric Cardiology
and Clinical Center for Congenital Heart Disease

February 5, 1986

Mr. Lester K. Calhoun
Patient Representative Specialist
Hahnemann University
Broad & Vine Streets
Philadelphia, PA 19102

Re: (NAGY (Seel), Maxwell P.
309 Homestead Avenue
Trenton, NJ 08620
DOB: 10/2/85

Dear Mr. Calhoun:

The above named patient was transferred to Hahnemann University Hospital from the St. Francis Hospital in Trenton, NJ, on 10/3/85. The transfer was prompted by discovery of complex congenital malformations. These included:

- Dextrocardia with situs solitus without structural cardiovascular anomalies
- Hypoplastic right lung and hypoplastic right pulmonary artery.
- Bilateral multicystic kidney with non-functioning left renal system and partial function of the right kidney

The patient was closedly followed by Drs. Douglas Holsclaw and Pamela Schuler, of the Division of Pediatric Pulmonary Disease.

The renal diagnostic work and plan of care was under the direction of Barney Faulkner, M.D., Director of Pediatric Nephrology.

Hypoplasia of the right lung appeared to be the contributing factor for the malposition of the heart. An echocardiogram revealed the right pulmonary artery to be hypoplastic.

If there is any additional information you may wish, please do not hesitate to let me know.

Sincerely yours,

Eshagh Eshaghpour, M.D.,F.R.C.P.(C)
Director, Div. of Pediatric Cardiology
Professor of Pediatraics and Medicine

EE/as

Hahnemann University, Suite 746 N.T., Broad & Vine, Philadelphia, PA 19102
(215) 448-8852

LOCAL AREA OFFICE
Burlington District Office

TELEPHONE
AREA CODE 609
261-0448

DIVISION MEDICAL ASSISTANCE AND HEALTH SERVICES

ADDRESS REPLY TO:
POST OFFICE BOX
50 Rancocas Road
Mt. Holly, N.J. 08060

Date: May 30, 1986

Hahnemann Hospital
230 North Broad St.
Philadelphia, Pa. 19102

Att: Billing

Re: Patients's Name Maxwell P. Seel-Nagy
Medicaid HSP Case# 0360250638-21

Dear Provider:

Your request for prior authorization for medical approval to provide the medical service or item listed below is granted subject to the customary utilization review.

This prior authorization is valid only if the recipient is currently financially Medicaid eligible as confirmed by the possession of a current New Jersey Medicaid Program validation card.

Since reimbursement is governed by limitations set by the New Jersey Medicaid Program, you should be aware that prior authorization does not assure that final reimbursement will reflect the charges submitted.

1. In-Patient Hospital Services during the period of 5-30-86 to 5-30-87.

2. Out-Patient Hospital Services during the period of 5-30-86 to 5-30-87.

* ~~3. Items~~

Please be aware that authorization does not guarentee patient eligibilit

4. Other It is your responsibility to see a current validation slip.

Attach a copy of this authorization to your billing to avoid delays in payment.

If you have any questions please contact this office.

Sincerely yours,

Conrad E. Bell D.O.

C. E. Bell, D.O.
Medicaid Medical Consultant
Medicaid District Office

CEB/hb
cc: Patient
Prescriber
Patient File/LMAU

*This letter authorizes the purchase (not rental) of the item(s). In accord with N.J.A.C. 10:59 - 1.9(c), the item(s) purchased for the Medicaid clients are owned by the Medicaid Program. When the client no longer requires the use of the item(s), the local Medicaid office is to be contacted.

New Jersey Is An Equal Opportunity Employer

LD-25 (Rev. 9/82)

PUBLIC HEARING NOVEMBER 17, 1986

HEARING: To examine the Medicaid and Medicare Programs from the perspectives of recipients and providers.

PRESENTOR: Daniel Alfieri, Executive Director of New Horizon Treatment Services Inc. 132 Perry Street, Trenton, New Jersey representing SUBSTANCE ABUSE TREATMENT PROVIDERS, INC AND NEW JERSEY ASSOCIATION FOR THE PREVENTION AND TREATMENT OF SUBSTANCE ABUSE. These associations represent the agencies in New Jersey which provide substance abuse treatment services in over 60 facilities throughout the state to both indigent and fee paying clients.

It is noteworthy that this hearing is being held during "Drug Awareness Week" in the state of New Jersey and also that we are in the midst of an epidemic with the continued increase of heroin use, the upswing in the use of: "Cocaine" and "Crack" and the ever alarming increase of other abused drugs by indigent persons who may or may not qualify for Medicaid or Medicare.

The State is to be commended for its actions in changing the Medicaid legislation two years ago to include coverage for the disease of drug addiction for the recipients of Medicaid. This action has resulted in a substantial number of needy people receiving treatment for their illness, both young and old. However we see an increasing need to expand these services to include those clients who require treatment but fall through the safety net which Medicaid and Medicare provide.

The following recommendations are being made for your consideration:

1. **Support bill S-2361 which provides for coverage for outpatient alcoholism treatment services and for the transfer of payment for alcoholism and drug treatment services for the Department of Health to the Department of Human Services. This will allow for these services to be treated as any other medical problem.**

2. **Expand the coverage of certain treatment services to include residential care in a state licensed free standing treatment program. It has been proven cost effective in the past to treat people with the disease of drug addiction and alcoholism first on an outpatient basis next in a state licensed residential treatment program and lastly in a hospital setting. However since residential treatment is not covered many referrals are inappropriately made to hospitals for which Medicaid and Medicare coverage is provided.**

3. **Revise the services covered for the disease of drug addiction. Services provided in substance abuse treatment programs are unique and separated from ordinary services provided in a mental health setting in some cases. The Division of Narcotics and Drug Abuse Control has recently established a new listing of these unique services and their definitions, these should be included under Medicaid and Medicare covered services. These services should only be reimbursed if provided in a state licensed treatment program by certified providers.**

With the inclusion of these recommendations those indigents who are afflicted with the disease of drug addiction and alcoholism will be the benefactors. -Thank you for your time and consideration.

NJANPHA
Founded 1931

New Jersey Association of Non-Profit Homes for the Aging

Apartments for Independent Living
Continuing Care Retirement Communities
Homes for the Aging
County Nursing Homes

Center for Health Affairs
760 Alexander Road, CN1
Princeton, New Jersey 08543-0001
(609) 452-1161

Donald L. Gilmore
President

Dennis R. Hett
Executive Director

November 17, 1986

TO THE ASSEMBLY HEALTH AND HUMAN SERVICES COMMITTEE

The New Jersey Association of Non-Profit Homes for the Aging draws your attention to six serious deficiencies in the Medicaid program:

1. The audit system is not cost-effective.

Audit teams spend months in individual facilities, often uncovering minor amounts due the state. The return per hour invested is minimal at best; and a waste of time at worst.

The process is also burdensome for the provider, which must provide space for the auditors and devote inordinate amounts of staff time to producing and copying records for the auditors.

In spite of efforts to improve the process, some facilities still wait for their 1981 audits to be finalized.

2. The reimbursement system does not even pay for minimum standards.

The Department of Human Services, in a 1983 report to the Joint Appropriations Committee, Report on Study Concerning Feasibility of Consolidating the Two Existing Levels of Intermediate Care Under the Medicaid Program, showed that "the weighted average number of hours which the (Medicaid program) currently utilizes for reimbursement purposes" should be increased by 12%. (See page 3 of attached report.)

No action has been taken to date, and we urge that the New Jersey Medicaid Nursing Home Reimbursement Study Commission, approved earlier this year, be convened at once.

Affiliated with
AAHA
AMERICAN ASSOCIATION OF HOMES FOR THE AGING
COMMUNITIES THAT CARE

3. Medicaid is not coordinated with the regulatory system.

For example:

- Medicaid's refusal to pay for a Department of Health nurse aide certification requirement has rendered the program almost meaningless.

- In many non-profit homes, recent Department of Health licensure fee increases are paid for entirely by residents who pay for their own care because Medicaid does not recognize the increase.

- Similarly, self-paying residents alone pay the cost of a new fire safety inspection fee in many non-profit homes because Medicaid does not recognize the increase.

We recognize that Medicaid cannot pay for every good idea that appears, but have maintained for some years that no new requirements should be enacted without proper reimbursement from Medicaid.

4. Medicaid does not promote genuine cost containment.

Although Medicaid does pay facilities a small incentive if they participate in purchasing groups, facility rates increase only if the facility increases its spending.

We again urge that the New Jersey Medicaid Nursing Home Reimbursement Study Commission be convened at once.

5. Medicaid itself encourages discrimination against Medicaid patients.

Fair rates, not punitive measures, would effectively reduce waiting lists. For example, facilities in Maryland recently withdrew a suit when the State introduced a fairer reimbursement system.

6. Asset divestiture still must be addressed.

Medicaid could save a significant amount of money if it could find a way to effectively prevent the divestiture of assets at less than market value for the purpose of qualifying for Medicaid.

As the population ages, awareness that assets will have to be used in the event that nursing home care is needed increases. Since the urge to leave an inheritance to the next generation is strong, early divestiture becomes more probable.

We urge that more effective means of detecting divestiture be developed, and that long term care insurance be advanced as a means of preserving assets.

Dennis R. Hett
Executive Director

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DRAFT

REPORT ON STUDY CONCERNING THE FEASIBILITY OF CONSOLIDATING THE TWO EXISTING LEVELS OF INTERMEDIATE CARE UNDER THE MEDICAID PROGRAM

TO

THE HONORABLE LAURENCE S. WEISS, CHAIRMAN
JOINT APPROPRIATIONS COMMITTEE

FROM

GEORGE J. ALBANESE, COMMISSIONER
DEPARTMENT OF HUMAN SERVICES

MARCH, 1983

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
CAPITAL PLACE ONE
222 SOUTH WARREN STREET
TRENTON, NEW JERSEY 08625

GEORGE J. ALBANESE
Commissioner

DRAFT

The Honorable Laurence S. Weiss, Chairman
Joint Appropriations Committee
State House
Trenton, New Jersey 08625

Dear Mr. Weiss:

I am pleased to present this report, which has been prepared by the Division of Medical Assistance and Health Services, Department of Human Services, in keeping with Resolution #3, P.L. 1982, C. 49, the State Appropriations Act for FY 1983. As you will recall, Resolution #3 stated:

> "The Division of Medical Assistance and Health Services shall by January 1, 1983 prepare and submit a report to the Joint Appropriations Committee concerning the feasibility of consolidating the two existing levels of intermediate care into a new, single level of intermediate care. The report shall indicate the number of nursing hours per day the new level will require and shall also estimate any savings to be realized in the inspections, rate setting and assessment process."

As you will also recall, an extension on the submission of the report was previously requested (Appendix 1) and approved. I hope the information contained in this report will be helpful to the Joint Appropriations Committee.

Sincerely yours,

George J. Albanese
Commissioner

GJA:2

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TABLE OF CONTENTS

Thomas M. Russo, Director
Division of Medical Assistance and Health Services
Department of Human Services

INTRODUCTION

At present, there is an Intermediate Care level A which requires 2.50 nursing hours of patient care per day and an Intermediate Care level B which requires 1.25 nursing hours of patient care per day. Different Medicaid per diem rates are established for each level at each long term care facility participating in the State Medicaid program.

The initial meetings to consider the feasibility of consolidating the two existing levels of intermediate care services in long term care facilities were held with various members of the Division of Medical Assistance and Health Services. This included administrative, fiscal, medical and nursing staff.

Following the initial meetings, it was decided that it would be necessary to involve representatives of the New Jersey State Department of Health and the long term care industry, i.e., The New Jersey Association of Health Care Facilities and the New Jersey Association of Homes for the Aged.

Several combined meetings of this work group followed. The Department of Health representatives indicated little concern with the proposed consolidation from their perspective and expressed a desire to have only one level of care combining both the skilled and intermediate levels. The Department of Health did not attend further meetings.

During the course of further meetings, the Executive Directors of the two long term care industry Associations proposed that a survey be done in the form of a time/motion study in order to have a more accurate and scientific basis upon which to set hours and rates for a merged intermediate level of care. Several states had conducted such studies, including Illinois, Ohio and Maryland. These studies were used to establish a basis for reimbursement in those states. This approach was agreed upon.

For use in the New Jersey program, the work group considered the Maryland study to be the most appropriate and was the most recent of the three State studies (Appendix 2). The consulting firm was Applied Management Sciences, Inc., of Silver Springs, Md., and, with the agreement of the Division, was engaged by the industry to conduct a study in New Jersey.

METHODOLOGY

The procedure used in the Maryland study by Applied Management Sciences was that their staff, with a team of nurses, recorded time worked by the nursing staff at selected facilities during the 7 A.M. - 3 P.M. and the 3 P.M. - 11 P.M. shifts. In order to time nursing care, the final result was weighted to cover care provided to patients on a 24-hour basis.

A nursing procedure was considered to include four aspects - preparation, travel, clean-up and administration. The administration portion of the nursing function was categorized as procedure and the non-administration portion was categorized as non-procedure.

A ratio of 60% of the time for each specific nursing function was allotted for actual hands on care, and 40% of the time was allotted for non-procedural functions, such as charting, meetings, planning, making schedules, clean-ups, talking to patients and coffee breaks. As a result of the study, average time allottments were set for nursing functions.

For the study in New Jersey, elements of the Maryland study method were adapted. Since time/motion studies had already been completed across the county and were fairly consistent (i.e., the time needed to give an enema or bathe different types of patients were the same wherever it was observed), it was felt that to do another time/motion study of these elements would be unnecessary.

Therefore, for the New Jersey study, it was only necessary to observe and report the procedures being given to patients and to then apply the times to the recorded procedures. The form used in Maryland was modified for use by a team of regional staff nurses from the Division (Appendix 3). A random sample of facilities across the State was selected by the Division's statistical section (Appendix 4) and included proprietary, non-profit and governmental representation.

Within the selected facilities, the sampling of intermediate care patients (levels A and B) was completed by the regional staff nurses as instructed by Applied Management Sciences and the statistical section of the Division. The entire sampling procedure was established by the Division with consultation from Applied Management Sciences.

A Patient Assessment Form was checked relative to dependency and independency as applied to patient capabilities, such as bathing, dressing, feeding and ambulation. Other areas were checked "Yes" or "No" regarding the need for injections, medication, restraints, positioning, decubitus care, suctioning, feeding needs, etc.

The collected data was then submitted to Applied Management Sciences where the actual time for nursing functions was decoded and applied to the care requirements noted by the regional staff nurses (Appendix 5). It must be noted that the New Jersey State Department of Health licensing Manual of Standards for Long Term Care Facilities was adhered to regarding the categorization of patient levels and need for all aspects of care.

APPLIED MANAGEMENT SCIENCES REPORT

The report submitted to the Division by Applied Management Sciences contained raw data on the length of time required for each patient that was selected in a statistically valid sample. The average hours of nursing care required for an ICF patient was determined to be 2.39 hours. The time study developed by Applied Management Sciences specified the amount of nursing care that appeared to be needed to satisfy all patient care needs as set forth by the State of New Jersey, based upon research at nursing homes throughout the country.

It should be noted that, according to this study, the minimum amount of time felt necessary to service the most independent patient is 86.39 minutes, or 1.44 hours. This is over the present State standard of 1.25 hours for ICF-B level patients.

DIVISION EVALUATION

Utilizing the Applied Management Sciences data, the combined time for the care of Intermediate Level A and B patients was analyzed by the Division's statistical section. Based on this analysis, the amount of time required per patient per day is 2.39 hours (2 hours, 23 minutes) (Appendix 6).

The Division also conducted an analysis of time utilizing current Medicaid and State licensing standards. This analysis was based upon a weighted average of the existing minimum number of hours required for both the Intermediate A and B levels of care. The findings of this analysis indicate that under a consolidation, the minimum hours required would be 2.14 hours (2 hours, 8.4 minutes) per patient per day (Appendix 7).

The 2.39 hours of care as determined by the Applied Management Sciences data represents a 12% increase over the 2.14 weighted average number of hours which the Division currently utilizes for reimbursement purposes.

ADVANTAGES OF CONSOLIDATION

The Division, in its evaluation, has identified a significant number of advantages for the consolidation of the existing two levels of intermediate care into one level of Intermediate Care. These advantages are applicable to the Department of Human Services, the Department of Health, and the long term care facilities which provide Intermediate Care services under the Medicaid program.

The advantages listed below affect staff time, effort, processes and procedures. Moreover, the advantages do not detract from the adequacy of patient care. It is difficult to quantify the dollar amount of administrative savings that would be realized because of the impact on many different segments of the program. The advantages are:

1. Savings would be realized through the reduction of administrative appeals and hearings before an Administrative Law Judge on intermediate level of care assessments and the establishment of per diem rates.

2. One intermediate level of care would facilitate the authorization and reauthorization of care by Division nursing staff and would result in increased administrative savings and in professional staff time since team conference time would be limited to skilled cases, possible denials or problem cases.

3. The rate setting process by the Health Economics section of the Department of Health would be simplified with inherent savings of staff time.

4. The payment and adjustment of per diem rates to facilities by the Division's Bureau of Claims and Accounts would be expedited.

5. There would be a decrease in the Division's administrative and professional staff time regarding changes of level requests within the Intermediate Care range.

6. The inspection and evaluation process by the Department of Health licensing unit would be less cumbersome because of the consolidation of licensure requirements.

7. There would be a decrease in administrative time involving the change of levels of care on the MCNH 7 form in the Medicaid District Offices.

8. Administrative time in preparation of cases for conferencing and scheduling would be minimized and professional staff would be able to devote more time to areas requiring increased attention, such as transportation, medical equipment, home health care and other community health services.

9. The process of post audit recalculation of rates as a result of audit findings and the computation of overpayments for recovery of funds would be simplified and expedited.

10. The reporting of data and expenditures for fiscal and budgetary purposes would be less cumbersome.

11. The problem of classifying the Intermediate Care level private patient days would be eliminated.

12. The entire audit process would be facilitated since intermediate levels of care would not have to be tested.

13. The review of proposed per diem rates recommended to the Division by the Department of Health would be simplified.

DISADVANTAGES OF CONSOLIDATION

The disadvantages of consolidation are outweighed by the advantages and are listed below:

1. Administrative time and effort would be required by the Department of Health and the Division to prepare and implement the various regulatory changes needed, such as standards, licensing, inspection, patient assessment, cost reporting, rate setting, etc.

2. A Medicaid State Plan Amendment would need to be submitted to and approved by the Federal Health Care Financing Administration prior to implementation.

3. Long term care facilities in the State that provide Intermediate Care services would need to be informed of the changes and provided with a period to adjust to the revised nurse staffing patterns.

4. There may be an incentive provided to long term care facilities to gradually adjust their case mix to maximize the number of patients who need the least amount of intermediate level care and to avoid the more intensive intermediate care patient in order to increase income from the one level per diem rate. This could make placement of the patient requiring a higher level of intermediate care more difficult.

SAVINGS FOR LONG TERM CARE FACILITIES

1. Administrative time for the discharge and re-admission of patients from one Intermediate Care level to another would be eliminated.

2. Recordkeeping and statistical reporting would both be simplified.

3. The Medical Director would be required to consider only two levels of care upon admission - skilled or intermediate.

4. It would be easier for facilities to staff for one level because of a simplified staffing pattern.

5. A facility would have more flexibility in adjusting nursing care hours to the facility's case mix.

6. The submission of annual cost reports would be simplified concerning nursing hours.

SAVINGS FOR STATE

The Division is of the opinion that definite administrative staff and dollar savings in all areas would accrue to the State with the adoption of one level of intermediate care, but that such savings will not be identifiable until the change has been operational for a period of time. For example, the simplification of audit rate recalculations and the acceleration of money recoveries would be realized in gradual future increments.

As a result, no specific dollar or staff savings are able to be identified at this time. It is suggested that, if the change is adopted, a follow-up study be conducted one year following its implementation for the specific purpose of identifying and quantifying both staff and dollar savings.

EFFECT ON STATE LICENSING

The minimum hours of care for the licensing of long term care facilities are a responsibility under the jurisdiction of the State Department of Health. The per patient per day hours required for Intermediate Care levels A and B are currently contained in the State Administrative Code as a licensing standard. Therefore, in order to consolidate and utilize one level of intermediate care, it will be necessary for the State Department of Health to consider and promulgate a change in the licensing standards as a requirement for all long term care facilities in the State, irrespective of whether or not they participate in the Medicaid program. This would require review by the Health Care Administration Board in the Health Department and the publication and adoption of a revised rule in the New Jersey Register.

EFFECT ON MEDICAID PROGRAM

The consolidation of intermediate care into one level would also require the publication and adoption of a rule change in the New Jersey Register along with a change in the Medicaid State Plan. Any change in the State Plan for this purpose would require the approval of the Federal Health Care Financing Administration prior to implementation.

SUMMARY

Based upon the information contained in this study, the Division is of the opinion that the consolidation of the intermediate levels of care into one level is feasible using a standard of 2.39 hours of care per patient day and will save money administratively, but is estimated to incur a cost of approximately $7.2 million (State and Federal share).

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APPENDIX INDEX

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Appendix I

State of New Jersey

DEPARTMENT OF HUMAN SERVICES

CAPITAL PLACE ONE
222 SOUTH WARREN STREET
TRENTON, NEW JERSEY 08625

GEORGE J. ALBANESE
Commissioner

MEMORANDUM

November 8, 1982

TO: Honorable Laurence S. Weiss
Chairman, Joint Appropriations Committee

SUBJECT: Joint Appropriations Committee Resolution #3
on Single Intermediate Care Facility Level

As you know, the above Resolution requires the Division of Medical Assistance and Health Services to prepare and submit a report to the Joint Appropriations Committee by January 1, 1983 concerning the feasibility of consolidating the two existing levels of intermediate care into a new single level of intermediate care.

The Resolution further requires that the report indicate the number of nursing hours per day for the new level, along with an estimate of any savings to be realized in the inspections, rate setting and assessment process.

The Division is working closely with the New Jersey Association of Health Care Facilities on the study and is currently engaged in a detailed analysis of nursing tasks and the time required to perform the task for ICF patients in such facilities.

It is possible that this study may not be fully completed for submission by January 1, 1983 and I am, therefore, requesting a two-month extension for the submission of the report to the Joint Appropriations Committee. Your favorable consideration of this request will be most appreciated.

George J. Albanese
Commissioner

GJA:2
c.c. Larry J. Lockhart
Thomas M. Russo
James E. Cunningham

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Appendix 2

HANDBOOK
ON
PATIENT ASSESSMENT

July 8, 1982

Medical Assistance Compliance Administration
Department of Health and Mental Hygiene
State of Maryland

The Patient Assessment Form

The patient assessment form has been designed to abstract a finite set of patient-specific characteristics for which Maryland nursing home providers will be reimbursed. This assessment form provides the State with the requisite data to determine reimbursement rates for nursing costs based on a patient's dependency in the Activities of Daily Living, the need for three specific special services (i.e., tube feeding, necrotic ulcer care, turning and positioning), and seven other categories of additional services.

Assessments will periodically be performed on all Medical Assistance patients so the instrument has been designed to capture data for each month between assessments. In addition to multiple month retrospective assessments, the form is also used to record either an initial admission or a conversion (i.e., from Medicare or private pay) assessment. All data items required to complete this form may be found in the patient's medical record. Instructions are provided to define ADL dependency and to count days of service. A cross-reference to the MAPP is also provided in the data sources.

PATIENT ASSESSMENT FORM

PATIENT NAME [ ] ASSESSMENT DATE [ ]
LAST FIRST

FACILITY ID [ ] MEDICAID ID [ ] ASSESSOR ID [ ]

PERIOD COVERING: MONTH 1 [ ] MONTH 2 [ ] MONTH 3 [ ]
MO. YR. MO. YR. MO. YR.

I. ADMINISTRATIVE DATA

1. Initial Assessment 0=No 1=Yes [ ]

2. Date of Admission or Conversion to Medicaid [ ] MO. DAY YR.

3. Date of Discharge, Transfer, Death, or Medicaid Lost or Denied [ ] MO. DAY YR.

4. Days of Home Leave Taken [ ] 1 2 3

II. ACTIVITIES OF DAILY LIVING
(Enter one code for each month)

5. Bathing 0=Independent 1=Dependent [ ] 1 2 3

6. Dressing 0=Independent 1=Dependent [ ] 1 2 3

7. Mobility 0=Independent 1=Dependent 2=Bed/Chair Confined [ ] 1 2 3

8. Continence 0=Independent 1=Dependent [ ] 1 2 3

III. SPECIAL SERVICES
(Enter number of days services are received for each month.)

10. a. Necrotic Ulcer Care [ ] 1 2 3

b. 0=Not present at admission 1=Present at admission [ ]

11. Turning and Positioning For a 24 Hour Period [ ] 1 2 3

12. Tubefeeding [ ] 1 2 3

IV. ADDITIONAL SERVICES
(Enter number of days services were received for each month.)

13. Restraints [ ] 1 2 3

14. a. Single Injections [ ] 1 2 3

b. Multiple Injections [ ] 1 2 3

15. Ostomy Care [ ] 1 2 3

16. Oxygen/Aerosol [ ] 1 2 3

17. IV/Subcutaneous [ ]

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FORM IDENTIFIERS

A. Patient Name - Print the patient's name in the box provided. Record the last name first and then continue with the first and middle names as space allows. It is extremely important that the name appears correctly spelled since this field will be used to match the assessment form with the payment voucher when errors are present in the patient ID.

B. Assessment Date - The date that the form is completed by the interviewer. Record month, day, and last two digits of the year. Zero fill boxes (e.g., 01 = January).

C. Facility ID - Each nursing home has a six-digit unique provider code. If the assessment occurs in the hospital or in other circumstances where the nursing home facility is unknown, then code '000000' in this field and write the name of the hospital at the top of the form.

D. MEDICAID ID - This ID will appear in the patient's medical records or in the business office. This should be copied very carefully because this is the means by which this form can be linked back to a particular patient's payment record. The ID should consist of 11 digits. If less than 11 digits appear in the patient's records, ask the nursing home staff to check the number.

E. Assessor ID - This field is for the use of the assessment contractor and should be used to uniquely identify each assessor. Every assessment form should have this field completed.

F. Period Covering - If this is an initial assessment, record all zeros (i.e., '0000') in the boxes for each month and be sure to code item 1 in Section I properly. If not an initial assessment, then the continuing assessment recorded on this form can be for any period up to the three months in length. If more than three months have elapsed since a previous assessment (or admission), please use more than one form. Indicate for each month (or part thereof) the month number and last two digits of the year. By doing so, all responses in Sections I through IV will be properly keyed to the month of review.

I. ADMINISTRATIVE DATA

1. Initial Assessment

Item Definition: The first assessment performed on a patient after he/she has been determined to be eligible for Medical Assistance (MA) and has been classified as appropriate for nursing home placement. This assessment will generally be performed either in conjunction with a medical eligibility review in a hospital setting or in the facility in the case of a private pay nursing home resident who is converting to MA.

Data Source: Accompanying initial medical review.

Code Explanation

Code		Meaning
0	=	No
1	=	Yes

NOTE: If the form is being used for an initial assessment, Sections III and IV need not be filled out.

I. ADMINISTRATIVE DATA

2. Date of Admission or Conversion to MEDICAID

Item Definition: The date a patient on Medical Assistance enters the nursing home, OR the date that the patient's payment status changes to Medical Assistance from private pay or alternative sources.

Data Source: These data can be found in the facility's business office on the admittance forms or at the beginning of the patient's medical record.

Code Explanation:

Code		Meaning
00-00-00	=	Patient has not, as yet, been admitted to the nursing home
AA-BB-CC	=	Month patient admitted to the nursing home or converted to Medical Assistance. Code as follows in first two fields, indicated here as AA: 01 = January, 02 = February .... 12 = December.
AA-BB-CC	=	Day patient admitted or converted to MA. Code in second two fields, indicated here as BB: 01 = first day of month .... 28, 29, 30, or 31 = last day of month.
AA-BB-CC	=	Year patient admitted or converted to MA. Code last two digits of the year in the last two fields, indicated here as CC.

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I. ADMINISTRATIVE DATA

3. Date of Discharge, Transfer, Death, or MEDICAID - Lost or Denied

Item Definition: When any of the above actions occur, the Medical Assistance reimbursement to that nursing home for the patient will be discontinued. It is imperative, therefore, to distinguish between an actual transfer/discharge and a patient who has, for example, left the facility for a brief hospital stay of, say, 72 hours, and for whom the facility is still holding their bed (the latter case should be regarded as the patient still being in the home). It is very important to get the exact date that the action occurred.

Data Source: Medical records; Business office

Code Explanation

Code		Meaning
00-00-00	=	Patient is still in the nursing home and is still receiving MA benefits.
AA-BB-CC	=	Month action occurred. Code in the first two fields, indicated here as AA: 01 = January, 02 = February .... 12 = December.
AA-BB-CC	=	Day action occurred. Code in the second two fields indicated here as BB: 01 = first day of month .... 31 = last day of month.
AA-BB-CC	=	Year action occurred. Code in the last two fields indicated here as CC the last two digits of the year.

I. ADMINISTRATIVE DATA

4. Days of Home Leave Taken

Item Definition: Patients are allowed up to 18 days of accumulated home leave each calendar year. During these visits, the nursing home will keep the bed available and Medical Assistance will continue to be paid.

Data Source: Medical records; Business office

Code Explanation

Code		Meaning
00	=	Home visits were not taken during the review month(s)
01-31	=	Code the number of days of home visits taken in each of the review month(s).

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II. ACTIVITIES OF DAILY LIVING

5. Bathing

Item Definition: Refers to the description which best typifies the patient's overall performance of bathing or showering activities in a given month.

Data Source: Medical records; MAPP form - Category II Functioning Status - Section 4, Personal Hygiene items 4, 5, and 6; Charge Nurse; Nurse's Aide.

Code Explanation

Code		Meaning
0	=	Independent - a resident is classified as independent if no other person is involved in any part of the process of taking a sponge bath, shower or tub bath to wash the whole body. This category may be applied however to the patient who requires supervision for safety reasons though he washes himself, and the patient who is only unable to wash one extremity. A patient is also classified under this category if he/she uses only mechanical aids to assist in the bathing process, e.g., shower/tub chair, grabrails, pedal/knee controlled faucets, long handle brush or mechanical lift.
1	=	Dependent - pertains to the individual who is assisted in washing; this includes the patient to whom water is brought even though he washes himself, and patient who is helped in or out of a tub as regularly as once a week. This category also includes the individual who is completely bathed by another person(s) and does not participate in the activity.

Put one code in each box for each review month by choosing the code which best describes the patient's overall abilities for the month.

II. ACTIVITIES OF DAILY LIVING

6. Dressing

Item Definition: The process of putting on, fastening, or taking off all items of clothing, braces, or artificial limbs that are worn daily by the individual, including obtaining and replacing the items from their storage area in the immediate environment. Clothing refers to the clothing usually worn daily by the individual. Individuals who wear pajamas or gown with robe and slippers as their usual attire are considered dressed.

Data Source: Medical records; MAPP-Category II Functioning Status, Section 5, Dress/Undress items 1-3; Charge Nurse; Nurse's Aide.

Code Explanation

Code		Meaning
0	=	Independent - pertains to the patient who does not receive personal help or supervision in getting clothes from the closets and drawers and in putting on the clothes, including brace (if usually worn) and including outer garments and footwear. Fasteners must also be managed without assistance, although, a resident who receives help in tying shoes only is included in this category. This class also includes the individual who uses mechanical help only to complete the dressing process. Such equipment or devices may include long-handled shoe horns, zipper pulls, velcro fasteners, adapted clothing, and walker with attached basket or some other device used to obtain clothing.
1	=	Dependent - includes patients who usually receive assistance from another person(s) in obtaining clothes, fastening hooks, putting on clothes, braces, artificial limbs or who require supervision or instruction in order to dress one's self. Also included in this category is the resident who receives human assistance (as specified above) and who uses the aid of mechical devices. Finally, this code includes patients who are completely dressed by another person(s) or who are bedfast and therefore remain partially or completely undressed.

Put one code in each box for each review month by choosing the code which best describes the patient's overall abilities for the month.

II. ACTIVITIES OF DAILY LIVING

7. Mobility

Item Definition: The patient's current performance, assessed with mechanical aids if customarily used, of moving from bed to chair or wheelchair, and from bed or chair to standing position. Exclude effort required to apply a brace or prosthesis (included in dressing).

Data Source: Medical records; MAPP-Category II Functional Status, Section 1 - Ambulation items 1-4, and Section 3 - Transferring items 1-4; Charge Nurses; Nurse Aides.

Code Explanation

Code		Meaning
0	=	Independent - requires no assistance in transferring and walking and/or wheeling.
1	=	Dependent - refers to the patient who is able to ambulate with or without mechanical assistance, but must be personally assisted getting in or out of bed or chair. This category also includes the patient who is unable to ambulate without human assistance or supervision, is wheeled, or is bed/chair confined. Patient cannot participate significantly in the process of walking/ wheeling or transfer, but is able to reposition self in bed or in chair.
2	=	Bed/Chair Confined/Unable to Reposition Self - refers to the patient who requires a daily maintenance schedule for positioning and turning by nursing staff to relieve areas of pressure and to prevent skin breakdown.

Put one code in each box for each review month by choosing the code which best describes the patient's overall abilities for the month.

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II. ACTIVITIES OF DAILY LIVING

8. Continence

Item Definition: Continence refers to the physiological process of elimination from the bowels and bladder where incontinence is the involuntary loss of control. This item only refers to the function of control and does not include hygiene, toileting, adjusting clothes, etc.

Data Source: Medical records; MAPP-Category II Functioning Status, Section 6 - Toileting items 4 and 7; Charge Nurse; Nurse's Aide.

Code Explanation:

Code		Meaning
0	=	Independent - pertains to the patient who is continent of bowel and bladder and the patient who can completely care for their own ostomy. Also includes patient who has accidents only 1 or 2 times per week and is not catheterized. Does not include patient whose continence is maintained only through regularly scheduled and documented staff assistance in advance of need.
1	=	Dependent - Includes patient who has accidents 3 or more times per week includes patient who has accidents at night only. Also includes patient needing regular, daily continence care due to patient's inability to control micturition or bowels, or to notify staff in advance of need. Includes patient whose continence is maintained through regularly scheduled and documented staff assistance in advance of need. Patients with indwelling catheters, suprabubic catheters, and Texas catheters should be regarded as incontinent.

Put one code in each box for each review month by choosing the code which best describes the patient's overall abilities for the month.

II. ACTIVITIES OF DAILY LIVING

9. Eating

Item Definition: Eating and feeding refers to the process of getting food by any means from the receptacle into the body. This item describes the function of eating after food is placed in front of the individual. This standard includes N-G tube feeding or gastrostomy feedings, but excludes patient being maintained solely by IV or being taught self-care of gastrostomy.

Data Source: Medical records; MAPP-Category II Functioning Status, Section 2 - Muscle Strength, Items 5 and 6; MAPP-Category III Nutritional Status, item 1; Charge Nurse or Nurse's Aide.

Code Explanation

Code		Meaning
0	=	Independent - no service. Patient may receive assistance in cutting meat, buttering bread, opening containers of milk, pouring milk or cereal, or cream in coffee, or in clearing up after accidents.
1	=	Receives personal help or supervision - refers to patient who receives some assistance or direct supervision in eating in order to achieve adequate nutrition on a daily basis or to guard against life-threatening incidents (e.g., choking).
2	=	Spoonfed - refers to patient who is routinely fed by a staff member because the patient is usually unable to bring food to his mouth. Patient may occasionally bring food to his mouth in an effective manner for one feeding or during two or more feedings.
3	=	Gastric tube/gastrostomy feedings - Patient is fed a prescribed diet via a naso-oral-gavage tube or gastro-gavage tube. Activity includes insertion of tube, care of the opening, and feeding through the tube.

Put one code in each box for each review month by choosing the code which best describes the patient's overall abilities for the month.

III. SPECIAL SERVICES

10a. Decubitus Care

Item Definition: Refers to the days of care given to patients with Stage III and Stage IV decubitus ulcers. A Stage III decubitus ulcer is defined as a skin break with redness and significant or extensive tissue involvement; a full thickness of skin is lost, possibly including subcutaneous tissue, producing serosanguineous drainage. A Stage IV decubitus ulcer is defined as a skin break with deep tissue involvement, necrotic tissue may be present. A skin break must be present in both types of ulcers; blisters only would not be considered a Stage III/IV ulcer.

Data Source: Patient observation; medical records; nursing notes.

Code Explanation

Code		Meaning
00	=	Care for a necrotic ulcer was not administered during that month
01-31	=	Number of days that necrotic ulcer care was administered each month. Care is defined as treatment ordered more often than daily for decubitus ulcers, stasis ulcers, or similar conditions by a physician of one or more of the following treatments: sterile dressing, moist packs, soaks, irrigations, heat lamp, oxygen, or other recognized therapy.

Note: A Stage I ulcer is defined as inflamation or reddening of the skin which does not clear with gentle hand massage and repositioning of the patient. A Stage II ulcer is a skin break with inflamation of surrounding skin which does not clear with gentle hand massage and repositioning of patient.

III. SPECIAL SERVICES

10b. Decubitus present at admission

Item Definition: Indicate if the necrotic ulcer was present upon admission to the nursing home. If a private pay patient converts to Medical Assistance, the assessor would still indicate if the ulcer was present at the time the patient admitted to the nursing home as a private pay patient. This field need only be completed on the patient's initial assessment and his/her first Continued Stay Review.

Data Source: Resident observation; medical records.

Code Explanation:

Code		Meaning
0	=	Ulcer not present at admission
1	=	Ulcer present at admission

III. SPECIAL SERVICES

11. Turning and Positioning

Item Definition: The number of days for which the patient requires 24 hour turning and positioning. This does not include those patients who can sit in a chair during the day but need turning and positioning at night only. (If resident is turned and positioned, Item 7, Mobility, should indicate resident is bed/chair confined.)

Data Source: Medical records; Patient observation

Code Explanation:

Code		Meaning
00	=	24 hour turning and position was not required this month
01-31	=	Number of days patients required 24 hour turning and positioning each review month.

III. SPECIAL SERVICES

12. Tubefeeding

Item Definition: Refers to the use of a naso-gastric or gastric tube as the primary method of feeding the patient. (If resident is tubefed, Item 9, Eating, should indicate such.)

Data Source: Medical records; MAPP Category III Nutritional Status, Item b - footnote; Patient observation.

Code Explanation

Code		Meaning
00	=	Patient was not tubefed during the review month
01-31	=	Number of days the patient was tubefed during each review month.

IV. ADDITIONAL SERVICES

13. Restraints

Item Definition: Number of days that physician ordered and patient was administered physical restraints, and/or the following protective devices: posey belt, geriatric chair. Restraints must be removed at regular intervals. Patients in protective devices must be repositioned at least every two hours. Protective devices such as mitts, elbow pads, knee pads, and heel pads are included as part of the dressing function and, therefore, are excluded here. Restraints can only be ordered for a 24-hour period; protective devices can be ordered for up to 30 days for skilled patient, and a maximum of 60 days for an ICF-level resident.

Data Source: Medical records; MAPP Category II Functioning Status, Section 3 Transferring - item 5; Patient observation.

Code Explanation

Code		Meaning
00	=	Restraints/protective devices were not used during the review month
01-31	=	Number of days that restraint/protective devices were used each review month.

80X

IV. ADDITIONAL SERVICES

14a. Single Injections

Item Definition: The number of days the patient was administered only one injection each day. Excludes resident who self-administers injections.

Data Source: Medical records; medication records/sheets.

Code Explanation

Code		Meaning
00	=	No single injections were received during the review month
01-31	=	Number of days patient received only single injections during review month.

IV. ADDITIONAL SERVICES

14b. Multiple Injections

Item Definition: The number of days that the patient receives two or more injections per day. Excludes patient who administers own injections.

Data Source: Medical records; medication records/sheets.

Code Explanation

Code		Meaning
00	=	No multiple injections were received during the review month
01-31	=	Number of days that the patient received multiple injections each review month.

IV. ADDITIONAL SERVICES

15. Ostomy Care

Item Definition: The number of days of care and/or irrigation of all ostomies including colostomies, ileostomies, ureterostomies; as ordered by a physician and care provided under supervision of a licensed nurse. Excludes the resident who is self-care.

Data Source: Medical record; Treatment records; Category II Functioning Status Section 6 - items 6, 8; Patient Observation.

Code Explanation

Code		Meaning
00	=	No care was given during review month
01-31	=	Number of days during review month the patient received care for the ostomy.

IV. ADDITIONAL SERVICES

16. Oxygen/Aerosol

Item Definition: Administration of oxygen and/or aerosol therapy (IPPB) respiratory care only as ordered by a physician and administered by a licensed nurse or a registered respiratory therapist. Self-administered oxygen nebulizers, vaporizers, or atomizers are not included in this category.

Data Source: Medical records; Treatment record; Charge nurse; Nurse's Aide; Patient observation.

Code Explanation

Code		Meaning
00	=	Oxygen/Aerosol Therapy was not administered during review month
01-31	=	Number of days that the patient received Oxygen/Aerosol treatments each review month.

84X

IV. ADDITIONAL SERVICES

17. IV/Subcutaneous

Item Definition: Parenteral solutions, with or without medication, ordered by a physician and administered under the supervision of a registered nurse who is available on a 24-hour basis, in compliance with licensure requirements. Resident who receives IV/Subcutaneous treatments for any part of a day is considered to have received treatment for a full day.

Data Source: The medication sheet must specify the solution, the date, the time administered, and the signature of the person administering the fluid. The patient's plan of care must be reevaluated by the physician after four days' administration.

Code Explanation

Code		Meaning
00	=	Patient did not require this type of care during the review month
01-31	=	Number of days the patient received this service each review month.

IV. ADDITIONAL SERVICES

18. Suctioning/Tracheostomy

Item Definition: Maintenance of patient airway ordered by a physician and performed by a licensed nurse, including the cleaning of inner and outer cannula and sterilization of needed equipment. The suctioning equipment must be located in the patient's room.

Data Source: Medical record; treatment records.

Code Explanation

Code		Meaning
00	=	Patient did not require suctioning or tracheostomy care during the review month
01-31	=	Number of days that patient received these services each review month.

86x

APPENDIX 3

PATIENT ASSESSMENT FORM

PATIENT NAME [LAST FIRST] ASSESSMENT DATE [ ]

FACILITY ID [ ] MEDICAID ID [ ] ASSESSOR ID [ ]

PERIOD COVERING: MONTH 1 [ ] MO. YR. MONTH 2 [ ] MO. YR. MONTH 3 [ ] MO. YR.

I. ADMINISTRATIVE DATA

1. Initial Assessment 0=No 1=Yes [ ]

2. Date of Admission or Conversion to Medicaid [ ] MO. DAY YR.

3. Date of Discharge, Transfer, Death, or Medicaid Lost or Denied [ ] MO. DAY YR.

4. Days of Home Leave Taken [ ] 1 2 3

II. ACTIVITIES OF DAILY LIVING
(Enter one code for each month)

5. Bathing 0=Independent 1=Dependent [ ] 1 2 3

6. Dressing 0=Independent 1=Dependent [ ] 1 2 3

7. Mobility 0=Independent 1=Dependent 2=Bed/Chair Confined [ ] 1 2 3

8. Continence 0=Independent 1=Dependent [ ] 1 2 3

III. SPECIAL SERVICES
(Enter number of days services are received for each month.)

10. a. Necrotic Ulcer Care [ ] 1 2 3

b. 0=Not present at admission 1=Present at admission [ ]

11. Turning and Positioning For a 24 Hour Period [ ] 1 2 3

12. Tubefeeding [ ] 1 2 3

IV. ADDITIONAL SERVICES

(Enter number of days services were received for each month.)

13. Restraints [ ] 1 2 3

14. a. Single Injections [ ] 1 2 3

b. Multiple Injections [ ] 1 2 3

15. Ostomy Care [ ] 1 2 3

16. Oxygen/Aerosol [ ] 1 2 3

17. IV/Subcutaneous [ ]

X88

Appendix 3

DEPARTMENT OF HUMAN SERVICES

INTER-OFFICE COMMUNICATION

THROUGH Ann Kohler

DATE December 3, 1982

Appendix 4

TO Jed Spector
James Cunningham

FROM James Bohan

SUBJECT Revised Sample of Long Term Care Patients

As requested, the sample of long term care patients has been revised to include a minimum number of facilities according to type; Proprietary (10 sample facilities), Governmental and Non-Profit which received Medicaid funds (5 sample facilities each). This remains a two stage sample and the instructions provided with the original sample still apply (copy attached). The lists of random numbers which correspond to the beds to be sampled are attached and grouped according to type of facility. A face sheet for each group identifies the facilities selected for review. In keeping with your cost and time constraints, the total sample size remains essentially the same. A total of 20 facilities will be selected each having 30 beds to review, with the exception of two small facilities in which all beds are to be reviewed (see face sheet).

The total number of facilities that were subject to sampling was revised from 242 to 238 facilities. Facilities are defined as units with discrete Medicaid provider numbers. As had been agreed and stated in the original memo, the sample frame excludes facilities which did not receive Medicaid funds for the report month of August 1982 (CP08). Statistically, inferences cannot be made relevant to these facilities. Also, this sample was not constructed to facilitate comparisons between level A and level B care. The new stratified format is likely to increase the sampling error from the previous target of ± 20 minutes. Sampling error can only be reduced by increasing the sample size. Again, the estimated sampling error is subject to the assumptions you provided.

If you have any questions regarding the above or experience problems selecting random samples at the facilities, please call me at 292-7341.

JB:jh

attachments

APPROVED: SEC
FHC
1024

Jed Spector, Chief, Bureau of Nursing Services
James Cunningham, President, New Jersey Association of Health Care Facilities
Dennis Hett, Executive Director, N.J. Asscciation of Non-Profit Homes for the Aging, Inc.

DEPARTMENT OF HUMAN SERVICES

INTER - OFFICE COMMUNICATION

To: Jed Spector

Date: November 5, 1982

From: Jim Bohan

Subject: Random Sample of Long Term Care Patients Level A & B

As requested, please find attached a statistically random sample of numbers which identify the nursing home beds to be used in your study of long term care. The sample is divided into two stages. The first identifies the 20 facilities to be visited out of the 242 facilities that received Medicaid payments during August 1982. The second stage identifies the 30 beds to be reviewed in each facility selected by listing 30 random numbers between one and the total number of beds in each respective facilit (Mj.) For example if the first selected facility had 100 beds, thirty rando numbers will be listed which could range from one to 100. In addition, eac facility has five reserve pool numbers. These are to be used only if one or more of the first 30 beds selected has a patient requiring skilled nursi care (which are not subject to review) or are empty during the time of review. An empty bed should be narrowly defined as 'empty for the duration of review time spent at the facility'. Reserve pool cases should not repla other beds for administrative convenience. Also, they must be used in the order given.

Because of the uncertainty of the physical layout or available records of each facility, the procedure for matching the sample of random numbers of actual beds in the facility has yet to be defined. If a facility has all rooms numbered in consecutive order from one to Mj and there are two beds to a room, the bed to be reviewed can be derived directly from the random nu An odd random number means you will review bed A, an even number equals bed The room number is derived by dividing the random number by 2 and rounding up to the nearest integer. An example, the random number 29 would correspon to bed A in room number 15 (29÷2=14.5,Rd=15). If room numbers are numbered consecutively but begin with multiple digits, eg., 101, 201, 1001, etc., disregard all digits to the left of 1-Mj. If rooms are not ordered consecutively, you can create a contiguous list by listing all beds accordin to hierarcy of room numbers (eg., 1A, 1B, 12A, 12B,... MjA MjB). Then the bed to be reviewed would correspond to the ordered position of the random number (eg., Random #3 corresponds to bed 12A in prior example). Other list are also suitable, such as, a file with one card for each bed, a ledger sheet listing all beds, etc. Again the bed selected for review would be according to its position in the files or list. However, any source for selection of sample beds must be complete (all occupied level A & B beds) and randomly ordered. The procedure used for each facility should be documented so that sample selected could theoretically be duplicated.

90x

Per the instructions of yourself and Jim Cunningham, this sample is constructed to provide an estimate of the average length of time required per day to service all level A and B patients in LTC facilities which received Medicaid funds. Statistically, inferences cannot be made relevant to private facilities, nor will this sample facilitate comparisons between level A and level B care. The amount of error of the estimate is expected to be ± 20 minutes at a 95% level of confidence. However, factors which determine sample sizes and distribution between stages were derived intuitive Samples of this type are extremely sensitive to such assumptions and sampling error may be adversely affected.

In order to make the necessary calculations after the sample is completed, the length of time of service per day for each patient sampled must be provided and grouped by pertinent facility. In otherwords, we will receive 20 groups of 30 numbers each.

If you have any questions regarding the above or experience problems selecting random samples at the facilities, please call me @ 292-7341.

JB:es

Attachments

9/X

SAMPLE FOR PROPRIETARY FACILITIES

FACILITIES SELECTED	PROVIDER NUMBER	NUMBER OF BEDS
Beachview Nursing Home	0102	104
Bel Air Nursing Care	0230	250
Lakewood of Voorhees	0410	240
Greenbriar Nursing & Convalescent Home	0801	220
Emery Manor Nursing Home	1206	100
H & H Nursing Home, Inc.	1311	115
The Grove Health C.C.	1366	121
Bayview Conva. Center	1505	323
Dolly Mt. Nursing Home	1609	32 (ALL)
Bridgeway Conva. Center	1816	120

SAMPLE FOR NON-PROFIT FACILITIES

FACILITIES SELECTED	PROVIDER NUMBER	NUMBER OF BEDS
Masonic Home	0313	239
Wesley Manor Methodist Home	0561	32 (ALL)
Lutheran Home, Jersey City	0964	81
Francis Asbury Manor	1362	67
Workman's Circle Home	2063	78

SAMPLE FOR GOVERNMENTAL FACILITIES

FACILITIES SELECTED	PROVIDER NUMBER	NUMBER OF
Bergen Pines County Hospital	0281	651
Cumberland Manor	0651	196
Meadowview Hudson County	0903	440
Roosevelt Hospital	1252	290
Preakness Hospital	1651	432

CONVERSION TABLE OF CODES DESCRIBING PATIENT CARE NEEDS

All Patients	Assessment Item No.	Service		Minutes PPD
	-	Director of Nursing	4.20	
	-	Night Shift	30.51	
	-	Medications	14.70	86.39
	5.	Personal Hygiene	11.59	
	6.	Dressing	16.03	
	-	Meal Preparation	8.89	
	-	Miscellaneous Services	0.47	
As required	7.	Mobility Asst. = 1	add	26.75
	8.	Continence = 1	add	4.89
		= 2	add	31.36
—	9.	Feeding = 1	add	20.42
		= 2	add	57.17
		= 3	add	57.17
	10.	Necrotic Ulcer Care = Y	add	51.85
	11.	Turning & Positioning = Y	add	26.23
	12.	Tubefeeding = Y	add	57.96
	13.	Restraints = Y	add	21.60
	14.	Single Injections = Y	add	4.80
		Multiple Injections = Y	add	9.60
	15.	Ostomy Care = Y	add	7.04
	16.	Oxygen/Aerosol = Y	add	6.25
	17.	IV/Subcutaneous = Y	add	20.00
	18.	Suctioning/Trach = Y	add	14.82

PATIENT ASSESSMENT FORM

PATIENT NAME [ ] ASSESSMENT DATE [ ][ ][ ][ ]
LAST FIRST

FACILITY ID [ ][ ][ ][ ][ ] MEDICAID ID [ ][ ][ ][ ][ ][ ][ ][ ][ ] ASSESSOR ID [ ][ ][ ]

PERIOD COVERING: MONTH 1 [ ][ ] MONTH 2 [ ][ ] MONTH 3 [ ][ ]
MO. YR. MO. YR. MO. YR.

I. ADMINISTRATIVE DATA

1. Initial Assessment 0=No 1=Yes [ ]

2. Date of Admission or Conversion to Medicaid [ ][ ][ ] MO. DAY YR.

3. Date of Discharge, Transfer, Death, or Medicaid Lost or Denied [ ][ ][ ] MO. DAY YR.

4. Days of Home Leave Taken [ ][ ][ ] 1 2 3

II. ACTIVITIES OF DAILY LIVING
(Enter one code for each month)

5. Bathing 0=Independent 1=Dependent [ ][ ][ ] 1 2 3

6. Dressing 0=Independent 1=Dependent [ ][ ][ ] 1 2 3

7. Mobility 0=Independent 1=Dependent 2=Bed/Chair Confined [ ][ ][ ] 1 2 3

8. Continence 0=Independent 1=Dependent [ ][ ][ ] 1 2 3

III. SPECIAL SERVICES
(Enter number of days services are received for each month.)

10. a. Necrotic Ulcer Care [ ][ ][ ] 1 2 3

b. 0=Not present at admission 1=Present at admission [ ]

11. Turning and Positioning For a 24 Hour Period [ ][ ][ ] 1 2 3

12. Tubefeeding [ ][ ][ ] 1 2 3

IV. ADDITIONAL SERVICES
(Enter number of days services were received for each month.)

13. Restraints [ ][ ][ ] 1 2 3

14. a. Single Injections [ ][ ][ ] 1 2 3

b. Multiple Injections [ ][ ][ ] 1 2 3

15. Ostomy Care [ ][ ][ ] 1 2 3

16. Oxygen/Aerosol [ ][ ][ ] 1 2 3

Appendix C

DEPARTMENT OF HUMAN SERVICES

INTER-OFFICE COMMUNICATION

THRU: Ann Kohler

To: Thomas M. Russo

Date: February 24, 1983

From: James Bohan

Subject: Hours of Nursing Home Care

Please find attached the technical notes describing the sample design and corresponding statistical formulas used for the sample which determined the combined hours of care provided to level A and B patients. This is to be included with the material sent on February 22, 1983.

JB:jh

attachment

cc: Jed Spector

SAMPLE DESIGN

Two-Stage Stratification Sampling With Systematic Selection of Primaries With Probability Proportionate to Size (PPS)

Define:

N_h = No. of units in population in h^{th} stratum

n_h = no. of units in sample in h^{th} stratum

Y_{ijh} = Observation for the j^{th} subunit within the i^{th} unit in population in h^{th} stratum

y_{ijh} = corresponding observation in sample.

$i = 1, 2, 3, \ldots, n_h$

$j = 1, 2, 3, \ldots, m_{hi}$

M_{hi} = No. of elements in the i^{th} subunit selected in h^{th} stratum

m_{hi} = No. of elements sampled out of M_{hi} subunits selected in the 2^{nd} stage from h^{th} stratum.

Population Mean for i^{th} subunit for h^{th} stratum $= \bar{Y}_{hi} = \frac{1}{M_{hi}} \sum_{j=1}^{M_{hi}} Y_{hij}$

Sample Mean for the i^{th} subunit for h^{th} stratum $= \bar{y}_{hi} = \frac{1}{m_{hi}} \sum_{j=1}^{m_{hi}} y_{hij}$

Let $M_{ho} = \sum_{i=1}^{N_h} M_{hi}$, $m_{ho} = \sum_{i=1}^{n_h} m_{hi}$, $m^*_{ho} = \sum_{i=1}^{n_h} M_{hi}$

$Y_h = \sum_{i=1}^{N_h} Y_{hi}$, $y_h = \sum_{i=1}^{n_h} y_{hi}$

Mean Per subunit for h^{th} stratum

$\bar{\bar{Y}}_h = \frac{Y_h}{M_{ho}}$, $\bar{\bar{y}}_h = \frac{y_h}{m_{ho}}$, or $\bar{\bar{y}}_{h(PPS)} = \frac{1}{n_h} \sum$

98X

Mean Per Primary Unit for h^{th} stratum

$$\bar{Y}_h = Y_{h/N_h} \quad , \quad \bar{y}_h = y_{h/n_h}$$

$$M_o = \sum_{h=1}^{K} M_h = 31532, \quad k = \text{No. of strata} = 3$$

$$m_o = \sum_{h=1}^{K} m_h = 599, \qquad M_o^* = \sum_{h=1}^{K} \sum_{i=1}^{n_h} M_{hi} = 4131$$

$$E(\bar{\bar{y}}_h) = \bar{Y}_h, \qquad s_{hi}^2 = \frac{1}{m_{h-1}} \sum_{j=1}^{m_h} (y_{ijh} - \bar{y}_{ih})^2, \; \bar{y}_{ih} = \frac{1}{m_h} \sum_{j=1}^{m_h} y$$

$$\& \quad \hat{V}(\bar{\bar{y}}_h) = \frac{1}{n_h m_{ho}^*} \sum_{i=1}^{n_h} (M_{hi} - \ddot{m}_{hi}) \frac{s_{hi}^2}{m_{hi}} + \sum_{i=1}^{n_h} M_{hi} \cdot (\bar{y}_{ih} - \bar{\bar{y}}_h)^2$$

To calculate

$$\bar{\bar{y}}_{st} = \frac{1}{M_o} \cdot \sum_{h=1}^{K} M_{ho} \bar{\bar{y}}_h$$

$$\& \quad \hat{V}(\bar{\bar{y}}_{st}) = \frac{1}{M_o^2} \cdot \sum_{h=1}^{K} M_{ho}^2 \, \hat{V}(\bar{\bar{y}}_h)$$

M_{ho} = Total no. of secondaries in stratum h

M_o = Total over all strata = $\sum_{h=1}^{K} M_{ho}$

and 95% confidence interval for $\bar{\bar{Y}}$ is

$$\bar{\bar{y}}_{st} \pm 1.96 \sqrt{\hat{V}(\bar{\bar{y}}_{st})}$$

CALCULATIONS:

NON-PROFIT	GOVERNMENTAL	PROPRIETARY
$\bar{y}_h = 136.9522$	$\bar{y}_h = 139.0849$	$\bar{y}_h = 145.8412$
$\hat{V}(\bar{y}_h) = 129.5075$	$\hat{V}(\bar{y}_h) = 182.2596$	$\hat{V}(\bar{y}_h) = 19.9154$

i) $$\bar{y}_{st} = \frac{21174(145.8412) + 4868(136.9522) + 5490(139.0849)}{31532}$$

$$= 143.2926$$

= 2.39 hours = 2 hours 23 minutes

ii) $\hat{V}(\bar{y}_{st}) = 17.5920$

iii) 95% confidence interval for $\bar{Y}_{st}$ = Population Mean is

$$\bar{y}_{st} \pm 1.96 \sqrt{\hat{V}(\bar{y}_{st})}$$

(135.0718, 151.5134)

= (2 hours 15 minutes, 2 hours 32 minutes)

iv) 99% confidence interval for $\bar{Y}_{st}$ is

$$\bar{y}_{st} \pm 2.58 \sqrt{\hat{V}(\bar{y}_{st})}$$

(2 hours 12 minutes, 2 hours 34 minutes)

100X

DEPARTMENT OF HUMAN SERVICES

INTER-OFFICE COMMUNICATION

THROUGH Ann Kohler

DATE February 22, 1983

TO Thomas M. Russo

FROM James Bohan

SUBJECT Results From Study on Hours of Nursing Home Care Provided

---

The following is a synopsis of the results derived from the survey on nursing home care. The time study questionnaire was completed by Division staff. Design of the time study and the subsequent conversion of the completed questionnaire into hours of care for each sample patient was completed by Applied Management Sciences of Silver Spring, Maryland.

The combined average length of time for care administered to level A and B patients was determined to be 2.39 hours (2 hours 23 minutes). The period of time covered by the study was essentially December 1982. Under our present two-tiered payment system, the comparable average time for which we reimburse nursing homes was 2.14 hours (ie., during December, 1982). The hours of care as determined by the study represents a 12% increase over the average number of hours for which we presently reimburse nursing homes. This increase in hours of care does not mean there will be an equal increase in cost. Hours of care is only one component of the total per diem rate. The total rate or cost is comprised of other items such as administrative costs, fixed and variable costs, and type of nursing care provided.

Since this study is based upon a statistically valid sample, there is a sampling error associated with the estimated 2.39 hours of care. This sampling error was calculated to be 8.22 minutes, or 0.14 hours, at the 95% confidence limit. The sampling error is less than the difference between the hours of combined care estimated in the sample and the hours of combined care when determined under our current reimbursement system. The difference equals 15 minutes or 0.25 hours. This indicates that, statistically, there is a significant difference between the hourly rates of care aforementioned.

I have attached for your reference copies of the memos sent to Jed Spector which describe the sampling format, and a copy of the survey questionnaire developed by Applied Management Sciences. Technical notes on the sample design and statistical formulas will follow.

For your information, Applied Management Sciences has requested that they receive findings of this survey. I will initiate a letter for your signature upon your request.

Division of Medical Assistance and Health Services
Department of Human Services

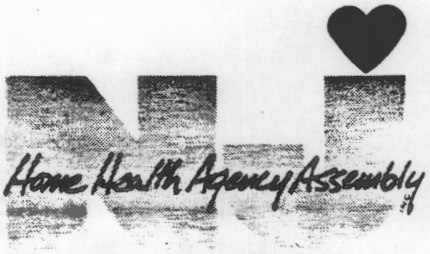
ANALYSIS OF TIME

The Division of Medical Assistance and Health Services' analysis of the statewide weighted average of the minimum number of hours worked required based on the present ICF-A and ICF-B hourly amounts is 2.14 hours. The statewide weighted minimum ICF hours per day has been determined as follows:

	% ICF At 6/30/82	X	Present Minimum Hours Work Required	=	Weighted ICF Hours
A	71.2%	X	2.5	=	1.78
B	28.8%	X	1.25	=	.36
TOTAL	100%				2.14

A breakdown of the 2.14 ICF standard hours per day is:

RN	.25
LPN	.12
Aide	1.77
TOTAL	2.14



Home Health Agency Assembly of New Jersey, Inc., 760 Alexander Road, CN-1, Princeton, NJ 08543-0001 609-452-8855

Testimony before the

Assembly Health and Human Services Committee

by

John Paul Marosy, Executive Director

Home Health Agency Assembly of NJ

November 17, 1986

Trenton, NJ

103x

Thank you for allowing me to speak today. I am John Paul Marosy, and I represent the Home Health Agency Assembly of New Jersey. Annually, our agencies serve 69,000 Medicare patients and 10,000 Medicaid patients. In recent years, we have observed with alarm a growing problem of unmet needs, especially in the Medicare program and most particularly among the chronically ill.

To begin, we observe that, in general, Medicare is failing to keep its promise to older Americans. Today, twenty years after the introduction of the Medicare program, older people are paying a greater per cent of their income on medical expenses than before Medicare's inception. There are a number of reasons for this phenomena:

. Health care costs have risen three times as fast as the cost of living.

. Deductibles and co-payments for hospital care have increased.

. There has been an increase in the amount between what the physician charges and the Medicare reimbursement rate, so that elders have to make up an ever-increasing amount out of their own pocket.

The most important point is that the Medicare benefit is limited and does not cover a number of significant medical needs. It does not cover eyeglasses, dental care, hearing aides, routine medical check-ups. And from our perspective, the greatest gap is that there is no coverage for the long term home care help needed by the elderly and disabled who suffer chronic illnesses.

The gap in coverage for chronic illness is the most significant factor in Medicare's falling behind in its promise to older and disabled Americans. Our population has aged in the last twenty years; and among the surviving aging, especially among those are the so-called "old, old", long term chronic illness is predictable. There is an increase in such debilitating illnesse

as diabetes, stroke, arthritis and Alzheimers disease.

The term, "No Care Zone", aptly describes the plight of seniors with chronic illness. Many chronically ill seniors need health care and social supports if they are to remain at home in dignity. Others need nursing home care. Under the current Medicare system, the only recourse for persons with these problems is to become Medicaid eligible.

In the last eighteen months, the situation has worsened in regard to home health care. Federal cost containment policies have restricted the use of the home health Medicare benefit by imposing new, more stringent interpretations for determining eligibility. For example, previously, nurses were allowed to make weekly visits to pre-fill the insulin syringes for blind diabetics living alone at home. Now Medicare no longer reimburses for such a home care visit.

In the short run, we feel that the State of New Jersey should provide increased funding for long term home care. Two bills now before the Assembly Senior Citizens Committee would do this: S.2132 and A.3177. In the long run, we need your help in our efforts to get the federal government to reverse these policies. This is our most pressing concern. We see a need to reform Medicare, to include in its design more comprehensive care. Chronic illness is a fact of life. Medicare's lack of coverage here is painfully inappropriate.

Thank you for your attention.

NJSHA

NEW JERSEY SPEECH—
LANGUAGE—HEARING
ASSOCIATION

Telephone: (201) 725-0660
120 Finderne Avenue
Bridgewater, New Jersey 08807

PUBLIC HEARING ON MEDICAID AND MEDICARE NOVEMBER 17, 1986

My name is Loreen Pretsfelder and I am a certified Speech-Language Pathologist licensed in the State of New Jersey. I also have a Masters Degree in Audiology. I serve as the rehabilitation coordinator for the Visiting Nurses' Association of Trenton. In addition I regularly provide Speech-Language Pathology services to medicare and medicaid patients in a variety of settings including patient's homes. I am grateful to the Assembly Health and Human Resources Committee for allowing me to testify on behalf of the New Jersey Speech-Language & Hearing Association, which represents close to 1,000 licensed Speech Language Pathologists & Audiologists.

As a professional who works with both medicare & medicaid patients every day, I am frustrated by the inadequacies of these two systems. The existing programs simply do not meet the needs of the communities they are attempting to serve. Speech-Language Pathologists & Audiologists treat medicare and medicaid patients. We typically serve patients who have suffered a stroke, experienced head trauma, undergone surgery for the removal of the larynx or voice box, or who have a hearing disorder or some other long term debilitating illness such as Multiple Sclerosis or Parkinsons Disease.

One of the biggest problems we face as practitioners is the arbitrary denial of services to patients. Whether we treat patients in their homes, or in the hospital, we have no clear guidelines for treatment eligibility. We often identify and treat a serious need, without ever knowing if that treatment is covered.

The claims reviewers often provide the wrong information. Their reviews appear to be wildly inconsistent. Medicare says that it reviews each claim individually; it appears that they deny each claim arbitrarily. We never know the criteria. When I explored some reviewers qualifications and background, I learned that they are not speech-language pathologists, audiologists or registered nurses nor are they trained in any allied health profession. Some claims reviewers have no more than a high school diploma.

106x

Some of the services that speech-language pathologists and audiologists provide seem to be misunderstood and undervalued by the medicare and medicaid systems. Several vital services receive no coverage or too little coverage. These services include swallowing or dysphagia training; hearing and aural rehabilitation (which aids individuals and especially the elderly with hearing impairment); and work with augmentative communication systems. Augmentative communication systems include construction and training to use special language boards or other systems used by multiple sclerosis and stroke patients and other nonspeaking persons.

In the hospital setting the Speech-Language Pathologist is the only person qualified to treat swallowing disorders.. Even this crucial service is not always covered in the home care setting. We are not even free to work with patients who are totally unable to speak! We are not allowed to work solely on augmentative communication, even if there is no hope of a patient ever speaking again! Medicare requires that evidence of progress in verbal communication before such services can be provided.

Audiology services are also too restricted under the present systems. Medicaid will not reimburse private practitioners for audiology in the home setting. The systen will, however, help pay for hearing aids if the testing is done in a physician's office or a hospital setting. This type of testing means considerable cost to transport the patient. Medicare, on the other hand, will not pay for a hearing aid or for any services related to acquisition of a hearing aid. Medicaid pays only for diagnostic audiological services.

The systems' coverage of long term care of patients with progressive diseases or post-stroke is also inadequate. We are typically allowed to treat a stroke patient for several months post-onset. Many stroke patients don't make any real speech-language recovery for three to six months after the stroke,and then recovery begins. The most pressing need for treatment occurs when we are no longer allowed to treat a patient. In the case of a patient with a progressive disease such as Parkinsons, the patient needs treatment immediately, and again periodically as the disease progresses.

Additionally the Alzheimers patient who lives at home or in an institution with no support from the system does not recieve the services that would improve their quality of life. The diagnosis of Alzheimers is typically a "red flag" for denial of services. In a home care setting, the Speech-Language Pathologist who is trained to help the patient and family communicate is prevented from doing so.

Thank you for allowing me to address the Committee about my concerns with the present medicare and medicaid systems.

Urban Dental Coalition
1 West Broadway
Paterson, NJ 07505

November 17, 1986

New Jersey State Assembly
Health and Human Resources Committee

The Urban Dental Coalition represents dentists who practice in the inner cities of New Jersey who accept patients under the New Jersey Medicaid Program. On July 9, 1986 our coalition received a Certificate of Appreciation for providing continuous, caring, and quality service to the Medicaid Program from Drew Altman, Commissioner of the Department of Human Services. We would like to bring certain facts to your attention and respectfully ask your help:

(1) As you know Governor Kean has recently signed legislation adding some 205,000 eligible patients.

(2) The number of dentists who accept medicaid has decreased by 17% in the past five years from 2,983 to 2,478 (see enclosed letter from Mr. Russo). Of this number only 156 dentists provided more than $10,000 in services during the past year.

(3) It is impossible to find providers in some geographic areas because of the poor fee schedule.

(4) Dental malpractice rates have increased 500% this year with a similiar increase projected for 1987. How can we be expected to extract a tooth for $9?

(5) Similarly dental supply and laboratory fees have risen dramatically. How can we be expected to restore a tooth with a two surface silver filling ---a thirty minute procedure --- for a fee of $13? This is far less than your auto mechanic charges on an hourly rate!

(6) The most recent issue of the Journal of the New Jersey Dental Association contained an interview with the current Dental Association President, Dr. Herbert Bressman. His comments regarding medicaid patients (see attached) require no explanation.

(7) We can provide many other examples of gross inequities if you request them. In 1974 medicaid reimbursement represented about 55% of the national median dental fee schedule. In the past twelve years we have received a fee increase of 8.3%. We now find that Medicaid reimbursement has fallen significantly below 50% of the median fee. We feel that it is unconsionable to ask providers to accept fees at this level.

(8) It is our inescapable conclusion that the situation we will be facing is a substantial increase in patient population coupled with a steady decrease in providers.

We desparately need a fee increase in order to continue to maintain a high level of dental care. We know that Thomas Russo, Director of Medical Assistance and Health Services; and Dr. Archie Bell, Director of Dental Medicaid, are sensitive to our problems.

We urge you to authorize and put into effect the medicaid fee increase which Dr. Bell has recommended. While it will not satisfy the problem it will at least demonstrate that the state is proceeding in a positive direction.

Sincerely,

Robert Russano, D. D. S.
Director, Urban Dental Coalition

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

ADMINISTRATIVE OFFICES
QUAKERBRIDGE PLAZA—BUILDING 7 & 5
QUAKERBRIDGE ROAD
TRENTON, NEW JERSEY 08619

ADDRESS REPLY TO
CN-712
TRENTON, NEW JERSEY

October 23, 1985

Robert O. Russano, D.D.S.
Urban Dental Coalition
1 West Broadway
Paterson, New Jersey 07505

Dear Dr. Russano:

On May 13, 1985, you wrote to me on behalf of the Urban Dental Coalition inquiring as to whether there has been a significant decrease in the number of dental Medicaid providers. I understand that Dr. Archie Bell suggested that we wait until the State fiscal year figures for 1985 became available and you agreed.

I am now able to provide you with a number of statistics which may help your study of Medicaid dental services. All statistics are derived from State fiscal year figures.

Dental Services

SFY	NO. RECIPIENTS TREATED	NO. PROVIDERS PARTICIPATING	TOTAL PAYMENTS
1981	NA	2,983	$21,570,814
1982	209,474	2,878	21,402,994
1983	202,000	2,828	21,498,131
1984	196,991	2,725	21,041,968
1985	187,316	2,478	21,384,013

I am sure you will find information provided herein satisfactory for the purpose req

We thank you for your interest in the Medicaid Program and invite you to submit your innovative ideas for our review.

Sincerely yours,

Thomas M. Russo, Director
Division of Medical Assistance
and Health Services

TMR:B1

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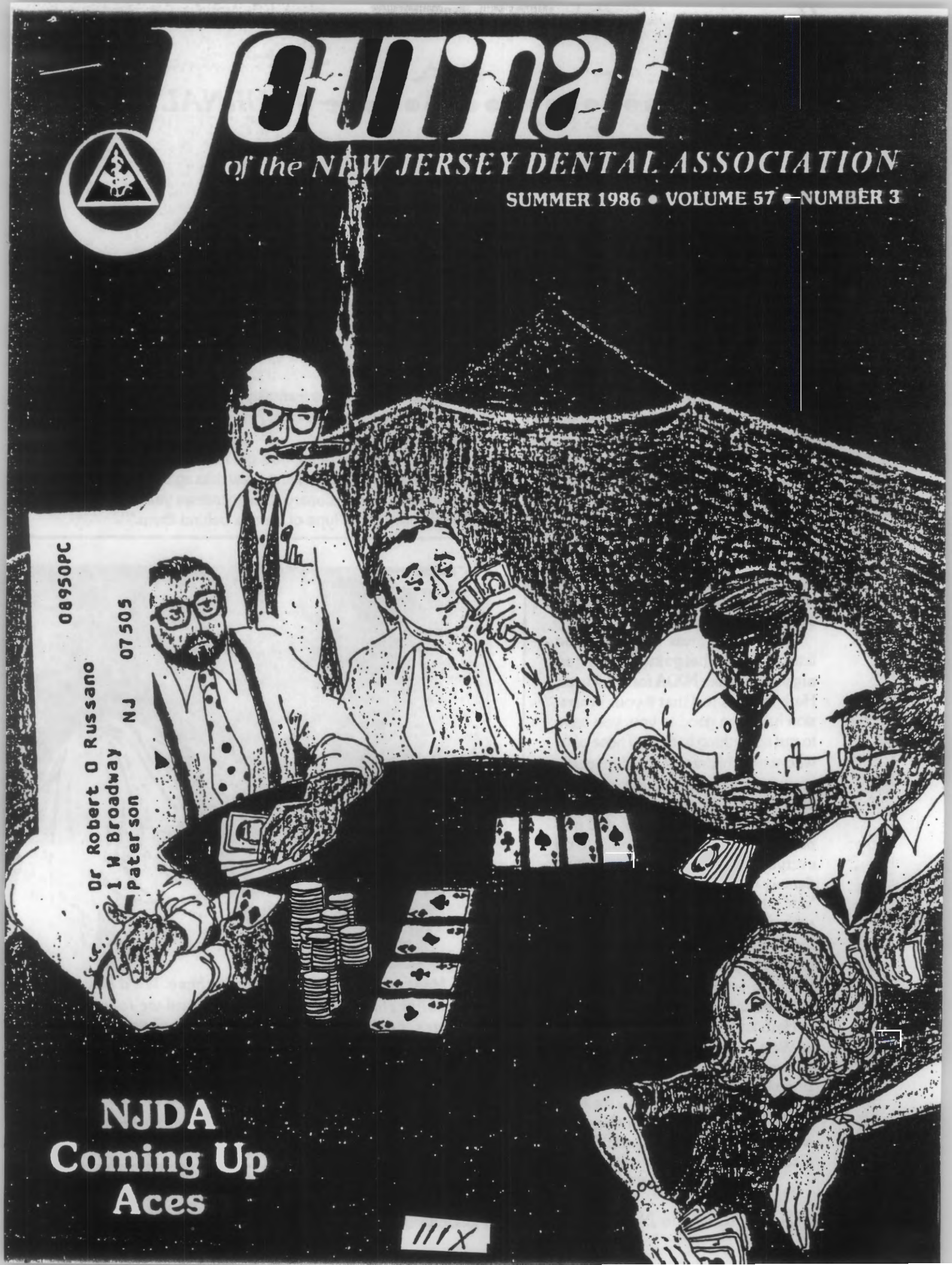
Journal
of the NEW JERSEY DENTAL ASSOCIATION

SUMMER 1986 • VOLUME 57 • NUMBER 3



NJDA Coming Up Aces

Herbert B. Bressman
NJDA President

A person of foresight, business acumen, understanding, warmth, adventu a family man, Herbert B. Bressman has a love of the dental profession an deep appreciation of the sacrifices made by his parents in giving him t opportunity to be a part of that profession.

■ "If you don't go forward, you fall backward . . .You have to forget the mentality of failure and look to success." Sou like a good inspirational motto for the new president of the New Jersey Dental Association and it's exactly the way H feels about life in general, as well as the New Jersey Dental Association.

Herb says, "I don't believe in living life without risks. You do nothing, you get nothing." Talking about the De Association, Herb says, "Somewhere along the line, we may have to start taking a few risks again. I don't know if now i time, but I just can't see going along with a continuing spiral of inflationary dues increases year after year. We hav conceive of methods that will have a minimal risk and some profit type of motive behind them."

The new president says, "With an Association and in your private life, you have to take a gamble. If you never gamble or venture forth, you'll be safe, but you'll never hit it big."

Of his willingness to expend the time and effort that go into heading an organization like NJDA for a full year, Herb says, "I feel that if your profession has been good to you, you have to put something back in. Those of us who were children of the depression know that our education was not easy to come by; that our parents sacrificed to send us to school and prepare us for the future. We have to do everything we can to leave a good dental profession to our children. I say 'our' children even though my two sons are anticipating careers outside the dental profession." He has a keen interest in young dentists and says he wants to see "young, bright people involved in the Association."

Herb and Sherrill met on the beach at West Hampton and were married 21 years ago next Thanksgiving. Sherrill is one of only nine realtors in Middlesex County to receive the Presidents' Club Award from the New Jersey Association of Realtors. She is also one of the 139 realtors in

Continued on next page

". . . Most of us appreciate what we have. We'd like to see the profession stay viable for the future and we're willing to pay our dues, both moral and financial. All of us are, in a sense, trying to pay back for a good life, a good professional life. Many of us had parents that brought us up during the depression years and we realize the sacrifices they made for us. Although our lives have probably been a lot easier, we'd like to leave a profession to the future, for our children and others, that they can be proud of."

JOURNAL: ***Let's talk about some of the other programs that we have that are on back burners. What are your plans for Outreach during the coming years? How do you think it can be made more effective?***

BRESSMAN: If the amount of money that we put in the budget passes our House, then we should start actively going forward. We have a new director in Dental Care. He's just getting his feet wet in that field and we have to start making contacts. We have to try and go forward with direct reimbursement within the same financial restraints.

JOURNAL: ***What do you think is on the horizon for New Jersey for direct reimbursement? How do you see it, do you think it's going to materialize?***

BRESSMAN: Direct reimbursement is not a cure-all. It's one way to go. It's an approach for smaller companies that have not had insurance. I don't think we can look at direct reimbursement as a replacement for the various types of insurance plans that we have. It sounds great, but when we try to put it into application, it usually means less in benefits or more caps. When we tried in terms of using direct reimbursement for our own staff at NJDA, we found out we were coming up with less in benefits and this becomes a problem when you have a plan already giving better benefits. It could be a starting point for companies that have not had benefits and there are many small companies that just can't afford bigger programs. So, it's a two-sided sword in some aspects. It has to be explored and it has to be explored carefully. I definitely applaud direct reimbursement in the cases where it would be applicable. But, looking at it as a panacea? It isn't.

JOURNAL: ***Let's touch on Peer Review. Let's ask the same questions asked of Chet Kulak (1982): "What do you think the future for Peer Review is? At this point, it's not mandatory. Do you think we have a viable program without a mandatory Peer Review System?"***

BRESSMAN: I have always thought that a mandatory Peer Review Program would be a good program. But with some of the recent legal decisions in various states that have involved the Peer Review System, there are definite possibilities that the Peer Review System may be wiped out. It may limit the confidentiality of the program. We'd have a lot more credibility if it was a mandatory type of program. But right now, it's premature to even go in that direction until we see what's happening around the country.

JOURNAL: ***Peer Review makes me think in terms of a state board. What would you propose in your administration as far as relationship between NJDA and the State Board of Dentistry?***

BRESSMAN: Well, I would certainly look to see improved relations. In the last few years, I've always had the feeling I am sitting there as an adversary and I really think our goals are the same — the protection of the public, and I don't think there should be an adversarial relationship. I would certainly like to see a much better relationship and I do think I would also like to see a State Board that has more help from the Attorney General. They are supposed to be getting more Attorney General help with the new increase in our registration fee. They're overworked in the sense that they can't accomplish a lot of things that they're supposed to be accomplishing. A lot of complaints that are valid are just put off for too long as they get bogged down with other matters.

> ***". . . Expanded duties have been tried in more than one state. They have not been totally successful. There have been states that have had expanded duties and have reverted back to less expanded duties. With the problems that we're having in finding dental assistants in general, it's very rare to find that many people that are even qualified to do expanded duties."***

JOURNAL: ***Okay, let's talk about another state agency. NJDA has been meeting with the Medicaid officers. Have you been at those meetings and what do you think the role of NJDA in the Medicaid program should be?***

BRESSMAN: I personally have not been at any of these meetings with Medicaid. I know Archie Bell and I know they've enlarged their consultant staff as they are expecting more people in the program. The Medicaid program has a big problem. The fees have stayed basically the same for years and years while the cost of dentistry and our office overhead has gone up. Many members would like to take Medicaid patients, but they find that they can't do proper dentistry at those fees. In my own office, years ago we used to take quite a few Medicaid patients and we were able to do pretty fine dentistry for them. It has gotten to the point where our laboratory costs for crowns are almost the cost of what Medicaid would pay us and it just became financially impossible to do it. We've had less and less

Continued on next page

". . . I don't believe in the reduction of supervision to the point where dental hygienists might be permitted to treat patients in an office without the presence of a dentist. I think, especially in this era of malpractice crisis and the escalating malpractice cases, the buck stops at the dentist. The dentist should be the person with the final responsibility in the office. The dentist should be supervising everything and checking everything. It is our legal responsibility; it is our educational responsibility. A hygienist was trained to be a hygienist and to do that job. They are wonderful adjuncts in the office, and that's what they should be, part of the staff."

Medicaid patients in our office and we find that we can only maintain most of the older patients who continue to come. We don't encourage people to come. We don't turn them away if we can treat them, but there are cases that we just can't treat. You'll find that most Medicaid patients have periodontal problems and I know of no specialists that would accept a Medicaid patient for periodontal treatment. It puts great restraints on the practitioner. The practitioner is getting basically to the point where he says if I'm going to extend charity, let me pick the patients. So it's a big problem and unless more funds are available and the fee schedule is increased, basically you're going to see the patients treated in the large Medicaid-type of practices.

JOURNAL: ***You mentioned before that the New Jersey Delta Service Plan helped us tremendously in the Impaired Dentists Program. But, we've also had a recent problem with Delta and that's with their alternative delivery system, a capitation program, Flagship. How do you feel about this and the role of NJDA and you, as president, in dealing with Delta?***

BRESSMAN: Basically, I can understand where Delta is coming from. They felt the need to be more competitive in the marketplace. You have to understand that I treat Delta at this point as another insurance company. At one time, the relationship was different. We, in a way, financed it with out contributions but we are separate organizations. Delta has done a lot of good things. They're usual, customary and reasonable concept and filing of fees have made a lot of the other insurance companies responsible and kept them in UCR when they may have gone into other modes of insurance. At a certain point, Delta felt threatened as far as losing its groups, and they felt they had to offer something different. I don't have a problem with it as long a the members themselves understand what these programs are and what they're getting into when they go into a program like that. Unfortunately, a lot of our members don't read everything. We cannot go out and say do this, do that, or join this or join that. Everyone has to make a decision on their own. We can give them information. We can give them statistics, and if someone feels that is the way they want to practice, that's their individual decision to make. Even Delta feels that way. I don't think Delta wants every participating dentist to be in their capitation program. They probably want enough to be a viable entry in this field. Whether they will, I think only time will tell. Under the stress of the busyness problems that dentists have had in the past, they make strange decisions. I hope our members will carefully consider before making their decision. I certainly would not tell any dentist how to run his practice. I would just say, read carefully, talk to an attorney, know what you're doing and make sure that you know what the end results will be.

JOURNAL: ***You mentioned that you look at Delta as a separate business, as a separate insurance company. Are you planning anything to improve our relation-***

Gertrude B. Brundage, M.D.
572 Park Avenue
East Orange, New Jersey 07017

November 12, 1986

The Honorable Harold L. Colburn,Jr., M.D., Chairman
Assembly Health and Human Resource Committee
CN-068
Trenton, New Jersey 08625

Re: Nov. 17, 1986
Medicaid Hearing

Dear Assemblyman Colburn:

First my apologies for not being there in person to present this paper. As you will understand by the time I finish, I cannot afford to take a day off from my practice these days. My plight may be a bit atypical - there are few physicians who could, or would, practice under these circumstances.

I entered practice in 1975 - I am a Pediatrician in East Orange - hoping to be a positive influence in that rather troubled city. About 50% of my patients are on Medicaid. I do not run a "Medicaid Mill," but see between 20 and 30 patients a day. No patient is turned away because of method of payment or coverage, and <u>all</u> patients are treated equally, to the best of my ability. This is the way I understood Medicaid was set up to be - to enable the poor to obtain the same quality of medical care as the rest of our society, and I have tried to carry out that principle in my practice.

Pediatricians deal with children and their parents - in my practice most often there is only one parent, a teenage mother, inexperienced, almost a child herself. A great deal of time is

required to teach the mother to care for her child, how to feed, bathe, clothe and nurture her child - all very time-consuming, but necessary if conditions are to be improved. When I first entered practice in 1975, Pediatricians were being paid $8.40 for an office visit. Now, eleven years later, we are being paid $9.00. I do not need to remind you what has happened to the economy in the intervening years. No one has imposed a freeze on the costs of running my practice. I have prepared a chart to illustrate what has happened to my expenses from 1978 through 1985 (see Fig. 1 page 5.) Lest you think that I am spending too much on a flashy, expensive office, let me say that mine is a "bare bones" practice. I have one full-time worker who serves as receptionist, secretary, insurance clerk and general helper, and one part time person, when I can find one, to help Monday evenings and Saturday mornings. I do my own laboratory work, laundry and bookkeeping. My fees are modest ($23.00 for a regular office visit as of January 1, 1986)- they have to be if I am to remain in East Orange and serve that community. Those who do pay their own bills cannot afford high fees, and would not be able to come to my office if my fees were much higher. I believe the data in Fig. 1 speak for themselves. While my fees have risen over the years, so have my expenses. Medicaid payments on the other hand have been fairly static (Fig. 2) from $18,600 in 1979 to $21,600 in 1985. Most of that increase can be attributed to increases made by Medicaid to cover the escalating costs of immunizations -increases which were late in coming and too small.

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The cost of a vial of DPT has risen from $2.50 to $170.00. From 1978 to 1985, the years for which I have data, treating Medicaid patients has cost me approximately $112,000.00 - that is the difference between my regular charges and what Medicaid has reimbursed me for the care I give my patients. At present my yearly net income from my practice is about $17,000. How many professionals can be expected to accept that kind of a return? I spent 25 years in education and a lot of hard earned money to become a pediatrician. I do not ask to be rich, but I do need to make a living. I currently am living with my father, - I would have a very difficult time renting or owning my own residence. I have no dependents. If I did, I simply would not be able to continue in my practice, and I don't think I will be able to do so very much longer unless there is some change in Medicaid reimbursement. Good doctors are being driven away from serving the poor by the economic realities of today. Those of us who try to continue, must practice in dangerous environments. I have been mugged (see footnote Fig. 1 for 1978) and my office has been burglarized 3 times. I have even been robbed by people in my office while I was seeing patients - I now remove valuables from my purse and lock them up during office hours. We also have to lock up the typewriter each night - I have had to replace it twice now -the police just shrug and say I'm lucky it isn't more often. I only remain because I feel a deep committment to the work I am doing. I can't move to a safer area without abandoning my

patients as there is no convenient transportation for people who don't have cars. Some of my patients must take 2 buses as it is. Fewer and fewer doctors are willing to take Medicaid patients today, placing more of a burden on those of us who remain. It is very hard to obtain qualified referral services for Medicaid patients. Surgeons and ENT specialists who do take my patients do so more as a personal favor to me but refuse most others. We will not be able to continue much longer. It is becoming almost impossible to pay my bills. My accounts payable are a nightmare. I believe I practice a high quality of medical care for my patients, and I would like to continue to do so. Unless Medicaid fees to physicians are increased to a reasonable level, I will not be able to do so, and neither will other doctors. The real losers will be the poor, who will again be forced to seek such care from dreary clinics and medicaid mills where numbers are more important than people and little health <u>education</u> is accomplished. Better health care for the poor can have far-reaching benefits for all society. <u>Good</u> doctors are needed to make this come about. The present fee schedule makes this next to impossible. I implore your committee to consider this in your deliberations, and thank you for your time.

Sincerely yours,

Gertrude B. Brundage, M.D.

Gertrude B. Brundage, M.D.

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FIGURE 1.

INCOME AND EXPENSES

Year	Total Bus.	Total Cash Received	Expenses	Net
*1978	53,543.63	39,616.48	20,464.56	19,151.92
1979	73,304.00	49,696.21	29,775.79	19,920.42
1980	78,558.00	62,831.30	32,908.25	20,928.05
1981	78,564.00	63,355.07	41,860.01	21,495.06
1982	81,547.50	59,782.72	41,823.40	17,959.32
1983	94,838.50	65,523.09	44,547.32	20,975.77
1984	97,626.50	68,189.72	50,995.59	17,194.13
1985	94,704.00	67,880.07	51,636.27	16,243.80

FIGURE 2.

COMPARE MEDICAID TO INCOME

Year	Total Bus.	Med.Charges	Med.Pymts	Med.Deficit
1978	53,543.63	19,535.70	14,293.86	5,241.54
1979	73,304.00	28,308.10	18,672.66	9,641.94
1980	78,558.00	35,389.28	25,129.36	10,227.62
1981	78,564.00	30,909.02	19,487.23	11,421.79
1982	81,547.50	34,241.00	18,508.90	15,832.10
1983	94,838.50	45,233.50	20,903.55	24,329.92
1984	97,626.50	41,514.03	22,746.15	18,722.58
1985	94,704.00	38,627.60	21,637.14	16,982.46

* Out of work for 9 weeks after suffering two broken arms during a mugging at my office one Saturday A.M.

Family Planning Advocates of New Jersey

132 West State Street
Trenton, New Jersey 08608
(609) 393-8423

Testimony submitted to the Assembly Health & Human Services Committee to be added to the record of the Public Hearing on Medicaid & Medicare, held November 17, 1986.

Family planning providers in New Jersey are as concerned as other health care providers about the low rates of Medicaid reimbursement inn New Jersey and its impact on the health of our poorer citizens.

It is particularly shortsighted of the state not to reimburse for the full cost of providing family planning services, when the federal Medicaid program will reimburse 90% of the costs for family planning services.

At the present time, the statewide of network of 25 organized family planning providers is serving approximately 13,500 women on Medicaid annually. The 20 free standing agencies serve 10,000 of these women, at flat rates set for the clinics by the Division of Medical Assistance & Health Services of the N.J. Department of Human Services. Five other programs are hospital based and are reimbursed at rates calculated for each hospital based on their actual cost for outpatient services.

The standard rates set for the clinics covers less than 30% of the cost of serving these women. Other state, federal, or local funds are currently being used to subsidize services to women on Medicaid, at the expense of other women in need of services under the poverty level who cannot afford to pay, and who cannot, under the rules of the major federal funding program meant to serve them, be charged fees either.

As we pointed out above, the federal reimbursement rate for family planning is 90%. Thus, for a relatively modest increase in state expenditures (about $80,000), New Jersey would receive more than $700,000 to cover the full costs of providing care to the Medicaid group, and free up that much of other funds to serve other poor women.

Currently, the organized family planning providers in the state are serving less than 30% of those estimated to be at risk of an unintended pregnancy and in need of free or subsidized family planning services. To help reach more of those women, we strongly recommend that in addition to increasing the present reimbursement rates, that the Medically Needy program be expanded to provide coverage of family planning services for adult caretakers of dependent children. To do so would require no additional eligibility determination. It makes no sense to provide care for pregnant women who are categorically and income eligible, and not for those trying to avoid pregnancy -- particularly when a 90% federal match is available.

The relevant cost data is summarized on the next page.

New Jersey Medicaid cost data for family planning services in freestanding clinic:

Average annual Medicaid reimbursement at clinic per woman	=	$30.96
(at current reimbursement rates) x 10,000 women served	=	$309,690
federal share (90%)	=	270,864
state share (10%)	=	30,096
Actual cost to clinic of service, per woman per year	=	$110
(if rates raised to cover costs) x 10,000 women served	=	$1,100,000
federal share (90%)	=	990,000
state share (10%)	=	110,000
Increase stated funds required	=	79,904
Increased federal funds received	=	719,136

Current freestanding clinic reimbursement rates:

$25 = initial or annual visit
$10 = medical revisit
These fees include provision of the contraceptive method chosen (diaphragm, cycles of oral contraceptives, foam, condom) with exception of the IUD, for which $10 additional is provided. There are various other smaller fees provided for other services and lab tests.

GARDEN STATE PHARMACY OWNERS, INC.

December 9, 1986

TESTIMONY FOR
THE ASSEMBLY HEALTH AND HUMAN RESOURCES COMMITTEE

By William Weinert, Executive Secretary
Garden State Pharmacy Owners, Inc.

As Executive Secretary of the Garden State Pharmacy Owners, an association of nearly 400 independent New Jersey pharmacy owners, I am pleased to submit this testimony for your consideration. The testimony examines the impact of the medicaid and medicare programs on the delivery of health care to our patrons from our perspective as community pharmacists.

Local pharmacies are concerned citizens in their communities and they play an increasingly critical role in the state's health care delivery system. Health care costs in New Jersey have spiraled out of sight. In 1981, New Jersey's annual health care expenditures reached $6.8 billion and those expenditures have risen steadily since.

Many factors have contributed to the escalation of health care costs. Nationwide, our population is aging and here in New Jersey we have attracted an increasing share of those individuals over 65. In fact, the size of New Jersey's over-65 population ranks second only to Florida's.

122x
156 Paris Avenue Northvale New Jersey 07647 Telephone 201 768-7373

To control the escalation, New Jersey instituted the Diagnosis Related Group (DRG) Program. DRG's have limited medical costs partly by shortening the length of hospital stays.

These two trends, shorter hospital stays and a growing population of senior citizens, have made home health care an increasingly important dimension of New Jersey's health care delivery system. Home health care is especially important to the aging and poor served by the medicaid-medicare systems.

Community pharmacies are critical to the success of home health care. In most geographical areas, we open early and we can stay late. We deliver medical supplies to house-bound invalids, and we offer charge services to our customers. We stock the medical equipment patients need to recover from surgery at home. We provide the professional advice people need in a hurry. We supply the drugs, equipment and support older people need to remain independent.

In addition, prescription drugs are the most cost-effective type of health care. New drugs, even if very expensive, allow more people to avoid surgery, nursing homes, and hospitalization, and help to prevent many other severe debilitating diseases, such as heart attacks and strokes.

Despite its imperfections, the system developing in this country to deliver medical care to American citizens

continues to be the best in the world. I take considerable pride in the community pharmacist's role in this system. We are a high-quality, cost-effective link in the system.

Tragically, many of the high-quality, cost-effective services provided by community pharmacies are not uniformly available to medicaid patients across the State. Especially in poor urban areas where many medicaid patients live, there are too few community pharmacies. Those pharmacies that do survive cannot provide the same services that their suburban counter-parts can. In areas where the crime rate is excessively high, for example, pharmacy-owners cannot provide delivery, charge-accounts, or late night hours.

There is an additional 9-cent impact fee (over and above the regular dispensing fee) provided by the medicaid system to compensate community pharmacies that serve the State's poorest communities. Although this amount was increased a few years ago, it is still much too low. I strongly urge you to consider increasing the 9-cent impact fee to help the surviving urban pharmacies. A fee increase would provide urban pharmacy owners with the measure of economic stability they need to more fully serve the medicaid patients in their communities.

A similar problem is caused by the special pharmaceutical needs of medicaid patients who are aging and/or are sick with multiple illnesses. Such patients often

require special compounds that take excessive time to prepare, and a high-cost inventory of drugs in stock for their needs. (Some infrequently dispensed medications can cost hundreds of dollars per order.) Regretfully, unlike other third party programs, there is no special add-on medicaid fee to cover the inventory expense of stocking high-cost drugs or to cover the time taken by special compounding.

Some medicaid patients are probably now inconvenienced searching for pharmacies economically healthy enough to stock high-priced drugs and staff a special compounding service. To help make these services more widely available to medicaid patients, there should be an add-on fee for compounding and an additional fee for stocking high-cost drugs.

Finally, in order to better serve the needs of medicaid patients everywhere in New Jersey, community pharmacy owners need a basic dispensing fee increase. In 1982, Myers and Stauffer, an independent accounting firm, determined that the average dispensing fee in New Jersey should be $3.95 per prescription. Since 1982, the Legislature has increased the dispensing fees in stages. Each increase has taken us a step closer to reaching the Myers and Stauffer 1982 estimate for a fair and equitable dispensing fee. The current fee is $3.72, still below the level recommended four years ago.

We know that in the four years since 1982 the variables have changed significantly. This year the Department of

Human Services again commissioned Myers and Stauffer to conduct a survey, which is now complete. Its final report has been submitted to the Department of Human Services, and we're confident that the new survey's results will document a need for a dispensing fee increase.

The impact of a fee increase upon pharmacy owners as individual small businesses providing medicare-medicaid services would be significant. Under the current dispensing fee reimbursement, the 1,600 community pharmacies in New Jersey are still losing millions of dollars. These losses weaken the financial stability of our small businesses, and weaken our role as a high-quality, cost-effective link in the home health care system.

Theresa Grotta Center For Rehabilitation

20 SUMMIT STREET, WEST ORANGE, NEW JERSEY 07052 (201) 736-2000

November 3, 1986

The Honorable Harold Colburn, M.D.
General Assembly, State of New Jersey
223 High Street
Mt. Holly, New Jersey 08060

Dear Assembly Colburn:

I am aware that the Assembly Health & Human Resources Committee will be holding a public hearing on the impact of both Medicare and Medicaid on November 11, 1986. As I have a prior commitment that will necesitate my being out of town, I wish to share with you my comments and thoughts in a written format and hope you will find them both informative and useful.

Thank you for the opportunity to present my comments and for your courtesy in reading the enclosed.

Sincerely yours,

Robert Meyers, FACHA
Executive Director
THERESA GROTTA CENTER

RM/pb

Enclosure

cc: Craig A. Becker, Vice President
NJHA, Government Relations

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"NEW JERSEY AND YOU"

I am the Executive Director of a 142 bed rehabilitation center which additionally is licensed as a skilled nursing facility, like many facilities throughtout the State of New Jersey, a non-profit, community health care agency, organized in 1916 to provide for the health care needs of our immediately surrounding populas.

On January 16, 1986, Governor Kean signed legislation to provide higher Medicaid reimbursement rates to all County and State administered long-term-care institutions in New Jersey.

There is no question that the county and state run nursing homes are in need of additional Medicaid reimbursement. One could argue that to give one group of nursing homes higher Medicaid reimbursement is discriminatory to the other non-profit nursing homes that suffer from a lack of adequate Medicaid financing. To simplify a very complex reimbursement formula, there are three levels of Medicaid reimbursement to nursing homes which I will call one, two and three. The differences are in terms of the amount of resources that a patient utilizes based on severity of need. The maximum rate that the state will pay us*, regardless of our certified cost is $73.00 per day for the highest level, $70.00 per day for the mid-level, and $53.00 per day for the lowest level of care. I have taken the liberty of averaging these three various levels of reimbursed care to arrive at an average of $65.00 per day. For example, within the complex Medicaid reimbursement formula is a maximum, the state will reimburse for nursing care as follows:

Level 1	1.25 nursing hours in a 24 hour period
Level 2	2.50 nursing hours in a 24 hour period
Level 3	2.75 nursing hours in a 24 hour period

This formula covers nursing care hours, including Registered Nurses, Licensed Practical Nurses and nursing assistants. Within this unbelivably low time permitted, patients need:

dressing changes
medications, charted and administered
baths, showers, and washing up
assistance with meals
bladder and bowel training
copious record keeping (State required)
checking on IV's tubing etc.

with no time for psycho-social interaciton or "a moment to inquire about a patient's health."

The Theresa Grotta Center for Rehabilitation's actual certified cost of a Medicaid patient is $82.00 per day, or a short-fall of $17.00 per day. Taking this $17.00 and multiplying it by the number of Medicaid patients (35) and multiplying this by 365 days per year, there is a Medicaid short-fall over cost of more than $217,175.00 a year.

This short-fall is made up in three general ways.

1. It is made up through contributions, generously given, by our Board of Directo and Board of Governors.
2. It is made up by various fund-raising efforts, including the Jewish Federation of MetroWest, which give generously along with "United Way", to help support patients at our Center who can not pay for the cost of their care.
3. By patients paying privately. (Cost shifting)

*as of 1/1/86

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On Friday, March 29th, a lead article by Ronald Sullivan titled "Three Are Charged With Soliciting From The Aged", was published in the Metropolitan Section of the New York Times, (see attached copy). The villain in this situation is the state controlled and approved Medicaid reimbursement formula. A federal amendment called the Borem Amendment mandates all long care facilities in the nation received "adequate" reimbursement as long as they operate both efficiently and economically. If I were to extrapolate the Medicaid short-fall as described earlier for the Theresa Grotta Center and apply that to the Hebrew Home For The Aged, the formulas shown on the first page of this letter will indicate the potential short-fall of Medicaid income. Quoting from this article that there are 90% of the patients on the Medicaid program, I will take the 90% of their eleven-hundred patients, multiply that by 365 days a year which results in 361,350 Medicaid patient days. If the short-fall in New York State was similar to my own facilities' experience of $17.00 per day, that provides a deficit to the Hebrew Home of more than $6,142,950.00. With all due respect, I ask you how this short-fall can be made up? The amount of funds available through the Board and Fund-Raising activities are somewhat limited. It is the inadequacy of the Medicaid reimbursement in the first place that results in a prestigious, well intentioned, and well run long-term care institutions in the State of New York to "stoop to requiring contributions from families" in order to just simply servive. As non-profit facilities, their goal is to take care of their patients, both present and future, and one wonders with the inadequate reimbursement system how this can be done.

Having twenty years of experience in the acute care hospital field in New Jersey, I can not help but think of a parallel situation that existed in hospital reimbursement which was correctly identified and remedied by this same legislative body. Until 1981 there was something called cross subsidization of payment for hospital bills. What this meant was that if one category of payor did not pay their full share or there was reimbursement for indigent patients, the other payors were charged more than their "actual cost" to make up for the short-fall. The legislators and the Governor saw fit, and correctly so, to change the method of reimbursement of all the acute care hospitals in out State to what is now called an "all payor" system. Briefly stated, all various types of payors, be they Medicare, Medicaid, Private Pay, Commercial Insurance, Workman's Compensation, etc. all are charged and all pay the same "exact" amount of reimbursement for each illness category as the others.

To summarize, while the State and County homes do need more reimbursement, there are community based non-profit agencies that also require higher reimbursement. The fact that there is this discrepancy in the maximum that the Medicaid program will pay is a sad "state of affairs" for a "state" that has already identified the unfairness in a paralled hospital system.

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3 Are Charged With Soliciting From the Aged

By RONALD SULLIVAN

Two of New York City's most prominent nursing homes and three of their officials were indicted yesterday on charges of soliciting $55,000 in contributions in return for admitting Medicaid patients.

The special state prosecutor for Medicaid fraud, Edward J. Kuriansky, said the chief fund-raiser for the Hebrew Home for the Aged at Riverdale in the Bronx and the executive director and the fund-raiser for the Menorah Nursing Home in Brooklyn had been indicted by grand juries in the Bronx and Brooklyn on charges of illegally soliciting contributions from the relatives of patients seeking admission.

There was no allegation that any official from the two nonprofit homes took any funds for personal profit.

The indictments were the first brought under a 1982 state law that made such solicitations a felony.

Wrongdoing Denied

"... economic exploitation of the elderly indigent and their families — whether with noble or ignoble intention — will simply not be tolerated any longer in New York State," Mr. Kuriansky said.

He said the illegal solicitations extended "well beyond" the two indicted nursing homes and that the investigation would continue.

The homes — widely regarded as two of the best in the city — denied any wrongdoing and promised to contest the charges in court. They denied that contributions were a condition of admission.

As with most other nursing homes in the city, the care of more than 90 percent of the two homes' patients is covered by the Federal-state Medicaid program for the poor.

Because the most desirable nursing homes, especially those with religious affiliations, have long admission waiting lists, a state investigation in 1981 found a pattern [illegible] institutions of seeking contributions as a condition of admission.

What the Law Says

That investigation, organized by Mr. Kuriansky, led to the enactment of the 1982 law making it a felony to solicit any gift, money or donation as a condition for admitting or expediting the admission of a Medicaid recipient.

Named in yesterday's indictment were Shirley Windheim, the executive director of Menorah, and Barry Gradman, the home's development director, and James Leest, the Hebrew Home development director.

The grand jury said that last summer Mr. Leest solicited and accepted $20,000 from an undercover agent posing as a relative of a Medicaid patient to expedite and insure the patient's admission to the 1,200-bed Hebrew Home.

Miss Windheim and Mr. Gradman were charged with soliciting $25,000, of which $12,500 was received, from an undercover agent. Mr. Gradman also was charged with soliciting $10,000 a year ago from a patient seeking admission to the 520-bed institution.

The defendants could face up to five years in prison if convicted. Each home could face civil penalties of up to $15,000.

1.30-X

Teresa Grotta Center For Rehabilitation

20 SUMMIT STREET, WEST ORANGE, NEW JERSEY 07052 (201) 736-2000

November 11, 1986

The Honorable Harold Colburn, M.D.
General Assembly, State of New Jersey
223 High Street
Mt. Holly, New Jersey 08060

Dear Assemblyman Colburn:

Enclosed please find further comments regarding health care coverage. Also enclosed are two articles on Medicare that are quoted in my comments.

If I can be of any further service, please do not hesitate to contact me.

Sincerely,

Bob Meyers/pb

Robert Meyers,
Executive Director

RM/pb

Enclosure

MEDI (NON) CARE, MEDI SCAM OR THE "HOAX OF MEDICARE COVERAGE"

The Medicare law as it applies to Rehabilitation Services for those over the age of 65 was written in 1966 and substantialy there have been no changes to the law in the past twenty years.

Three major changed interpretations of the regulation did take place, and they are as follows:

1. Medicare no longer pays with a blank check for all expenses occured; to this I say bravo, and Medicare was quite correct.
2. Medicare no longer pays for the number of days of coverage as they did in the past; for this I do not say bravo. and
3. While Medicare did pay for many diagnosis of rehabilitative care, at this point the numbers of diagnosis that are covered are sadly inconsequential.

In a recent publication by the New Jersey State Department of Health, it states on page 9 in "New Jersey Guide To Selecting A Nursing Home", that Medicare pays for less than 1% of all long-term care costs in the State of New Jersey.

To simplify a very complex Medicare reimbursement system, the Federal Government does not deal directly with providers of care. They do contract with an insurance company, such as Blue Cross or Prudential, to act as the fiscal intermediary between Medicare and the patient. Congressional Hearings have stated these fiscal intermediaries are hired on a quota system. Clearly there is pressure for Blue Cross, in our case, to cut, cut, and cut desperatly needed services to our senior citizens.

The insidious reduction of coverage by Medicare can be seen by the below listed simple numbers:

In 1972, out of 142 licensed beds, 130 patients on any given day were covered by the Part A (in-patient) benefits of the Medicare law for either skilled nursing or skilled rehabilitation services. Today, as I write, there are six patients covered for part A coverage. Let me repeat, I did not say that there were sixty or sixteen, I said six out of the 142 beds, or stated as a percentage, the number of Medicare covered patients in 1975 was 90%, compared to 1986 where the number of Medicare patients for th number of licensed beds has a percentage is 6%.

Sadly, at a time when the D.R.G.'s are allegedly sending out Medicare patients "quicker and sicker" the same Medicare program which in the past had covered them for post-hospital care for either skilled or rehabilitation care is also reducing, in dramatic and drastic numbers, those patients that they are willing to pay for as well as severly limiting the number of days paid for, if in fact they consent to pay anythi

The situation has gotten so dreadful that the followino attached articles, one titled "Medicare Group Spreads the Word: Appeal" - states that more than 80% of Medica recipients who have been denied coverage for part A are successful in theis appeals an the second article titled "Aid Voted On Challenge Of Medicare", clearly depicts the New Jersey Senate is in the process of establishing a state funded program to provide legal aide for Medicare patients that have been denied benefits improperly. This bill S-2484, passed the Senate by a vote of 33 to 1, and is presently in the Assembly for their consideration; according to Senator Frank Pallone, "In some cases benefits are denied in violation of federal law and regulations".

The number of patients who are referred to our services at the Rehabilitation Center have increased dramaticly, however, the number of patients that Medicare finds to be covered under their subjective interpretation "performed by the fiscal intermediary on behalf of Medicare" have, as mentioned earlier, shrunk from 130 patients on a daily basis, to 6, as of this A.M.

To summarize, the hospital Medicare program is getting patients out sooner, (quicker and sicker) at the same time while being rushed out of the hospitals into lower cost rehabilitation centers, like the Theresa Grotta Center, they are also being told they have no coverage. What makes this process the sickest, is that in order to participate in the Medicare program we the provider, the non-profit, seventy-year-old Theresa Grotta Center for Rehabilitation, must send a letter, required by Medicare, telling the family of the loved one that WE find they are no longer covered by the Medicare program. This letter is not optional. Obviously it appears that we are the mean ones, we are the villains, we are the ones who wish the family and patient not to be covered by Medicare so that our greeds coffers can be filled to overflowing levels.

You might ask, if only six of our patients are covered by Medicare, what happens to the others? Sadly, we can only take care of those patients, even though we are a non-profit community agency, who can afford to pay for services that had been previously covered under their Medicare part A benefit. I guess that if Ronald Reagan were a patient, it wouldn't bother him because he would be one of those who could afford to pay the $3,000.00 a month that is required for good solid post hospital rehabilitative care, on an average length of stay of between four and six weeks.

CENTER FOR MEDICARE ADVOCACY, INC.
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October 22, 1986

Jennifer Masson
Utilization Review Coordinator
THERESA GROTTA CENTER
20 Summit Street
West Orange, New Jersey 07052

Dear Ms. Masson:

I am writing in reply to your letter of October 9, 1986. The New Jersey state government is currently planning its new Medicare advocacy program. For some time, it had been intended that the program would be run through the State Department of Human Services; recently, however, I learned that the project would probably be sponsored by the Division on Aging of the Department of Community Affairs. Appropriation bills are reportedly pending in the New Jersey Legislature. For more up-to-date information, you might call Theresa Dietrich at (609) 984-6953.

Yours truly,

Charles C. Hulin
Attorney-at-Law

Aid Voted on challenge of Medicare

The Senate passed legislation yesterday that would establish a state program of legal aid for Medicare patients who believe they have been denied benefits improperly.

The bill (S-2484), sponsored by Sen. Frank Pallone (D-Monmouth), passed 33-1 and was sent to the Assembly for consideration.

Despite the overwhelming vote, the bill sparked a brief debate, an unsuccessful attempt to amend it and an exchange of sharply worded prepared statements following the session.

The bill appropriates $90,000 for legal representation to help Medicare recipients get the maximum benefits due them.

"In some cases, benefits are denied in violation of federal law and regulations," Pallone said. "Therefore, a program of legal assistance to aid New Jersey Medicare beneficiaries in appealing such denials should be established."

Sen. William Haines (R-Burlington) objected that $90,000 was not enough to do the job. Sen. Peter Garibaldi (R-Middlesex) unsuccessfully tried to amend the bill to increase the appropriation to $235,000.

Pallone objected, saying that at no time during committee consideration of the bill had anyone suggested that more money was needed. Garibaldi's motion to open the bill to amendments was defeated, 20-15. Adoption of amendments would have delayed passage of the bill.

Following the session, Sen. James Hurley (R-Cape May), on behalf of the Senate Republicans, issued a press release charging that Pallone is "cruelly raising the hopes of these people by promising them something he cannot deliver."

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Hospitals, 9/20/86 P. 91

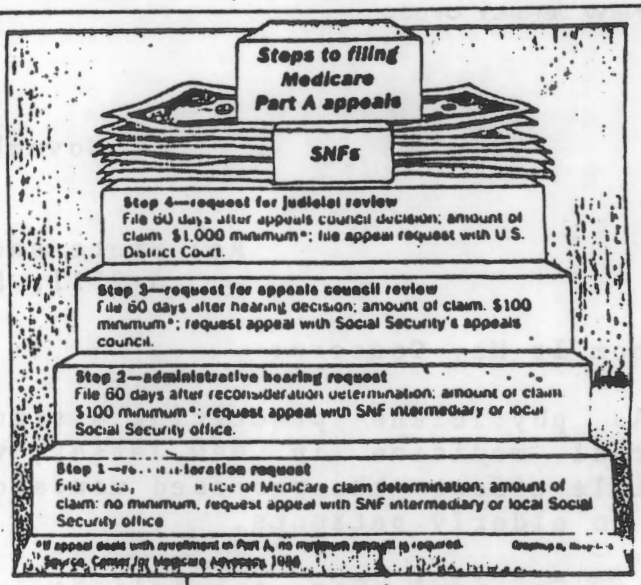
Medicare group spreads the word: appeal

A hospital-based skilled nursing facility (SNF) is denied Medicare reimbursement for a physical therapy patient because, according to its fiscal intermediary, the patient can walk 50 feet without assistance. Outraged by the "arbitrary" reimbursement requirement, hospital officials are appealing the denial (see "HCFA plays 'keep away' with SNFs' payments," Jan. 20, 1986, p. 106).

This situation is typical of the very few instances in which Medicare denials are appealed, says Charles Hulin, codirector of the Center for Medicare Advocacy, Inc., South Windham, CT. In fact, only one in 300 SNF denials nationwide were appealed to the administrative-hearing level (see figure) from 1978 to 1981, says Hulin, former codirector for nine years of Connecticut's Legal Assistance to Medicare Patients.

According to John Whitman, president, John Whitman and Associates, Philadephia, a geriatric health care consulting firm, the low appeal rate isn't surprising: Unless SNFs take an aggressive role in encouraging a beneficiary to appeal the denial, beneficiaries tend to "sit back and fold their hands" on the issue, he says.

High success rate. But when denials are appealed, they're likely to be successful, Hulin contends. His new advocacy program—which focuses on developing advocacy coalitions among patients, state governments, physicians, and health care providers—touts an 80 percent success rate in appeals and claims several recent victories in federal class-action litigation.



Two recent examples: In *Fox v. Bowen*, decided in April, a U.S. District Court ruled that procedures used by the Department of Health and Human Services to deny Medicare coverage to nursing home patients in need of physical therapy treatment were unconstitutional. Then, in May, a federal court ruled in *Hooper v. Bowen* that HHS routinely denies Medicare coverage to hospital patients receiving intense rehabilitation—even when the treatment is medically necessary and unavailable in other facilities. The court is considering whether the policy is unconstitutional.

People apparently are catching wind of Hulin's successes: Similar programs have sprung up in Illinois, Minnesota, New Jersey, and Massachusetts, and Michigan and Ohio plan to follow suit.

Jack Christy, senior policy analyst, American Association of Retired Persons, Washington, DC, adds that the likely passage of federal legislation (HR 4638), which would again allow providers to directly represent beneficiaries appealing denials, as well as providers' growing discontent with the Health Care Financing Administration's "haphazard and shaky bureaucratic procedures," soon may make the word *appeal* an industry buzzword.—*Jane Newald*

STUART M. HOCHRON, M.D.
MATTHEW H. SMITH, M.D.
DAVID S. GOLDSTEIN, M.D.
CHARLES E. BRANCATO, M.D.

95 ADAMS STREET
ISELIN, NEW JERSEY 08830

28 THROCKMORTON LANE
OLD BRIDGE, NEW JERSEY 08857

November 15, 1986

Re: State and Assembly Bills
A-2511, S-2473, S-2585

To Whom It May Concern:

As physicians practicing a significant amount of geriatric and internal medicine in New Jersey, we are very concerned about the possible effects the proposed mandatory Medicare acceptance bill might have on elderly patients.

As Critical Care specialists, we frequently deal with very ill hospitalized Medicare patients. In a large number of cases, our policy is to accept Medicare and Medicaid payments as payment in full because of individual need. In these and other cases, we have recognized a very disturbing and unfair policy by Medicare..namely that only a small portion of the patients bill is "allowed" despite tremendous efforts by physicians throughout the hospitalization to work on the patients behalf. Usually, an arbitrary number of days is "allowed" to be recorded for billing, without any review of the patients hospital record. This may mean the adjustment of 75% or more of the patients bill. If the new law is effected, the practitioners of the critically ill would not have any idea what real reimbursement they could expect on an individual case, and lengthy review and appeal battles might drive doctors away from specialized and more demanding cases. In some cases, even 100% of our fees are being denied simply because there needed to be two specialists delivering specialized care. Medicare again makes arbitrary decisions regarding the need for doctors without knowing anything about the particulars of a case, and these decisions ofter appear final. The best doctors who delivered expert crucial, and timely care to the sickest might be forced to work for free if this bill passes. Thus, the elderly could be denied the right to the best critical care medicine because there is marginal reimbursement for his skill and care, and the sickest patients again suffer the most.

In the same arbitrary way, Medicare commonly "denies" services provided in the office, laboratory,and other areas. Since Medicare is considered by other insurers to be the "primary" carrier, these troublesome and arbitrary denials "trickle down" to the secondary insurance companies, not allowing the patient access to laboratory testing, rehabilitation facilities, or physician attention because of a denial for more than what Medicare "allowed". Reaffirming

edicare's role as the "judge" of indicated services and fees assumes heir ability to do this in a fair and just way..this simply has not een the truth in our experience, and the facilities which depend on artial Medicare revenue may cease to exist if this law and the trend o cut costs through arbitrary Medicare decisions continues.

As you are aware, there is a movement to provide health care on an utpatient rather than an inpatient basis. Besides the lack of edicare approval for the ambulatory outpatient, the sickest patients ould again suffer the most if Medicare is allowed to determine bsolute charges and reimbursement. We routinely make house calls on he very ill or those unable to travel to our office. This includes atients on home ventilators. Medicare has decided that having a hysician visit his patient should be reimbursed less than a routine isit from a visiting nurse. Currently, we charge less for house alls than any appliance repairman I know, and if we had to accept edicare's fee, it would not be possible to continue to spend the mount of time necessary for this life extending service.

Medicare has not appreciably added any covered services in the last several years. Thus, while medical research has advanced and has ow unequivocally demonstrated the life extending benefits of several reatment modalities, Medicare continues to deny payment for these herapies. Specifically, all pulmonary and most cardiac ehabilitation is excluded from Medicare coverage. This means that edicare patients are now routinely "denied", and would not even be given the opportunity to participate in life extending therapy should he proposed legislation pass. Furthermore, even patients with Major edical co-coverage would be denied these therapies by the "trickle own" denial phenomenon noted above.

Medicare designates a certain arbitrary level of follow up care nd testing which is permitted as an outpatient. No reimbursement, even inadequate reimbursement, is permitted for a patient whose care profile or number of tests falls outside these arbitrary limits. No consideration is given as to the particulars of each individual case, nd reduces medicine to a cookbook level. Again, the ill patient may ot receive necessary studies because the laboratory or physician nows reimbursement will not follow, leaving the patient to suffer the atural history of his disease. For example, Medicare "approves" of ne electrocardiogram per six month interval, and may deny eimbursement despite heart disease which the physician needs to follow.

In Massachusetts where similar legislation now exists, physicians are abandoning their practices and leaving the state. New physicians are unable to begin practices, and are therefore not replacing them. This is the ultimate in loss of patient access to quality care. Each hospital with which we are associated has seen a number of applications from physicians leaving Massachusetts and relocating.They are simply unable to survive with Medicare's arbitrary and inadequate reimbursement schedule. Multiply a few physicians per hospital by the number of hospitals in the northeast United States and the magnitude of the physician gap becomes ominous.

Most people do not understand the structure and function of a health insurance system. Many believe in the "cradle to grave welfare society" myth when it is time to pay for health care. The original framers of the Medicare Act never intended it to be the only health insurance a patient would need, but only intended it to serve as a supplement to help assure access to adequate medical care. This legislation casually seeks to eliminate the other side of the insurance equation, which would shift the entire burden of healthcare payment to the federal government from the private sector, but which would return the elderly to the loss of medical care access with which they were faced in the 1960's.

With costs for medical school approaching or exceeding $20,000 per year, it would follow that New Jersey would not see young American medical school graduates in the future if practice opportunities were so bleak as could be expected if this bill were to pass.

Physicians have already been placed under tremendous financial strain as a result of skyrocketing operating costs including insurance, salaries, benefits, and taxes. The Medicare freeze which fixed our fees at 1984 levels has already been an unfair burden. Unlike other sectors of the economy, we have not received cost of inflation increases. While this bill looks like a panacea, it is really a pandora's box into which the elderly healthcare consumer would be herded.

We hope you will take the above points into consideration, and defeat Assembly and Senate Bills A-2511, S-2473, and S-2585.

Sincerely,

Stuart M. Hochron, M.D.

Matthew H. Smith, M.D.

David Goldstein, M.D.

Charles Brancato, M.D.

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Home Care Council of New Jersey
The State Association of Homemaker-Home Health Aide Agencies
60 South Fullerton Ave., Montclair, New Jersey 07042 (201) 744-5524

November 17, 1986

Testimony presented before the Assembly Health & Human Resources Committee

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My name is Jean Holtz. I represent the Home Care Council of New Jersey -- the state association of nonprofit home care providers. Our member agencies provide in-home, health supportive services to the homebound frail elderly, sick and disabled residents of New Jersey. Many of the services provided by our agencies are reimbursed under Medicare and Medicaid. Today I would like to speak directly to two specific Medicaid programs -- the Personal Care Assistance Program (PCA) and the Community Care Program for the Elderly and Disabled (CCPED) -- and to offer what the Council feels would be a much more equitable reimbursement policy for providing these services.

Currently, our member agencies -- located in counties through the state -- are reimbursed for the PCA and CCPED programs for homemaker-home health aide services to a maximum of $8.30 per hour. Due to varying economic and geographic factors in each of these counties, this generic reimbursement rate does not always meet the actual cost-per-hour incurred by many of our agencies for providing these services. For instance, in 1986 our Essex County agency's cost/hour was only $7.95, whereas our Cape May agency's was $10.25. This range in fees is due to several factors, the major ones being competitive wage practices for employment of home health aides and transportation costs.

Agencies located in densely populated urban areas, with large manpower pools of low income, entry level workers, have no difficulty attracting home health aides, as evidenced by the lower cost/hour rate in Essex County. Conversely, agencies located in suburban and rural counties, with more limited manpower resources, are forced to pay higher wages in order to recruit aides. Additionally, in these rural counties, clients live further apart and further away from the agencies, therefor transportation costs are much higher in places like Cape May.

The current $8.30 reimbursement cap on the PCA and CCPED programs poses a difficult decision for the suburban and rural agencies: Should they provide necessary services to clients under these programs and risk insolvency, or should they not take the cases at all? Apart from these two programs, in order to maintain adequate staffing, home care agencies have had to increase home health aide wages, which in turn has produced increases in the cost of service. As a result, these agencies actually loose money when they serve

a PCA or CCPED case. To date, these losses have been subsidized through United Way and other charitable funding sources -- rather than turn away needy clients.

I would like to suggest that the PCA and CCPED rate be based on a more equitable reimbursement schedule, rather than being identical for all providers in all counties regardless of their very different actual costs. A more equitable and cost effective alternative would be to establish a statewide base rate and set specific rates for each county based on scores derived from weighted cost factors -- Federal Wage Basket Index, Unemployment Rates and Population Density. The latter being directly related to transportation costs. This suggestion is not precedent-setting. In fact, Medicare reimburses on a base rate plus an additional figure derived from the SMSA (Standard Metropolitan Statistical Area).

By employing such a method, more agencies would be able to participate in these programs and meet their costs.

The Council would like to offer their assistance to the Committee in developing such a reimbursement schedule for Medicaid programs.

TESTIMONY ON THE EXAMINATION OF THE MEDICAID AND MEDICARE PROGRAMS PRESENTED TO THE NJ STATE ASSEMBLY HEALTH AND HUMAN RESOURCES COMMITTEE NOVEMBER 17, 1986.

The Medical Tranportation Association of New Jersey (MTANJ) represents the private professional medical tranporters throughout our State. It is unfortunate that this hearing comes at a time when the Association President, Mickey McCabe, and Executive Director, John L. Tweed, are attending the annual Convention of the American Ambulance Association in Philadelphia. At this gathering Richard P. Kusserow, Inspector General, Department of Health & Human Services, is speaking at the luncheon reviewing the survey recently conducted by his office on an evaluation of the medical transportation industry across the nation.

Obviously the impact of the Medicare and Medicaid programs on this industry are significant. The reason is the majority of the ridership are either those people who are older Americans or medically indigent, who because of their condition, require specialized transfer techniques.

A major fact to consider during the following explanation is that this industry was only recently regulated (April, 1985). While the industry recognizes the many pluses that regulation has provided it also recognizes the increase in cost that accompanies such regulation. It is impossible, however, to pass these increased costs on to the major payors for our services, Medicare and Medicaid. This makes the burden of high quality delivery of services the responsibility of the provider alone. Although both programs were aware and involved with the formation of the regulations neither has assumed a position to purchase the increased quality of service.

The Medicare program utilizes a system which establishes a profile for this as well as other services based upon the billings of the provider groups in the industry throughout a locality. New Jersey has one locality for the entire state. Once all the data is collected the reimbursement is made at the 75th percentile. The American Ambulance Association along with this and other State associations was recently sucessful in appealing to Senators and Congressman to preempt an attempt at reimbursing this industry at the 25th percentile. Additionally legislation was recently passed calling for the payment by the carrier (Prudential) of 95% of all clean claims within 27 days. HCFA is currently attempting to get this changed to 30 days. Last week we were notified that Prudential has received favorable word from HCFA Region II to pay providers on a weekly basis instead of the bi-weekly payment system established in 1982.

A study is currently being conducted by Congressmen Claude Pepper and James Fiorio, for which we gave testimony, evaluating the possibility of a Medicare Part C which would allow the program to reimburse for services which are currently excluded from the program such as wheelchair transportation for Medicare beneficiaries. Legislation such as this would enhance service availability for beneficiaries who today must either pay for services less than ambulance transfer by themselves or not go. In some instances it could allow for movement of a beneficiary by a more cost effective method than an ambulance.

While all the foregoing information sounds positive to the provider community it does not begin to address the shortcomings encountered by New Jersey's medical transportation providers. New Jersey's Medicare carrier, (Prudential) is reluctant to pay providers for a beneficiaries return trip from an emergency room if it is found they are not to be admitted. Nor does it serve the beneficiary who is discharged from a hospital to a skilled nursing facility or a private residence. The unfortunate part of this claims adjudication is that the neighboring states (New York, Pennsylvania, Delaware and Connecticut) do reimburse for these transports. However, the transportation providers of New Jersey are being unfairly segregated against on this issue. Even more concern comes when we see that providers serving perimeter towns (Camden, Cherry Hill, Bergen and Sussex County communities) are losing business to out of state providers who are able to bill and receive payment for the same conditions which cause a claim to be rejected in New Jersey.

Because of the carrier's determination to reject these claims hospitals and nursing homes are forced to seek out contracts with providers for payment through the facility. Some facilities, however, are unable to budget funds for the transfer of their patients. Therefore, beneficiaries without families to bear the cost of the service go without proper treatment and end up waiting until the transfer must be accomplished in the emergency mode.

Although the Medicare reimbursement has been frozen over the past two years we have now been informed that the 1% withheld by the Gramm-Rudman Act has been halted effective October 1, 1986. Additionally, the freeze has ended and a new profile will be established effective January 1, 1987. This will only leave questions as to the method of determining the adjudication of claims consistant with the rest of the country.

On the other hand the Medicaid program does reimburse for all levels of medical transportation services. Unfortunately, the reimbursement is so far below adequate that benenficiaries oftentimes find services unavailable at

the time they need them. We have been in a comprehensive review of the entire Medicaid medical transportation manual in efforts to streamline some of the unnecessary administrative requirements as well as addressing additional costs which have arisen as a result of the industry's maturity.

The levels of reimbursement were first established at the inception of the program in 1969. In 1975 as a measure to insure the future of the Program all payments to providers were reduced in reimbursement and 10% was withheld. In 1978 in an effort to offset the administrative hardships encountered with the withholding of the 10% new rates were established allowing for a lower base rate and an increase in the mileage reimbursement. This only came after 18 months of arguing for increases because of the drastic rises in gasoline prices.

On June 24, 1984, we found ourselves again explaining to Medicaid the hardships experienced by a tight economy and uncontrolled insurance prices and only an outlook for a harder time ahead. Mr. Thomas Russo, Director of the Program, told us that we could work with a committee of Medicaid staff people to address all the issues. In June, 1985, we again met with Mr. Russo to discuss hardships experienced by the Program in moving Medicaid receipients throughout the state. A major reason for this concern was that several companies went out of business representing approximately 75 medical transportation vehicles and were replaced by a few companies representing only approximately 15 vehicles. However, the program insists on sending out information that alleges the Program is sought after by virtue of the continued number of new companies joining.

In June, 1986, after many manhours and considerable expense we were able to deliver to the Director, Mr. Russo, a finished product which addressed all aspects of the medical transportation industry in New Jersey. While rates were a key issue, we also offered several recommendations for administrative relief which would save money for both the provider and the Program and streamline the system considerably. However, we received no comment from the Director's office.

On July 29, 1986, we met the new Commissioner, Drew Altman, and had the opportunity to share the concern over the silence from the Director's office. He suggested that the Deputy Commissioner, Larry Lockhart, would look into this matter. However, once again we have heard nothing.

As recently as two weeks ago we have been questioned by the Program as to the why Medicaid receipients were still having difficulty receiving rides. Because of reimbursement levels many companies are forced to limit their number of Medicaid

clients serviced in a day. A practice many doctors and clinics have done routinely.

Because of the low reimbursement and the increased demands for training of personnel to staff ambulances and invalid coaches it gets increasingly difficult to attract enough qualified people to accomplish the job. Part of the problem is the inability of the provider to pay a professional wage and the exclusion by the state to involve the private professional in the performance of paramedic and prehospital care.

To compound this problem we see the state appropriate money to the City of Camden once again excluding private enterprise. In Camden a bid that was turned down at $500,000 to the private community was awarded to the State under the umbrella of UMDNJ at $700,000. The question comes up as to where are these funds when the private community seeks them through the Medicaid program.

Medicaid's budget has to be affected by this Camden situation as well as the way hospitals now bury the cost of reimbursing ambulance companies for their services. It would be more cost effective for the Program to reimburse the provider directly instead of adding the administrative costs connected with involving other parties.

Unless the Medicaid program addresses these issues they will start to see providers questioning whether Program participation is worth involvement.

With administrative adjustments both the Medicare and Medicaid programs could be a benefit to the public they serve. Left in its current state the programs have negative impact on an increasing number of their beneficiaries as well as the provider community.

We thank you for the opportunity to speak before your committee and look forward to assisting you in anyway we are able.

Middlesex County Child Adult Protection Coalition
P.O. Box 1052, New Brunswick, New Jersey 08901

December 1, 1986

David Price, Committee Aide
Assembly Health and Human Resources Committee
State House Annex CN-068
Trenton, New Jersey 08625

Dear Sir:

Enclosed please find a copy of a letter which I trust you will find to be self-explanatory.

Very truly yours,

Susan Castano, A.C.S.W.
Chairperson, Adult Committee

145X

December 1, 1986

Mr. Harold L. Colburn Jr., Chairman
Assembly Health and Human Resources
Committee
223 High Street
Mount Holly, New Jersey 08060

Dear Chairman Colburn:

We regret not being able to testify at the November 17th Public Hearing dealing with Medicaid and Medicare but would like to provide you with this written statement of our views.

As providers of services to the vulnerable elderly and disabled of Middlesex County, the Adult Committee of the Middlesex County Child Adult Protection Coalition has been examining this issue of cuts in Medicare and Medicaid as it relates to protecting this population. We find it more and more difficult to prevent and alleviate potential abusive and neglectful situations due to the reduction of available services.

As far as Medicaid is concerned, we have experienced that even when a client is found eligible for Medicaid, often there are not sufficient home health aides to meet the needs of the situation. In our County, Medicaid contracts with only one home health care provider, thus limiting resources.

It is especially difficult in rural areas to secure home health aides. Often geographics alone is the determining factor in which client gets the service.

It appears necessary to examine the home health care industry and the reasons why there is such a shortage of home health aides. How can individuals be encouraged to become home health aides when the pay scale is so low and the benefits are so poor? Why should an individual chose to become a home health aide under those conditions and then be expected to deal with extremely difficult, often dangerous, case situations.

I am enclosing a copy of a position paper compiled by our health needs sub-committee regarding cuts in Medicare which was sent to Senator Bill Bradley. Please accept this to support our position on this subject.

If you have any questions or would like to meet with us around these issues, please feel free to call me at (201) 745-3635 (Middlesex County Board of Social Services - Adult Intervention Project).

Thank you very much.

Very truly yours,

Susan Castano, A.C.S.W.
Chairperson, Adult Committee

SC:vp
Enclosure

CC: David Price, Committee Aide
Assembly Health and Human Resources Committee
State House Annex CN-068
Trenton, New Jersey 08625

147x

Middlesex County Child Adult Protection Coalition
P.O. Box 1052, New Brunswick, New Jersey 08901

September 12, 1986

Bill Bradley
U.S. Senator
731 Hart Building
Washington, DC 20510

Dear Senator Bradley:

Please accept this letter as an expression of our wholehearted support for the healthcare legislation which you have proposed.

The Adult Committee of the Middlesex County Child/Adult Protection Coalition is comprised of hospital and community social workers, case managers and nurses from twenty-five (25) agencies in Middlesex County. The Coalition's primary goal is to foster the prevention and alleviation of abuse and neglect in Middlesex County. Member agencies are committed to the protection of vulnerable and endangered adults, and, we, together with our clients, have witnessed the gradual reduction of available community services, especially those provided under Medicare.

We have listed below a few examples from our experiences which demonstrate the urgent need for the passage of your legislation.

I. HOME HEALTH SERVICES DENIED

A. Cancer patients requiring home health services are denied these services under Medicare because they are not considered homebound when they receive life-sustaining radiation treatments at a hospital.

B. Renal Patients requiring home health services are denied these services under Medicare because they are not considered homebound when they receive life-sustaining hemodialysis treatments at an out-patient center.

C. Frail elderly requiring home health services are denied these services under Medicare because they are not considered homebound when they attend a nutrition site to receive a balanced meal.

II. TRANSPORTATION DENIED TO THE PHYSICALLY DISABLED

A. Cancer and renal patients requiring ambulance transportation to and from life-sustaining treatments are denied these services under Medicare if they are not "stretcher-bound". No exception is made for wheelchair patients who are unable to drive a car or utilize public transportation.

II. TRANSPORTATION DENIED TO THE PHYSICALLY DISABLED (CONTINUED)

B. Fractured hip patients requiring transportation to and from physical therapy are denied these services under Medicare if they can ambulate with a walker. No exception is made for fractured hip patients who reside on a second floor and are unable to climb up and down stairs.

C. Wheelchair patients requiring transportation to and from physical therapy are denied these services under Medicare. No exception is made for wheelchair patients who are unable to drive a car or utilize public transportation.

III. PHYSICAL THERAPY AND SOCIAL WORK SERVICES DENIED

A. Frail elderly requiring physical therapy to ensure a safe return home after hospitalization are denied these services under Medicare if the diagnosis is not recognized by Medicare. No exception is made when physical therapy is ordered by the primary physician.

B. Homebound patients requiring social work assessments are denied home visits by social workers under Medicare.

We hope that your colleagues in the Senate will join with you in stopping these tragedies and pass legislation which will guarantee adequate and quality home health services.

We respectfully request an opportunity to meet with you or a member of your staff to discuss these issues. We would very much appreciate any information which you can supply regarding pertinent subcommittee or committee hearings. Rest assured that we stand ready and able to assist you in supporting the health-care legislation which you have proposed.

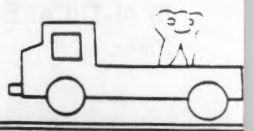
Sincerely,

Carol Womack

Carol Womack, MSW
Chairperson
Health Services Sub-Committee
Adult Committee of the Middlesex
County Child/Adult Protection Coalition
(201) 442-3700, Ext. 2766

CW/ls

Mobile Dental Care



ON-SITE DENTAL CARE FOR THE ELDERLY AND HANDICAPPED

Stanley Markman, DDS
Administrator

268 BROAD AVENUE
PALISADES PARK, N.J. 07650
TELEPHONE: 201/224-4302

November 4, 1986

To: Assembly Health and Human Resources Committee

In August, 1986, I began what I believed would be a highly noble program for society by inaugurating a mobile dental service. We began by soliciting nursing homes but decided to limit our service to one medium sized nursing home. This nursing home, like most, did not have dental equipment in its facility. We brought, in our own van, mobile dental equipment which we set up in the facility's beauty parlor. Our equipment included a dental x-ray, compressor, portable chair, dental unit, light, instruments and supplies. We examined and took x-rays for approximately 50 Medicaid recipients and developed modest treatment plans. The following is a description of our first encounter with Medicaid. I might state at the onset that our attention was immediately drawn away form health care delivery and became focused on regulations.

Of the 50 recipients examined, 28 had x-rays. Medicaid lost three complete x-ray series. That's an 11% failure rate. When I called to find out where the x-rays were, we were tol to use dual pack x-ray film. (They will not accept a duplicate film of an x-ray series). Dual pack x-rays have 2 films in each x-ray pocket. They are more expensive than single pack film and require double developing and mounting time. In short, the provider is expected to pay for the shortcomings of the administration of the program. In contrast, commercial insurance companies regularly accept duplicate x-rays.

After our examinations, Medicaid sent a dental consultant to the nursing home to check on the appropriateness of treatment and to see if the patients really wanted treatment.

While provider fees have been raised by but 23% since the inception of the Medicaid program, Medicaid can afford to send out a dental consultant to check on treatment plans by interviewing retarded, confused patients and otherwise physically debilitated residents. A dental consultant actually asked a retarded woman with loose teeth, infected with periodontal disease, if she wanted a denture. The consultant wrote on her form that the patient doesn't want a denture.

Actually, nursing home patients don't really know what is in their best interest since many are frankly confused. That is precisely why they are there. If the same patient decided not to eat, within three days there would be a gastric tube in his or her esophagus, whether they wanted it or not. I think it is noteworthy to point out that if a disturbed nursing home resident fell and broke an arm, would one think to ask, "Do you want a cast for treatment?". Yet, no less than three patients with broken teeth in their gums were asked by a Medicaid reviewer, "Do you want treatment?". When these confused patients respond, "No", the reviewing consultant denied care stating on the form that the patient does not wish care.

The Dental Medicaid Administrators rightly want to control costs so that taxpayer monies aren't wasted. When legislative budgets are prepared, one can see past and future revenue projections by providers. What is less obvious is the administrative costs - like the cost of sending a dental consultant from Trenton to Wayne, New Jersey.

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The following are examples of how the dental Medicaid system creates provider frustration which results in focusing on rules and regulations rather than the delivery of dental care:

1. X-rays were taken of the upper and lower jaws of a patient. The clinical examination and a reading of the x-rays revealed that treatment was required in the upper jaw and an x-ray of the upper jaw was sent for authorization of care. The form was returned with a disallowance of the fee for the lower x-ray because the lower x-ray was not sent along with the upper x-ray, even though that x-ray was irrelevant for authorizing care. As a provider, a letter has to be written with a labeled x-ray attempting to collect the one or five dollars (depending upon the type of x-ray) for a service which I performed.

2. A patient was examined and x-rays were taken. The x-rays were negative but the patient required a denture refit. We sent in for authorization of the refitting procedure and that form was returned, denying the x-ray fee because it wasn't enclosed with the form, even though the x-rays are not relevant to care. Again, I must write a letter, enclose the x-rays and request authorization for payment for x-rays.

3. Codes have to be written for necessary services. Medicaid at its option will unilaterally change codes written by the provider and select a code which pays less. The provider is then faced with the choice of providing a more expensive treatment for a lesser fee, withholding care, or writing appeals to the Medicaid administrators. The choices boil down to working for less or writing more letters.

The question that must be asked is: How can we focus on the delivery of care when our attention is constantly diverted by the knit picking? After dealing with these kinds of frustrations - lost x-rays, non-payment for provided services, letters and forms going back and forth, the provider begins to think, "Who needs this headache?".

Not all providers, though, think that way. There is at least one mobile dental care service that is fully conversant with the fact that knowing the rules is what is important. This organization can examine 60 or more patients a day in what is termed in Medicaid parlance as "gang exams". They're in and then out. They know how to fill out forms quickly and rapidly and that is how the game of dental care in nursing homes is often played. Patients, therefore, get very little care. There are at least four reasons for this:

1. Most nursing homes have no dental facilities.

2. Dentistry is not a priority health service in a nursing home and many administrators are concerned only with meeting the Department of Health requirement that patients receive a dental exam 180 days after admission.

3. Treating debilitated, sick, confused patients is, at best, very difficult work which most dentist are not interested in doing.

4. Finally, the fee schedule is very low.

Medicaid allows nine dollars for a nursing home visit, whether you come by yourself or with a truck load of equipment, which takes ½ hour to unload and set up.

Our population is aging. By the year 2040, the over 85 group will have grown from the present 2.2 million to nearly 13 million. In roughly the same period, moreover, the number of Americans over 65 is expected to grow from 26 million to 66.6 million. In New Jersey, everyday 57 people become 65 years old. Many of these people will find themselves in nursing homes or on public assistance, They are going to need all kinds of support care including dental care. This is not dentistry's problem, rather it is a societal problem. If you do not provide adequate compensation for dental care for the indigent, these people are not going to get it. I am not talking about increasing Medicaid fees by 5 or 10 per cent.

I am involved in a mobile dental care service. We go to patients in nursing homes and those who are homebound. Recently, the parent of a Medicaid recipient called requesting dental care for her retarded crippled 35 year old daughter. Does it make sense to drive from my office to someone's house, bring in equipment, do an examination and return to my office for a $6 Medicaid fee. Of course, forms have to be filled out properly in order to receive the $6. I have treated patients at home, who are victims of stroke, multiple sclerosis, Lou Gehrig's Disease, etc.

There is a real need to reach out to people who need care and who are covered by Medicaid - people who are stuck at home with infirmities - residents in nursing homes with mutilated mouths, who require the simplest and basic treatments.

My recommendation is that Medicaid dental fees be raised substantially. I personally have no ax to grind, because my noble experiment is over. There are many people who are able to pay private fees for my service. Who will care for the indigent homebound or attempt to deliver quality care to Medicaid recipients in nursing homes?

I recommend that mobile dental care services be certified or licensed by the Department of Health to deter the entrepreneural "gang examiners". I recommend that Medicaid pay a realistic fee for bringing a dental office to a nursing home facility or short of that, that the Department of Health could require that each nursing home set up its own dental operatory. Somehow when a Medicaid resident needs emergency dental care, Medicaid finds the funds to transport the patient to and from a dental office with the ambulance company collecting substantially more than the dentist gets for doing the treatment. Interesting that $200 can be found to drive a patient to and from a dental office while no funds or fees are available to bring equipment from a dental office to a nursing home facility.

The matter of health care, whether it be medical or dental, is a societal matter. I hope you make the correct decision.

Stanley Marks DDS

IEW JERSEY GUILD OF HEARING AID DISPENSERS

979 SOUTH BROAD STREET TRENTON, NEW JERSEY 08611
(609) 599-1739

December 2, 1986

Honorable Harold L. Colburn, Jr., Chairman,
New Jersey Assembly
Committee on Health and Human Resources
State House
Trenton, New Jersey 08625

Dear Chairman Colburn:

The New Jersey Guild of Hearing Aid Dispensers thanks the Committee and its Chairman for this opportunity to record its views on the manner in which New Jersey's Medicaid and Medicare ricipients can be served most intelligently and economically.

Bilateral Hearing Loss

Just as normal human eyesight enables a healthy person to judge distances via depth perception by the operation of two eyes, normal human hearing enables a healthy person to sense the direction of a source of sound. Until we suffer a loss of hearing, it is our nature to take this ability for granted. But, while we would never conceive of treating bilateral vision loss with a single lens, our State continues to treat bilateral hearing loss by correcting only one ear!

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The Guild believes that the programs of this State should be improved so that, where needed, binaural amplification can be provided (using a second hearing device). Under policies and procedures still in effect, binaural amplification is available only in "certain cases" at the discretion of the Medicaid central office; others in need go without.

On-site Nursing Home Service Calls

Economy and efficiency would combine with a touch of convenience if a minor change were made in the servicing of Medicaid recipients in nursing homes. The program makes no provision, currently, for the costs of a site visit to repair, clean, adjust or fit a hearing aid mold for a patient confined to a nursing home (for lack of special transportation or otherwise).

In many cases reaching our attention, individuals who depend on hearing aids are required to choose between a visit to the dispenser's office (at costs easily ranging around one hundred dollars, round-trip medical van) or foregoing the service. The dispenser, when made aware of the need and in recognition of the dilemma, finds himself or herself performing the house call at considerable personal expense.

Adopting the belief that medical transportation costs for such cases represents a poor use of scarce resources, but mindful of the inequity of causing the conscientious dispenser to bear the costs of the service, the Guild proposes that a minor adjustment in the prevailing policies would entitle the dispenser to a modest reimbursement (twenty-five dollars) to defray the costs of the on-site visit. The Guild suggests that the policy would not only improve service to the elderly, but would reduce the gross costs of reaching the home-bound patient.

Testing and Fitting Devices

As you may be aware, under the laws of New Jersey, the license issued to a Hearing Aid Dispenser signifies his or her capacity to perform testing of human hearing. This attribute of the skill, training and licensure of the Dispenser is often ignored to the detriment of our system of health-care provision. The Guild believes that our programs and our recipients of these services would benefit if Medicaid and Medicare would ut lize the testing services which licensed dispensers provide daily to the general public. No practical basis exists to justify <u>exclusive</u> reliance by these programs on the testing services of audiologists.

Reimbursement Rates

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In coopertion with the central administration of the Division of Medical Assistance, certain rates of reimbursement were established in 1982 for all hearing aid dispensers participating as vendors. The rate schedules are now in need of revision. The Guild suggests that a modest revision would occur if the Medicaid reimbursement were brought into line with the rate structure utilized by the Department of Labor in its Vocational Rehabilitation program. Using its current rates as a benchmark, the Medicaid reimbursement adjustment would be approximately nine percent, less than one percent per annum!

Age Barriers - Testing

Finally, in view of the well known fact that hearing loss can be experienced at any age, the Guild believes that Medicare recipients should have the benefit of a hearing test. Rather than selecting senior citizens for testing at late stages of life, perhaps it would be more meaningful to provide all medicare eligible citizens at age seventy-five and above with financial assistance in the purchase of an aid. Legislation (S-2048) sponsored by Senators VanWagner and Pallone is supportive of this concept and deserves the attention and support of the Legislature.

The Guild appreciates this opportunity to express its

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opinion on these matters of mutual importance. We stand ready to respond to any questions of your Committee in futherance of its understanding of our service to the public.

New Jersey Guild of Hearing
Aid Dispensers

J D Fishman

By: J. D. Fishman, President

157X

NJHA NEW JERSEY HOSPITAL ASSOCIATION
The Center for Health Affairs

760 Alexander Road
CN-1
Princeton, New Jersey 08543-0001

Louis P. Scibetta FACHE
President

TESTIMONY OF

NEW JERSEY HOSPITAL ASSOCIATION

ON THE MEDICARE AND MEDICAID PROGRAMS

BEFORE THE

ASSEMBLY HEALTH & HUMAN RESOURCES COMMITTEE

TRENTON, NEW JERSEY

NOVEMBER 17, 1986

10-8X

Good day, my name is Craig Becker, Vice President for Government Relations of the New Jersey Hospital Association, which represents all of New Jersey's acute care facilities and who are, incidentally, prime care givers to the State's Medicare patients.

The Hospital Association is proud of its record in providing the best in health care to its senior citizens, in the most cost effective manner. In 1984, the most current data available, New Jersey's 96 acute care facilities provided care $338 less per admission than the rest of the nation and an impressive $597 less than the rest of the northeast.

These savings, we believe, have not come at the cost of decreased quality of care. Having said that, there is no question that all patients, not only Medicare patients, are being discharged sooner than they were three years ago. The average length of stay in a New Jersey hospital went from 8.7 days in 1979 to 8 days in 1984. Nationally, New Jersey is still higher in its average length of stay which stands at 7.3 days.

Clearly, we need to send a message to Congress that it cannot continue to allow the bureaucrats to determine when it is feasible to discharge a patient. As long as Medicare continues to be finance-driven and as long as health care is held hostage to the tyranny of the PROs, there will be complaints of patients being discharged in a frailer condition.

As for Medicaid, Congress has wisely spared this system the meat cleaver approach to budgeting. States can still opt to maximize their indigent care dollars by receiving about one federal dollar for each state dollar put up.

New Jersey has a fairly generous system, covering inpatient care. However, with the indigent care load climbing to over $300 million next year, it would be wise for lthe legislature to consider expanding the eligibility standards even more to capture those patients still not covered.

In testimony before this Committee, Thomas M. Russo, Director of the Division of Medical Assistance and Health Services, stated that if the Medically Needy Program was expanded to cover inpatient care, it would cover about $110 million of the $300 million. Obviously ,this would not require full funding of the $110 as about $55 million would come from federal matching grants.

The NJHA believes this is a prudent and cost effective expenditure of state dollars.

In conclusion, I would like to thank the Committee for the opportunity to testify before it and for its interest in the health of New Jersey hospitals. We are hopeful that this Legislature will help us to continue to provide the best possible in health care to all New Jersey citizens.

New Jersey Foster Parents Association

P.O. Box 220, Middlesex, NJ 08846 • (201) 356-0667

TOUCH A LIFE

ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES

Performance of Medicaid and Medicare Program
and Impact it has on Health Programs

Honorable Harold Colburn, Chairman

Testimony of New Jersey Foster Parents Association
Presented by Sue Dondiego, President
November 17, 1986

162x

I AM SUE DONDIEGO, A FOSTER PARENT AND PRESIDENT OF THE NEW JERSEY FOSTER PARENTS ASSOCIATION. I WANT TO THANK THIS COMMITTEE FOR PROVIDING AN OPPORTUNITY FOR US TO EXPRESS OUR CONCERNS.

TODAY THERE ARE OVER 56,000 CHILDREN UNDER THE SUPERVISION OF THE DIVISION OF YOUTH AND FAMILY SERVICES. THESE ARE OUR MOST VUNERABLE CHILDREN, MANY LIVING IN POVERTY, ARE HOMELESS OR WITHOUT PROPER HOUSING, AND HAVE INADEQUATE OR NON-EXISTANT MEDICAL SERVICES.

OF THE 56,000 CHILDREN UNDER THE SUPERVISION OF DYFS, APPROXIMATELY 7,000 ARE IN FOSTER CARE. WHILE THESE FOSTER CHILDREN NO LONGER LIVE IN POVERTY AND HAVE THE SECURITY OF A HOME, THEY DO NOT HAVE ADEQUATE MEDICAL SERVICES.

CHILDREN NEED PROPER HEALTH CARE AND THOSE CARING FOR THEM, WHETHER THEY ARE BIRTH PARENTS OR FOSTER PARENTS, MUST HAVE ACCESS TO TIMELY, APPROPRIATE MEDICAL SERVICES. AT THE PRESENT TIME, THESE SERVICES ARE, IN MANY CASES, UNAVAILABLE OR NON-EXISTANT.

IN SOME AREAS THERE ARE NO DOCTORS, DENTISTS,PSYCHIATRISTS, PSYCHOLOGISTS OR OTHER MEDICAL PROFESSIONALS WHO ACCEPT MEDICAID. IN OTHER AREAS, THE LIST OF THOSE WHO DO ACCEPT MEDICAID IS CONSTANTLY DWINDLING BECAUSE OF THE INADEQUATE REIMBURSEMENT RATE FOR SERVICES AND THE UNREASONABLE LENGTH OF TIME IT TAKES FOR PAYMENT OF THE SERVICES PROVIDED.

MORE AND MORE FOSTER PARENTS ARE HAVING TO TRAVEL GREATER DISTANCES TO FIND PROPER HEALTH CARE FOR THEIR FOSTER CHILDREN. MANY MORE FOSTER PARENTS ARE NOW PAYING THEIR OWN DENTISTS AND PHYSICIANS FOR THE MEDICAL SERVICES THEIR FOSTER CHILDREN NEED.

A VAST MAJORITY OF CHILDREN COMING INTO FOSTER CARE TODAY NEED COUNSELING. BECAUSE THE NUMBER OF PROFESSIONALS ACCEPTING MEDICAID IS LIMITED, THE WAITING LIST CAN BE ANY WHERE FROM THREE TO SIX MONTHS, AND SOMETIMES LONGER. FOR SOME OF THESE CHILDREN, ESPECIALLY THOSE WITH SEVERE BEHAVIORAL PROBLEMS, THIS LONG WAIT FOR SERVICES MEANS PLACEMENT DISRUPTION. THIS ONLY CAUSES MORE PROBLEMS FOR THE CHILDREN AND THE BURNOUT OF FOSTER PARENTS.

WE BELIEVE THAT PREVENTION OR IMMEDIATE ATTENTION TO A MEDICAL PROBLEM, WHETHER IT IS PHYSICAL OR EMOTIONAL, IS IN THE BEST INTEREST OF CHILDREN. IF LEFT UNATTENTED, MINOR ILLNESSES OR INJURIES BECOME MAJOR -- EMOTIONAL PROBLEMS CAN BECOME SEVERE MENTAL DISORDERS.

THE CONSEQUENCES OF THIS "PENNY PINCHING" ARE HIGHER MEDICAL EXPENSES AND THE NEED FOR RESIDENTIAL OR INSTITUTIONAL PLACEMENTS. AS TAX PAYERS, THIS MAKES NO SENSE TO US.

IF FOSTER PARENTS ARE TO HELP THE CHILDREN PLACED IN THEIR CARE, THEY MUST BE ABLE TO GIVE THEM MORE THAN LOVE AND A GOOD HOME. THEY MUST HAVE ACCESS TO THOSE WHO CAN PROVIDE THE PROFESSIONAL HEATH CARE THEIR FOSTER CHILDREN NEED.

WHILE THE CONCERNS WE RAISE TODAY RELATE TO FOSTER CARE, WE URGE THIS COMMITTEE TO RECOMMEND AND SUPPORT AN INCREASE IN MEDICAID REIMBURSEMENTS AND A TIMELY PAYMENT SYSTEM, SO THAT PROPER HEALTH CARE IS AVAILABLE FOR ALL OUR CHILDREN AND FAMILIES.

SUE DONDIEGO
11/17/86

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New Jersey Pharmaceutical Association

118 WEST STATE STREET, TRENTON, NEW JERSEY 08608-1184 PHONE: 609/394-5596

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MONDAY, NOVEMBER 17, 1986

TESTIMONY BY THE NEW JERSEY PHARMACEUTICAL ASSOCIATION
TO THE ASSEMBLY HEALTH AND HUMAN RESOURCES COMMITTEE

RE: THE MEDICAID PRESCRIPTION DRUG PROGRAM

MY NAME IS LEON LANGLEY AND I REPRESENT THE 3500 PHARMACIST-MEMBERS OF THE NEW JERSEY PHARMACEUTICAL ASSOCIATION. I WANT TO THANK THE COMMITTEE FOR GIVING US THE OPPORTUNITY TO SPEAK ON THE MEDICAID PRESCRIPTION DRUG PROGRAM. I SEE FROM YOUR INVITATION THAT THE PURPOSE OF THIS IS TO CONSIDER THE IMPACT OF THE PROGRAM ON THE DELIVERY OF HEALTH CARE. I CAN TELL YOU THAT AS FAR AS PHARMACY IS CONCERNED, THE IMPACT OF THE MEDICAID PRESCRIPTION DRUG PROGRAM HAS BEEN SOMEWHAT LESS THAN PERFECT.

WE DID A STUDY THREE YEARS AGO COMPARING THE YELLOW PAGE PHARMACY ADVERTISING FROM THE YEAR 1965 VERSES THE YEAR 1983 IN TWO CITIES, NEWARK AND TRENTON. IN 1965 THERE WERE 147 PHARMACIES IN THE NEWARK AREA AND IN 1983 ONLY 53 WERE LEFT. IN TRENTON IT DROPPED FROM 47 TO 14. THE BULK OF THE PRESCRIPTIONS FILLED IN THESE AND OTHER URBAN AREAS OF THE STATE ARE PAID FOR THROUGH THE MEDICAID PRESCRIPTION PROGRAM. THE DEPLETION OF APPROXIMATELY TWO THIRDS OF THE PHARMACIES IN THESE TWO URBAN AREAS INDICATES THAT THERE IS SOMETHING SERIOUSLY WRONG WITH THE PROGRAM.

INADEQUATE PAYMENT, A CUMBERSOME BILLING PROCEDURE, COMBINED WITH A THREE PERCENT ERROR RATE BY THE STATE IN THE AREA OF PATIENT ELIGIBILITY HAS RESULTED IN A LARGE DECREASE IN THE NUMBER OF PHARMACIES WHICH ARE AVAILABLE TO MEDICAID PATIENTS. MEDICAID PATIENTS ARE THE LEAST MOBILE SEGMENT OF OUR SOCIETY AND THE DISAPPEARANCE OF THESE NEIGHBORHOOD HEALTH CARE CENTERS HAS AN ABSOLUTE IMPACT ON THE RESIDENTS WHICH FORCES THEM TO FIND THESE SERVICES AT CONSIDERABLE DISTANCES FROM THEIR HOMES.

PHARMACISTS ARE PAID FOR FILLING MEDICAID AND PAAD PRESCRIPTIONS ON THE BASIS OF A FIXED FEE SET BY THE STATE PLUS THE ACTUAL COST OF THE DRUG. THAT FIXED FEE WAS EXTREMELY INADEQUATE FOR A VERY LONG TIME, BUT I MUST TELL YOU THAT THE STATE HAS ADDRESSED THAT ISSUE OVER THE LAST THREE OR FOUR YEARS WITH INCREASES IN THE FEE THAT WERE SUBSTANTIAL BUT WHICH STILL FALL SHORT OF ADEQUATELY COMPENSATING PHARMACIES FOR FILLING PRESCRIPTIONS. SEVERAL YEARS AGO OUR ASSOCIATION LEADERS WORKED WITH DIVISION PERSONNEL TO DEVELOP A FEE PAYMENT SYSTEM THAT ALLOWS FOR A SLIGHTLY HIGHER FEE TO PHARMACIES, MOSTLY INNER CITY PHARMACIES, THAT DO MORE THAN 50% OF THE PRESCRIPTION BUSINESS WITH THE TWO STATE PRESCRIPTION PROGRAMS. THIS SYSTEM IS UNIQUE IN THE NATION AND HAS NOT BEEN PICKED UP BY ANY OTHER STATE MEDICAID PROGRAM. ACTUALLY THESE PHARMACIES GET 15¢ PER PRESCRIPTION MORE THAN PHARMACIES THAT ARE DOING A LESSER PERCENTAGE WITH THE MEDICAID AND PAAD PROGRAMS. WE CALL THIS AN "IMPACT AREA FEE" AND IT IS AN INTERESTING CONCEPT THAT THIS COMMITTEE SHOULD CONSIDER IF THE PURPOSE OF THIS HEARING TODAY IS TO IMPROVE THE AVAILABILITY OF VARIOUS HEALTH CARE SERVICES TO MEDICAID RECIPIENTS. THE SAME CONCEPT OF A HIGHER PAYMENT TO INNER CITY HEALTH CARE PROVIDERS COULD BE APPLICABLE TO OTHER PROVIDERS IN ADDITION TO PHARMACIES. THE 15¢ EXTRA IS INADEQUATE AND WE CONTINUE TO SEE A REDUCTION IN THE NUMBER

OF PHARMACIES IN OUR INNER CITIES. THIS COMMITTEE COULD PERHAPS MAKE A RECOMMENDATION TO THE ADMINISTRATION AND THE APPROPRIATIONS COMMITTEE IN AN EFFORT TO IMPROVE THAT PAYMENT SYSTEM TO PREVENT FURTHER EROSION OF PHARMACIES AND TO ENCOURAGE ALL OF THE NECESSARY SERVICES WHICH PHARMACISTS PROVIDE.

THE FEE PAID TO OTHER PHARMACIES THAT ARE NOT SO DEPENDENT ON THE TWO STATE PRESCRIPTION PROGRAMS IS INADEQUATE FOR THEIR NEEDS ALSO, ALTHOUGH IT PROBABLY DOES NOT FORCE THEM TO CLOSE. THEY SIMPLY CHARGE HIGHER PRICES TO OTHERS TO MAKE UP FOR THE LOSS INCURRED IN THE STATE PROGRAMS. THIS IS TOTALLY UNFAIR TO THOSE OTHER PRESCRIPTION DRUG CONSUMERS IN THAT THEY SUBSIDIZE THE PROGRAMS TWICE, THROUGH HIGHER PRESCRIPTION PRICES AND THROUGH THEIR TAX DOLLARS. THE DIVISION HAS RECENTLY ASKED PHARMACY OWNERS TO PARTICIPATE IN A STUDY TO DETERMINE EXACTLY WHAT IT COSTS A PHARMACY TO FILL A PRESCRIPTION. THE RESULTS OF THAT STUDY WILL BE AVAILABLE SOON AND I WOULD ASK THIS COMMITTEE TO ASK THE APPROPRIATIONS COMMITTEE AND THE ADMINISTRATION TO RESPOND TO THIS STUDY WHEN DEVELOPING NEXT YEAR'S BUDGET FOR THESE PRESCRIPTION PROGRAMS.

YOU SHOULD BE AWARE THAT THE MEDICAID PRESCRIPTION DRUG PROGRAM ACCOUNTS FOR APPROXIMATELY 6 TO 7% OF TOTAL MEDICAID PROGRAM COSTS BUT GENERATES APPROXIMATELY 50% OF THE TOTAL MEDICAID PROGRAM PAPERWORK. THE TIME INVOLVED IN PROCESSING THIS MASSIVE PILE OF PAPER INTERFERES TREMENDOUSLY WITH THE CASH FLOW THAT BUSINESSES REQUIRE IN TODAYS MODERN MARKET PLACE. BOTH THE CUMBERSOME PAPERWORK AND THE CASH FLOW PROBLEMS COULD BE ADDRESSED THROUGH THE ADOPTION OF A PRESCRIPTION VOUCHER PAYMENT SYSTEM WHICH HAS BEEN EXPERIMENTED WITH IN A COUPLE OF OTHER STATES. WHILE WE DO NOT HAVE THE TIME TO GO INTO DEPTH ON THAT PARTICULAR PAYMENT

SYSTEM TODAY I WOULD OFFER TO WORK WITH THE DIVISION OF MEDICAL ASSISTANCE IN THE DEVELOPMENT OF SUCH A PRESCRIPTION PAYMENT SYSTEM IN THIS STATE IF THIS COMMITTEE WOULD RECOMMEND THAT THE DIVISION LOOK INTO IT.

IN THE AREA OF PATIENT ELIGIBILITY, I WOULD MENTION THAT THE STATE IS DEVELOPING AN ELECTRONIC ACCESS SYSTEM THAT WILL ALLOW HEALTH CARE PROVIDERS, WHEN IT IS FULLY DEVELOPED, TO HAVE IMMEDIATE ACCESS TO THE MEDICAID MASTER ELIGIBILITY LIST TO DETERMINE IF IN FACT A PARTICULAR PATIENT IS ELIGIBLE ON A CERTAIN DAY. THAT SYSTEM IS SCHEDULED TO BE IN PLACE SOMETIME DURING 1987 AND WE WOULD LIKE TO COMMEND DIVISION PERSONNEL FOR DEVELOPING IT. IT WILL SOLVE A MAJOR LOSS PROGRAM THAT PHARMACISTS HAVE BEEN EXPERIENCING FOR MANY YEARS.

WE STRONGLY RECOMMEND THAT THIS COMMITTEE EXAMINE THE ISSUE OF THE SEPARATION OF THE VARIOUS HEALTH CARE PROFESSIONS THAT SERVICE MEDICAID AND MEDICARE PATIENTS. THERE IS A RAPIDLY EXPANDING EFFORT BY HEALTH CARE PRESCRIBERS TO ACTUALLY OWN THE VARIOUS BUSINESSES WHICH SUPPLY THE DRUGS AND MEDICAL EQUIPMENT THAT IS BEING PRESCRIBED. BECAUSE OF THE POSSIBLE ABUSE, MISUSE AND OVERUSE OF PROGRAM DOLLARS WHICH MIGHT OCCUR IF THE PRESCRIBER DERIVED AN ECONOMIC BENEFIT FROM THE PRODUCT HE OR SHE IS PRESCRIBING, WE BELIEVE IT IS IN THE PUBLIC INTEREST FOR GOVERNMENT TO KEEP THE VARIOUS HEALTH CARE PROFESSIONS SEPARATE AND INDEPENDENT.

THERE ARE VARIOUS CONCEPTS WHICH NEED TO BE PROMOTED. THE DIVISION IS CURRENTLY CONSIDERING A UTILIZATION REVIEW PROGRAM WHICH WILL IMPROVE PATIENT CARE WHILE PROJECTING A REDUCTION IN HOSPITAL COSTS INCURRED

OF ABOUT 4%. THE COST EFFECTIVENESS OF THIS PROGRAM HAS BEEN PROVEN IN ABOUT 14 OTHER STATES. WE ARE HOPING TO SEE THIS PROGRAM OPERATIONAL IN 1987.

WE BELIEVE THE MEDICAID DIVISION DESERVES OUR FAVORABLE COMMENTS ON THE USE OF PHARMACIES TO COMMUNICATE IMPORTANT POLICY CHANGES TO THE MEDICAID RECIPIENT AND POTENTIAL RECIPIENT. WE HAVE WORKED TOGETHER TO PUT INFORMATIONAL POSTERS AND LITERATURE IN PHARMACIES WHEN ELIGIBILITY CHANGES HAVE OCCURRED. WE WILL SHORTLY DISTRIBUTE A POSTER ALONG WITH A GUEST EDITORIAL BY ASSEMBLYMAN DEVERIN PROVIDING KNOWLEDGE ABOUT THE MEDICALLY NEEDY LAW TO OUR MEMBERS FOR THIS PURPOSE.

I WANT TO THANK YOU FOR GIVING ME THE OPPORTUNITY TO DISCUSS PHARMACY PROBLEMS WITH THE MEDICAID PRESCRIPTION DRUG PROGRAM, AND I CERTAINLY WOULD BE WILLING TO ANSWER ANY QUESTIONS THAT YOU MIGHT HAVE.

LRL/DT

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OCEAN COUNTY SENIOR COORDINATING COUNCIL, INC.

TOMS RIVER, NEW JERSEY 08753

MICHAEL G. CARRIG, PRESIDENT
246 CENTRAL BLVD.
BAYVILLE, NEW JERSEY 08721
201-269-5616

GOOD MORNING, MR. CHAIRMAN AND HONORABLE MEMBERS OF THE COMMITTEE.

MY NAME IS MICHAEL G. CARRIG, PREISDENT OF THE OCEAN COUNTY SENIOR COORDINATING COUNCIL, REPRESENTING SIXTY SEVEN (67) ORGANIZATIONS WITH A TOTAL MEMBERSHIP OF OVER 60,000 SENIOR CITIZENS THROUGH-OUT OCEAN COUNTY.

WHEN WE DISCUSS PROBLEMS OF THE ELDERLY AND DISABLED, THERE IS NO PROBLEM THAT IS MORE WORRISOME THAN MEDICAL COSTS.

THE CONSTANT THOUGHT THAT A CATASTROPHIC CONDITION WILL PREVAIL AND WILL TAKE AWAY WHATEVER SAVINGS OR RESOURCES PEOPLE WORKED FOR ALL THEIR LIVES WILL BE EXHAUSTED AND THEY WILL HAVE TO DEPEND ON MEDICAID OR A HANDOUT OR GO TO MEMBERS OF THE FAMILY FOR ASSISTANCE. THAT'S SOMETHING WE DO NOT WANT TO FACE.

WHEN THE MEDICARE PROGRAM WENT INTO EFFECT IN 1966, WE THOUGHT WE HAD ONE OF THE BETTER HEALTH PROGRAMS. THE YEARS HAVE GONE BY AND THE PROGRAM, PRESENTLY, IS NOTHING TO BE PROUD OF.

THE MAIN AND SPECIFIC REASON FOR OUR THINKING IS THAT FEW PHYSICIANS WILL ACCEPT MEDICARE ASSIGNMENT. THEY COME UP WITH MANY REASONS WHY THEY DO NOT ACCEPT ASSIGNMENT, SUCH AS 'MY OVERHEAD, MALPRACTICE INSURANCE PREMIUMS AND ETC., ETC." BUT THE MEDICARE REGULATION PAYMENT IS SIMPLE AND SPECIFIC. IT INCLUDES REASONABLE CHARGES.

THE MEDICARE CARRIER IN EACH AREA DETERMINES THE APPROVED CHARGES FOR COVERED SERVICES

OCEAN COUNTY SENIOR COORDINATING COUNCIL, INC.

TOMS RIVER, NEW JERSEY 08753

EACH YEAR THE CARRIER REVIEWS THE ACTURAL CHARGES MADE BY DOCTORS IN EACH AREA. NEXT THE CARRIER DETERMINES THE PREVAILING CHARGE FOR EACH COVERED SERVICE. THE PREVAILING CHARGE IS THE AMOUNT WHICH IS HIGH ENOUGH TO COVER THE CUSTOMARY CHARGE IN 3 OUT 4 BILLS SUBMITTED IN THE PREVIOUS YEAR FOR EACH SERVICE.

WHEN A MEDICAL CLAIM IS SUBMITTED, THE CARRIER COMPARES THE ACTUAL CHARGE SHOWN ON THE CLAIM WITH THE CUSTOMARY PREVAILING CHARGE. CHARGE APPROVED BY THE CARRIER WILL BE, EITHER THE CUSTOMARY CHARGE, PREVAILING CHARGE, OR THE ACTUAL CHARGE, WHICHEVER IS THE LOWEST.

MOST DOCTORS CLAIM THEY CANNOT GET ALONG WITH THE FEES THEY RECEIVED FROM THE CARRIERS -(N.J. Prudential Ins.Co.).

THE STATISTICS WE HAVE INDICATE THE AVERAGE INCOME FOR DOCTORS IN THE NATION FOR THE YEAR 1984 WAS $180,000. PER ANNUM AND THIS CAN GO HIGHER, BASED ON THEIR SPECIALITY.

MUST WE PONDER AND QUESTION THIS IMPORTANT FACT? DOCTORS SHOULD ACCEPT THE MEDICARE ASSIGNMENT BASED ON A MONETARY CONCEPT AS STATED ABOVE, BUT MOST OF ALL, ON HUMANE PRACTICE BASED ON THE HIPPOCRATIC OATH THEY ALL TOOK WHEN THEY BECAME PHYSICIANS.

ON BEHALF OF MYSELF AND THE OCEAN COUNTY SENIOR COORDINATING COUNCIL, I THANK YOU FOR THE OPPORTUNITY TO SHARE MY VIEWS ON THIS VERY IMPORTANT ISSUE.

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Gerald S. Packman, M.D.
Brewster Rd. & Chestnut Ave.
Vineland, N.J. 08360

11/12/86

Mr. David Price
Office of Legislative Services
Room 455
State House Annex
CNO 68
Trenton, N.J.08625

Dear Mr. Price

A call to your office today revealed that there are already many speakers scheduled to present at the Health & Human Service's public hearing 11/17/86. For this reason I am writing to you to present the concerns of the Cumberland County Medical Society about the possibility of legislation requiring acceptance of assignment by physicians for medicare patients. Such legislation is a means of requiring a substantial discount to the medicare patient, based on a presumption that medicare patients are unable to afford their medical care.

Most physicians in our component of the Medical Society of New Jersey give unpaid service to the truly needy in the normal course of practice, and accept this as an obligation of the profession. We try to determine the needy using two criteria, both the financial need and the medical need.

Many medicare patients are not needy, and do not require charitable discounts. Unnecessary discounts given to such patients will result in increased charges to patients not protected by similar laws. These will frequently be working people with families who should not have to subsidize medicare patients who are in satisfactory financial condition.

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Medicare patients are already receiving discounts, because fees to such patients have been "frozen" by law, while other fees have risen appropriate to rising costs and the marketplace.

Deep discounts on a large scale provides economic incentive for the formation of high quantity low quality "mills" that will profit under such discounts.

Deeply discounted care "en masse" to a specified group of patients makes that group less desirable as patients. Passage of this type of legislation will increase the difficulties of the elderly to gain access to medical care.

Price reduction by government fiat that is not related to the real costs of a quality service will not make things better for our elderly citizens.

Speaking for our membership, I appreciate your time and effort in transmitting our feelings to the assemblymen on the Health & Human Services Committee.

Sincerely,

Gerald S. Packman, M.D.
President - Elect
Cumberland Co. Medical Society

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TESTIMONY BEFORE THE HEALTH AND HUMAN SERVICES COMMITTEE.

NOVEMBER, 17TH, 1986. TRENTON.

It is commonly known that while the level of care that Medicaid recipients receive is the same as private patients, the milieu in which they receive these services is often less than ideal. The level of remuneration is so low that, for many providers, it does not make economic sense to cater to these patients. An oppressive bureaucracy makes accepting these patients additionally undesirable. Thus, Medicaid recipients are frequently forced in to a clinic situation or in to a "Medicaid Mill" in order to receive medical care. While one does not wish to expand on this theme, I have brought up this issue to illustrate the outcome of a fixed sub-economic fee schedule - and that is a two-tiered system of health care.

While Medicare was instituted to supplement the medical financial obligations of the elderly and disabled, it was never intended provide complete coverage for a physicians fee. The level of remuneration was initially fixed at the 83rd percentile of prevailing private policies, but in 1972 was reduced to the 75th percentile. Subsequently reimbursement rates were related to the economic index, further diminishing the correlation with reasonable customary charges. Finally, the Medicare freeze has fixed Medicare remuneration at the 1982 level. In reality, therefore, Medicare rates have, over the years, been reduced to approach the 50th percentile of reasonable and customary fees. The appellation of the term "Reasonable" by Medicare for their schedule of fees is ludicrous in the context of the skyrocketing cost of

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running a medical practice which has further been inflated by punitive malpractice insurance rates.

In spite of the falling ratio of Medicare remuneration to a reasonable private rate and in spite of rising costs, physicians have continued to render care to senior citizens, and to treat them on an equal footing with their non-Medicare recipients. A two-tier system has never been introduced for these patients. While about 30% of physicians are "participating", 70% of all Medicare services are rendered on an "accept assignment basis". Additionally many other Medicare recipients are given discounts if their financial situation warrants it. One can therefore conclude that the Medical Profession has realized it's obligation to our Seniors to render services according to their ability to pay, and will accept assignment when indicated. However, the vast majority of Medicare patients are not economically disadvantaged and have the wherewithal to pay the difference between Medicare remuneration and the physicians reasonable fee.

Having addressed the needs of the overwhelming majority of senior citizens we turn to the less affluent. In the first instance it is imperative that a financially disadvantaged person identify his problem to his physician so that an accommodation can be made in terms of the fee. However, for the financially needy senior who is unable find a physician who accepts assignment, Union County already has an established system whereby an impoverished patient will be referred to a volunteer physician, with Medicare payment being the sole remuneration for the service. Ocean County is in the process of setting up a similar plan which should be up and running within a

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month. We would hope that other counties would follow our lead in this regard, or perhaps the State could aid with the provision of a similar Statewide Plan. With such a plan, and with the continued goodwill of physicians, it is our contention that it is both redundant and unfair to introduce Draconian legislation such as Bills A-2511, S-2473 and S-2585.

Should these bills be enforced the goodwill of physicians would be lost and the seniors would be the first to suffer. Many doctors would adopt the same attitude towards Medicare recipients as towards Medicaid patients and would close their doors to them. Physicians whose practices would be rendered unprofitable would either leave the State or take early retirement. As in Massachusetts, the newly qualified physician would seek employment in a State where this awful legislation would not exist. In all instances the senior citizen would find it harder to find the sympathetic, competent physician that he has been accustomed to. Furthermore, because of financial necessity, those physicians who continue to treat Medicare recipients would be forced to raise their fees to the younger non-Medicare group in order to continue to maintain their practices. We should remember that many younger people have as difficult a time meeting their bills as do the elderly.

Finally, we find it incomprehensible that any licensing standard be fixed to acceptance of a fee. It is in the interest of both physician and patient alike that a plenary license to practice medicine be related to those factors that concern themselves with the quality of care, namely the physicians education, his competence and moral character.

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Ian D. Samson, M.D.

President, Ocean County Medical Society.

President, Vascular Society of New Jersey.

Chief of Surgery, Kimball Medical Center.

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