

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24

STATE OF NEW YORK
DEPARTMENT OF HEALTH

COMMISSION ON HEALTH CARE FACILITIES
IN THE 21ST CENTURY

Commission Meeting

DATE: January 12, 2006
TIME: 1:30 p.m. to 3:00 p.m.
LOCATION: Empire State Plaza
Meeting Room #6
Albany, New York

1 H.C.F. Commission, 1/12/06, Albany, NY

2 STATE COMMISSION MEMBERS:

3 Stephen Berger, Chair

4 Leo P. Brideau

Craig A. Duncan

5 Robert J. Gaffney, Telephonically

Rosa M. Gil, Telephonically

6 Robert R. Hinckley

Howard T. Howlett

7 Ruben Jose King-Shaw

Mark L. Kissinger

8 Patrick P. Lee, Telephonically

Kristin M. Proud

9 Neil G. Roberts

Theresa A. Santiago

10 R. Buford Sears

Albert J. Simone

11 Bishop Joseph Sullivan

Pete Velez, Telephonically

12

REGIONAL COMMISSION MEMBERS:

13

Patricia L. Acampora

14 Stephen L. Albertalli

Paul S. Boylan

15 Bert Brodski

Peter Capobianco

16 Susan M. Crossett

Jeffrey Davis

17 Robert Doar

Richard V. Guardino, Telephonically

18 John F. Haggerty

Dorothy M. Harris

19 Judge Joseph Mattina

William Mooney

20

21

22

23

24

1 H.C.F. Commission, 1/12/06, Albany, NY

2 Heidi A. Nauleau

Donna O'Brien

3 Jeffrey Sachs

Andrew Sichenze

4 Arthur Spiegel

Arthur Weintraub

5 Lelia Wood-Smith

6 ALSO PRESENT:

7 Neal Lane

Betty Rice

8 David Sandman

Mark Ustin, Esq.

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

1 H.C.F. Commission, 1/12/06, Albany, NY

2 (The meeting commenced at 1:30
3 p.m.)

4 MR. BERGER: It is one-thirty and
5 the meeting of the Commission on Health Care
6 Facilities in the Twenty-first Century is called to
7 order. We're joined by the state-wide members and
8 regional members of the Commission. I welcome you
9 all here, as well as our audience.

10 Could I get -- can I find out who
11 is on the phone, please? Would you identify
12 yourselves?

13 Talk -- talk into the phone and see
14 if you get anything better.

15 (Discussion among members)

16 MR. GUARDINO: Rich Guardino, Long
17 Island Region.

18 MR. BERGER: Thank you. Can you
19 hear us, Rich?

20 MR. GUARDINO: I'm having a little
21 trouble.

22 MR. BERGER: Is there anybody else
23 on the phone?

24 (Discussion among members)

1 H.C.F. Commission, 1/12/06, Albany, NY

2 MR. BERGER: Well, when we hear
3 funny sounds, then we'll -- we'll know people have
4 gotten on or gotten off.

5 What we'd like to do today, we're
6 going to spend a large portion of the meeting dealing
7 with one of the two major areas that this Commission
8 has been charged with, which is -- which is on the
9 long-term care side. And we'll have some
10 presentations, as well as some discussion by the
11 Commission and -- and by the regional commission --
12 commission members.

13 One thing I -- I want to do up
14 front, we -- since we are taking minutes of the
15 meeting, and since we don't have -- we're not all
16 mic'ed, so that as -- if regional members comment
17 during the course of this meeting, I'd ask you to
18 speak up, and that will also allow the stenographer
19 to hear -- to hear comments that you're making.

20 Who joined us now?

21 (Discussion among members)

22 MR. LEE: Patrick Lee has just
23 joined.

24 MR. BERGER: Hello, Patrick.

1 H.C.F. Commission, 1/12/06, Albany, NY

2 Welcome.

3 All right. Now, I'm going to ask
4 our executive director, David Sandman, to begin the
5 meeting by giving us an update on the progress
6 report.

7 David.

8 DR. SANDMAN: Thank you, Mr.
9 Chairman. It is has been a busy and productive
10 period and I'm pleased to bring the report on our
11 progress since our last meeting.

12 With respect to our work plan, all
13 aspects of phase two have been completed and we are
14 now in the early parts of phase three. Since our
15 last meeting I am especially pleased to report that
16 the governor has made his appointments to the
17 regional advisory committees, or the RACs.
18 Significantly the RACs are launched and have
19 initiated their work. The RACs held their kick-off
20 meetings in December of last year and several have
21 since held additional meetings. The RACs also
22 generally included some of our regional members at
23 those kick-off sessions, so as to establish a
24 communications process going forward.

1 H.C.F. Commission, 1/12/06, Albany, NY

2 Among their other responsibilities,
3 the RACs will soon begin holding public hearings
4 across the state, and we will provide notice of those
5 hearing dates on the Commission's website once they
6 are confirmed.

7 With the establishment of the RACs,
8 we have also extended our policies regarding the
9 disclosure of potential conflicts of interest. All
10 of the state-wide and regional RAC members have been
11 asked to submit such disclosure statements. Staff
12 has compiled those statements and distributed them
13 among our membership, as directed by the bylaws
14 adopted by the Commission.

15 At our last meeting in November, a
16 proposed statement to the P.H.C. and to SHRPC,
17 regarding the certificate-of-need process was
18 discussed and tabled. Since then, with the support
19 of the membership, Chairman Berger has reached out to
20 the chairs of both P.H.C. and SHRPC and offered to
21 appoint a liaison from the Commission to those
22 bodies, to promote a regional stream of information
23 and ensure that all bodies remain cognizant of what's
24 on the job list.

1 H.C.F. Commission, 1/12/06, Albany, NY

2 The chairs of P.H.C., both of whom
3 we're privileged to have with us today, have each
4 accepted those offers, and Chairman Berger has
5 appointed the Commission's deputy director and
6 general counsel, Mark Ustin, to serve in that
7 capacity as our liaison.

8 Also in our last meeting, the
9 Commission unanimously adopted a set of criteria --.

10 FROM THE MEMBERS: Hello.

11 DR. SANDMAN: Hello.

12 FROM THE MEMBERS: Hello. I have
13 Dr. Gil on the line.

14 MR. BERGER: Yeah. Thank you. I
15 was going to -- I was going to take -- we've begun
16 the meeting I will take and -- I will -- I will
17 note --

18 MR. GAFFNEY: This is Bob Gaffney
19 joining, as well.

20 FROM THE MEMBERS: Okay. Very
21 good. Let me put Dr. Gil on. Thank you.

22 (Discussion among members)

23 MR. BERGER: Okay. I'm sorry.

24 DR. SANDMAN: At our last meeting

1 H.C.F. Commission, 1/12/06, Albany, NY
2 the Commission unanimously adopted a set of criteria
3 to be used in our right-sizing analytic framework,
4 and we are in the process of beginning to apply that
5 framework.

6 MR. GAFFNEY: Hello. Yeah. This
7 is Bob Gaffney.

8 MR. BERGER: Bob, we have -- for
9 all of you on the phone --.

10 DR. GIL: And talking is Rosa
11 Gil.

12 MR. BERGER: All right. For all of
13 you on the phone, the meeting began at one-thirty.
14 We are convened and David Sandman is making his --
15 his progress report here, and we're in a public
16 meeting, and welcome, all of you.

17 DR. SANDMAN: The first step in
18 getting started was to build a master list of all of
19 the hospitals in the --.

20 (Discussion among members)

21 MR. BERGER: The meeting has
22 started guys, so you can check the weather later,
23 please.

24 FROM THE MEMBERS: Okay. We'll

1 H.C.F. Commission, 1/12/06, Albany, NY

2 check the weather.

3 MR. BERGER: All right. We're in
4 the middle of the meeting, folks, and you're --
5 you're broadcasting through the loudspeaker. So,
6 please understand that.

7 DR. SANDMAN: In order to get
8 started we did begin by building a master list of all
9 the possible nursing homes in the state that are to
10 be evaluated. I know that might sound like a simple
11 task. It actually turned out to be monumental.

12 (Discussion among members)

13 DR. SANDMAN: Particularly because
14 we are --.

15 (Discussion among members)

16 DR. SANDMAN: Particularly because
17 we are collecting and then merging data from more
18 than twenty-five different sources, building a list
19 turned out to be a large task. The various data sets
20 often do not contain the same number of facilities,
21 and all of the data sets tend to come in very
22 different formats. Some identify facilities by name,
23 and the names alone are complicated by the fact that
24 facilities have changed their names, merged, or

1 H.C.F. Commission, 1/12/06, Albany, NY
2 closed over the years. Simply keeping track by name
3 can be complicated.

4 Some of the data sets identify
5 facilities by operating certificate numbers; some of
6 them do so by permanent facility indicators, or
7 P.F.I.s, and so, we needed to cross mark all of the
8 different data sets in order to ensure that we are
9 always talking about the same institution and
10 applying the right data to them.

11 The master list of facilities is
12 now developed. We are working through various other
13 data issues, and it will be a part of the framework
14 as charged.

15 The Commission continues to engage
16 in an active communications program, both for us to
17 receive information from the public and interested
18 organizations, as well as to make information readily
19 available to the public and our membership. We do
20 continually update the Commission's website. In
21 addition, our recent meetings and presentations with
22 various constituencies have included the Mental
23 Health Services Council, the New York Academy of
24 Medicine, the Brooklyn bureau president's office, at

1 H.C.F. Commission, 1/12/06, Albany, NY
2 which both Bishop Sullivan and Rosa Gil were
3 president; the Corporation for Supportive of Housing,
4 the New York Association of Homes and Services for
5 the Aging, at which Neil Roberts was present, as well
6 as the Hospital Trustees of New York State, arranged
7 by Howard and also attended by Stephen Albertalli.
8 And many additional presentations are scheduled
9 around the state.

10 As I reported at our last meeting,
11 the staff has been hard at work on an evaluation of
12 future system trends, such as demographic shifts, as
13 well as changes in technology and health-care
14 delivery. We have drafted a white paper on capacity
15 needs in a changing health-care system, and we will
16 be sharing that with the Commission in the very near
17 future.

18 So, in summary, Mr. Chairman, we
19 are on schedule and making good progress with our
20 work.

21 MR. BERGER: Thank you.

22 Any questions from members before
23 we move on?

24 I'd like to remind everybody that

1 H.C.F. Commission, 1/12/06, Albany, NY
2 as we talk about the future and we talk about how the
3 system -- the health system will change, remember
4 technology in and of itself won't solve all our
5 problems. We're learning that here today.

6 I'd like to have -- and bring in
7 Commissioner Neal Lane and -- and Betty Rice. You
8 guys join us.

9 This Commission has -- has mandates
10 in two major institutional areas, the acute care
11 system and the long-term-care system. And we would
12 like to begin this day of this with a discussion of
13 some of the visions for the long-term-care delivery
14 system.

15 Who starts? Here you go.

16 MR. LANE: Thank you very much, Mr.
17 Chairman, members, staff, and guests, it's good to be
18 with you today. And we'll just step right into our
19 remarks and -- and hopefully we'll move this along
20 and have time -- a good amount of time if you have
21 questions or issues you'd like to raise to us.

22 Most of us here in this room
23 understand that New York State is -- is a rich state
24 in terms of its service-delivery system and services

1 H.C.F. Commission, 1/12/06, Albany, NY
2 that are available to the customers within the state.
3 Before you is a list of Medicaid-supported programs.
4 I'll quickly pick through them, long-term-health-care
5 program, nursing-care services,
6 certified-home-health-agency services, private-duty
7 nursing, managed long-term care, possibly PACE.

8 In addition to that, we have public
9 initiatives that serve the ill and impaired New
10 Yorkers. We have several federal bureau choices; the
11 change grants. We have a number of long-term-care
12 demonstration programs, and then, of course, many of
13 you are aware of the Aging network and a set of
14 programs administered within that network,
15 extended-in-home-services-for-the-elderly program,
16 community services for the elderly, home delivered
17 meals, as well as not administered through the Aging
18 network, but -- but through state health -- State
19 Ed -- the Independent Living Center.

20 And of course, we are in the
21 process of examining the Olmstead decision, how it
22 relates to public policy and -- and our program
23 offerings within the state, and implementing the
24 guidelines given to us from the Olmstead decision.

1 H.C.F. Commission, 1/12/06, Albany, NY

2 Just a quick minute about where we
3 are in terms of demographics. This slide before you
4 gives you a sense of -- of what the impact of the
5 baby-boom generation is having, and -- and as the
6 side bar that I'll share with you today is that I'm
7 on that leading edge. I was born in 1946, so if you
8 look out there to 2011, you'll see that I'll be
9 sixty-five, along with a lot of other people. And
10 that's -- this is a -- a national look, but it is
11 a -- it's mirrored in New York State.

12 But less dramatic, and -- and
13 perhaps more importantly for all of us here in this
14 room, is the smaller bar that resides or floats
15 underneath the rather dramatic depression, the
16 conversion of our baby-boom generation to our
17 elder-boom, that is the eighty-five-plus population.
18 Now, why is that so important? Well, what we do know
19 is that for every -- every one -- one out of every
20 two persons over the age of eighty-five in New York
21 State requires the assistance, every day, of another
22 person to meet their daily living needs. And while
23 this bar does not appear very big, in fact it's
24 growing, by far and away, the fastest of any cohort

1 H.C.F. Commission, 1/12/06, Albany, NY

2 within the state.

3 So, if we look even back from 1990
4 to 2000, we see that this cohort, the
5 eighty-five-plus cohort, grew by something very close
6 to twenty-seven percent. Again, by far and away, the
7 fastest growing cohort within -- within our -- our
8 population. That great growth is not simply going to
9 be stable at that twenty-six and twenty-seven percent
10 increases, but we expect that level to accelerate
11 over the next three or four decades.

12 Back in 2002, the state
13 department -- the State Office for the Aging and the
14 State Department of Health sat down together to look
15 at the issues that were beginning to emerge from the
16 governor's projected 2015, and looking at the
17 demographics, the diversity, the implications for
18 public programs that were being -- that a light was
19 being shown on. And we -- we obviously included
20 long-term care as one of the critical areas that we
21 needed to think through and address.

22 And we felt that it was terribly
23 important for the State Department of Health and the
24 State Departments for the Aging to develop working

1 H.C.F. Commission, 1/12/06, Albany, NY
2 principals that we both would embrace and -- and
3 endorse. And this -- this slide gives you the voice
4 of that vision, that we -- the two departments,
5 agreed to. We agree that the long-term-care system
6 in New York State should be accessible. It should be
7 coordinated, and it should be person-centered; that
8 it should support self-determination and promote
9 personal responsibly; that it should seek to provide
10 the highest quality services that we possibly can;
11 and that those services should be directed to the
12 consumer needs; and finally, that the system should
13 be accountable, it should be efficient and it should
14 be affordable.

15 That dovetails us, I think, in --
16 in -- in a wonderful way, with the governor's
17 long-term-care work group -- actually,
18 health-care-reform task force, Chairman Berger's task
19 force, recommendations in their first report, the
20 interim report. And that report suggested that New
21 York should do a number of things in long-term care.

22 One: The first thing, is that New
23 York State should seek to establish a point of entry
24 for long-term care within New York State; that we

1 H.C.F. Commission, 1/12/06, Albany, NY
2 should look at the Medicaid program and -- and seek a
3 Medicaid waiver to eliminate the cycles that exist
4 even within that program. As Betty will talk about,
5 there are a number of state programs that are regular
6 programs as well as state-planned programs, and
7 sometimes it is a rather irrational
8 system, and the desire is to rationalize that.

9 There should be reforms in the
10 Medicaid eligibility -- eligibility for Medicaid;
11 long-term-care insurance should be much more
12 available, and much more -- what do I -- how shall I
13 characterize it? Much more to the preferences of the
14 population and therefore desirable as well as
15 affordable. And it is time for us to look at
16 innovations. We have our nursing-home sector. We
17 have many opportunities to do so in the near future.

18 What of our customers in New York
19 State who require private-care services, what does
20 the system look like for those folks? Well, this
21 is -- this is my simple character -- characterization
22 of that. It is that many of these people are
23 confronted with a whole set of -- of choices and --
24 and options for entering the system, but it is

1 H.C.F. Commission, 1/12/06, Albany, NY
2 extremely confusion -- confusing, and often decision
3 is made around chronic-care options, and choices are
4 made in the time of crisis. And we think that
5 system -- this nonsystem needs to change.

6 And so, we really have a nonsystem
7 in New York State. And that, ultimately, is a
8 very -- is very costly. It's very costly because
9 the -- the prime determinant of service is where the
10 customer enters the service system, and where they
11 touch the service system. The same customer in New
12 York -- in New York State, this is the customer who
13 has similar kinds of care needs and supports and the
14 like, can receive varying sets of services, based on
15 how and where they enter the system, versus a more
16 rational entry.

17 Additionally, we have, as -- as
18 many of stakeholders, as we know, we have a system
19 that requires many different assessments for the
20 customer to receive services, and this duplicative
21 process of assessment and case management is very
22 costly, to say nothing of very confusing to the
23 customer.

24 Additionally, one other problem of

1 H.C.F. Commission, 1/12/06, Albany, NY
2 our nonsystem is we have a lack of responsibility.
3 We all have our cycles; we all have our obligations
4 to Mary, the customer, but none of us have full or
5 all responsibly for Mary. So, the
6 certified-home-health agency is -- is responsible for
7 delivering the skilled-nursing care for Mary, and
8 ensuring that that -- that care is high quality and
9 meets her skilled-nursing needs. Her personal-care
10 provider are all responsible for their own service
11 set, that they can -- quality services get delivered
12 in the right way. But they're responsible for their
13 service set, not for the outcomes of Mary.

14 Likewise, that's -- that follows
15 through to the system, so that while -- while there
16 are issues and problems in every long-term-care
17 delivery system, locally, there is no responsible
18 entity that problem-solves that and ultimately takes
19 responsibly for having a customer-oriented, quality
20 system.

21 As I mentioned, its fragmented and
22 confusing, very confusing to those seeking services
23 and support. And if we don't already know it, let me
24 just say it again: The current system, or nonsystem,

1 H.C.F. Commission, 1/12/06, Albany, NY
2 as we have it today, is unsustainable, because of
3 costs associated with it, and because there simply
4 are not going to be the -- the hands available to
5 deliver services as we deliver them currently today.
6 We have a -- a rapidly increasing number of persons,
7 frail persons, who are needing support.

8 Access to services can indeed be
9 improved, as the health-care-reform commission noted
10 and one strategy -- one important strategy is we
11 believe that we -- it's -- it's critical to do in New
12 York State is to establish a point of -- a point of
13 entry in the system for New Yorkers.

14 What are some of the
15 recommendations that the health-care-reform work
16 group noted would be important, as we look at point
17 of entry? We need to be able to provide customers
18 with comprehensive, unbiased information and
19 assistance across all services and across all
20 supports.

21 We need to provide the customer
22 with screening of social and medical needs, of their
23 financial status, the availability of various service
24 options, and that should be done for all customers,

1 H.C.F. Commission, 1/12/06, Albany, NY
2 regardless of payors. We need to provide the person
3 who needs it a comprehensive multi-disciplinary
4 assessment.

5 For those customers who need it,
6 service-care coordination should be available. We
7 also need a public-education campaign, an ongoing
8 effort that promotes planning of individuals,
9 promotes personal choice, and helps individuals
10 understand how they can prepare financially for
11 disability.

12 And as I mentioned in the case
13 management, in all factors, as we look at the
14 customer in the long-term-care system, we must
15 understand that it is always an interdisciplinary
16 approach. That it is not simply custom, it is not
17 simply social. It is the integration of those two
18 domains. Failure of either domain spells failure for
19 the customer.

20 What are the qualities that are
21 important for a point of entry in New York State?
22 Once again, that point of entry being available to
23 all individuals; that it be available to all
24 individuals, regardless of age or regardless of

1 H.C.F. Commission, 1/12/06, Albany, NY
2 disability; that it become, indeed, a trusted
3 resource for the individual and for their
4 care-givers; that it's connected to their community.
5 And by that I simply mean that it is able to deal
6 within the nuances of the local community; that it
7 can be a place, a recognized place for people to
8 either come to, or reach out to, or work with,
9 that -- but people don't. And that it's -- it's
10 available to serve not just the impaired person, but
11 those people who care for the impaired person, the
12 formal supports, the family members, as well as the
13 professionals.

14 One sidebar, if you will, if we
15 look at older New Yorkers who are living in the
16 community and who are -- who have care needs, eighty
17 percent of the care that is provided to those
18 individuals is given by the home system, mostly by
19 family members. The information that is available at
20 the point of entry must be reliable and it must be
21 impartial.

22 Another quality that we feel is
23 essential for a point-of-entry-system is that the
24 point of entry be accountable, that we have a

1 H.C.F. Commission, 1/12/06, Albany, NY
2 consistent and unbiased program throughout the entire
3 state. And we propose to do that by contractually
4 obligating the point of entry of these entities to
5 make a set of standards and performance
6 accountabilities.

7 And we also believe it to be very
8 important that we have a state-wide
9 information-technology platform, which I will talk
10 about at another time. We also believe that it is
11 critical that we have a statewide contractor or
12 contractors that will provide program monitoring as,
13 well as training for the point of entity -- point of
14 entry entity.

15 Who -- who is it that we attempt to
16 contract with for the point of entry? Well, we have
17 decided that the right of first refusal -- refusal
18 should go to county government. So, the county
19 governments will have the opportunity to apply to be
20 point of entries if they so choose. If they pass,
21 then we will do a hierarchy process that will seek a
22 not-for-profit entity to provide point-of-entry
23 activities within a given county.

24 And we are still open to other

1 H.C.F. Commission, 1/12/06, Albany, NY
2 models. But we must stress to everyone that it
3 cannot be a person or entity that has a service to
4 sell or provide to a customer. It must be unbiased,
5 impartial.

6 The information --
7 information-technology platform we believe is
8 critical in this process. It must be a waste --
9 web-based system; it must be HIPAA compliant; it must
10 provide customer access, both local -- for local
11 customers and long-distance caregivers; it should
12 have a component where the customer can enter
13 customer data by themselves; it should have a
14 component whereby the customer or family member can
15 communicate directly with the point of entry and
16 other service providers; and it must provide
17 information to the customer and assist with educating
18 the customer about their service choices, as well as
19 about their service options, about what -- about
20 long-term-care planning and the like.

21 And we believe it is critical to
22 push us more towards integrated care. We all know
23 that if we can -- all the professionals and all the
24 care givers can talk together easily, we can

1 H.C.F. Commission, 1/12/06, Albany, NY
2 understand the care needs of Mary; we can do a far
3 better job for Mary, if we can do that well.

4 I mentioned that initially we
5 believe that it is essential that we monitor the
6 performance of our local points of entry, and we will
7 be doing a state-wide contract for that, as well as a
8 state-wide contract for training.

9 A couple of important aspects, is
10 there change, yes, is there no change, yes. And --
11 and the -- the two areas where there is no change is
12 that assessment right now, and access -- controlled
13 access are two areas that will continue. And that is
14 that if a person is seeking publicly funded
15 long-term-care services, such as Medicaid, such as
16 office-for-the-aging services, they must undergo an
17 assessment and a care plan to help determine their
18 services, and that will stay in place.

19 What will change ultimately is that
20 the assessment will shift eventually in the second
21 phase to the point of entry for all those.

22 Point of entry in New York State --
23 doing anything in New York State is a big deal, doing
24 point of entry in New York State is a very big deal.

1 H.C.F. Commission, 1/12/06, Albany, NY

2 And we've concluded that it must be rolled out in two
3 phases.

4 First, we will offer phase one,
5 information, assistance, as well as screening, on a
6 state-wide basis. And that screening will consist of
7 a preliminary evaluation of the consumer's needs, the
8 caregiver's needs, the general and social -- social
9 and medical and financial needs, and help identify
10 service options and service choices for the
11 individual.

12 And that information assistance and
13 screening needs will be available to the customer on
14 the phone; that needs to be available on the web; it
15 needs to be a place where customers can get to; and
16 it needs to have -- the point of entries must have
17 the capacity to go out to the customer where they
18 are, as well.

19 Currently we are working with our
20 partner, the Department of Health, on standards,
21 requirements, program outcomes, and performance
22 measures, in preparation for issuing a request for
23 applications for P.O.E. entities; for the R.F.P. for
24 the I.T. platform; the R.F.P. for staff training; and

1 H.C.F. Commission, 1/12/06, Albany, NY

2 the R.F.P. for monitoring the point of entry.

3 Here's our tentative time line for
4 the roll out of phase one. Jointly the two agencies
5 will be developing the standards and performance
6 measures for phase one of the point of entry and the
7 I.T. contracts right now. That work is going on
8 right now and it will be completed by the end of the
9 winter or early spring. In -- in the spring, we
10 expect to enter -- to issue the R.F.A.s to counties,
11 and for those counties that pass, go through our
12 R.F.P. process within that county for the nonprofit
13 center. We also expect to issue the contract --
14 we'll call it the R.F.P. for the contract, with a
15 I.T. platform, as well as the training R.F.P.

16 During the summer months, we expect
17 that we will have completed the review of the
18 R.F.A.s; we will have selected the point-of-entry
19 entities; we will issue the awards to those entities;
20 and we will issue the training contract.

21 In the fall and early winter of
22 2006, we will begin the implementation of the point
23 of entries; we will be billing out the I.T. platform;
24 and we will have the monitoring and evaluation part B

1 H.C.F. Commission, 1/12/06, Albany, NY

2 left.

3 Phase two will be out several years
4 into the future and will bring on -- on line the
5 fully functioning point of entry that is envisioned
6 in the health-care-reform task force's interim
7 report, which will add into information assistance in
8 screening comprehensive-need assessment, as well as
9 service coordination.

10 Simultaneously to the
11 implementation of phase one, the two agencies will
12 develop standards and requirements for the phase two,
13 as well as the expected customer and system outcomes.

14 Briefly we want to share with you
15 what we've heard from the stakeholders on their
16 concerns. And the concerns of the stakeholders
17 largely focus on delays in customer movement and in
18 service acquisition, where there is a slight concern
19 over getting assessments done in a timely way;
20 establishing eligibility for publicly funded programs
21 in a timely manner, so customers are not backed up at
22 various transition points; that hospital discharges
23 move smoothly and are not negatively impacted; that
24 nursing-home admissions, those -- those admissions

1 H.C.F. Commission, 1/12/06, Albany, NY
2 that are necessary, will move expeditiously, and the
3 start -- the instituting of home-care services
4 happens as quickly as possible, and we do not delay
5 any of those major functions of customer's in the
6 system.

7 And I will tell you that as we
8 write our performance standards for the points of
9 entries, these are all areas of which performance
10 standards will be required for the points of entry to
11 address.

12 The other area of concern is: Will
13 we have adequate funding to do point of entry? And I
14 am here to assure you that we will be adding dollars
15 into the system to fund points of entry. No one
16 wants to put up points of entry that cannot meet the
17 demands of the customer.

18 And with that, Betty, I think I'm
19 going to turn it over to you.

20 MS. RICE: Thank you. You keep
21 clicking. I'll be happy to --.

22 FROM THE MEMBERS: Okay.

23 MS. RICE: Hi. I'm Betty Rice and
24 I work for the Health Department in the Medicaid

1 H.C.F. Commission, 1/12/06, Albany, NY
2 program. And I just want to talk a little bit about
3 the other activities that our two agencies are
4 partnered together in, and how we're moving forward
5 in restructuring of long-term care. Other activities
6 or other issues that were identified by the interim
7 group, as Neal -- and from working with, Neal pointed
8 out a little bit earlier, is that there was an
9 identification of inequities in the system, in the
10 types and levels of services that are provided to
11 individuals.

12 And I think that's important to
13 understand. Neal actually made a reference to -- we
14 have lots of services; we have independent waivers;
15 we have a waiver for the traumatic brain injury; we
16 have a long-term-home-health-care waiver; we have a
17 care-at-home waiver for -- for, you know, physically
18 disabled children, and we'll be bringing up another
19 waiver that I'll be speaking about, the
20 nursing-home-transition-and-diversion waiver.

21 Each one of these waivers has
22 separate eligibility criteria, and in many instances
23 do not provide the same scope of services within
24 them, at least when it comes to the waiver services.

1 H.C.F. Commission, 1/12/06, Albany, NY
2 And what, you know, we looked was, having -- having
3 to deal with that, having to -- to make that a better
4 way of -- of providing services without the emphasis
5 on a medical model. The things that we've learned
6 and the different things that I've learned from --
7 from our relationship with SOFA now, our agent, is
8 that people frequently -- maybe they don't need a
9 personal care aide. A person has -- has a problem
10 with meal preparation, and you know, our response
11 from a health side is, well, we'll give them a
12 personal-care aide, when maybe really all they need
13 is the delivery of Meals on Wheels; okay?

14 So, what we're looking at is
15 deemphasizing, if you will, the medical model, and
16 looking at what does the person really need? And
17 also dealing with that inflexibility. I mentioned
18 that we have all these separate waivers and the
19 inflexibility of when you're in there, those are the
20 rules that you follow. You're in that stove pipe.

21 So, the recommendation that came
22 out of this task force is to come up with an
23 integrated long-term-care Medicaid program, using a
24 single waiver.

1 H.C.F. Commission, 1/12/06, Albany, NY

2 And we talk a lot of waivers,
3 waiver this, waiver that, and we have to do that in
4 order to continue our federal funding; okay? The way
5 New York has its state plan and the options that the
6 federal government gives us, does not provide us with
7 the opportunities that we need to do what we want to
8 do, particularly when we're looking at nonmedical
9 models, without asking them for special permission to
10 do something different, and it's -- it's known as a
11 waiver.

12 What we're -- what we're starting
13 with is this past -- last year, which is the
14 nursing-home-transition-and-diversion waiver. We
15 were looking at this waiver as our first foray into
16 this environment and getting us ready. It should
17 give us the information -- additional information
18 that will be helpful as we go forward. Some people
19 have heard the term used, as the mega-waiver, or this
20 all-inclusive waiver.

21 In April of 2005, we issued an
22 R.F.I., request for information, and many people and
23 many of you sitting here today, are the individuals
24 that responded to us, giving us your feedback and

1 H.C.F. Commission, 1/12/06, Albany, NY
2 individuals that are at least eighteen years of age;
3 that are eligible for, or are already in receipt of,
4 Medicaid; they have to need a nursing-home level of
5 care; they have to be capable of being served in the
6 community. And what will be provided is the full
7 range of state-planned services; okay? So that
8 people will have access to personal care and
9 consumer-directed personal-assistance programs,
10 hospital, all the standard what we call state plan or
11 Medicaid services. But in addition, we'll be adding
12 waiver services.

13 What are wavier services? Some of
14 the things that will be available -- and we have a
15 pretty hefty laundry list, but I'll just mention a
16 few: Service coordination; assistive technology;
17 home visits by medical personnel; nursing
18 assessments; moving assistance; things like that will
19 be available as waiver services in this program.
20 Additionally, when we ask for a waiver to the federal
21 government to provide services in a different and
22 maybe somewhat unique manner, we have to assure the
23 federal government that we will spend no more money
24 than what we spent had we served this individual in

1 H.C.F. Commission, 1/12/06, Albany, NY
2 an institution, and in this case, a nursing home;
3 okay?

4 And the way this particular waiver
5 is set up is different than some of our other
6 waivers. Our long-term-home-health-care waiver, for
7 those of you that are familiar with that, and our
8 care-at-home waiver for fragile -- medically fragile
9 children, all look towards that individual remaining
10 within a path, on an appropriated dollar amount for
11 that individual. This particular waiver is what's
12 referred to as an aggregate cap, so that what we look
13 at is for all the participants in that waiver, in the
14 aggregate, do we stay under the cost for all of those
15 people had they been in nursing homes? So that you
16 have the opportunity to have more expensive people
17 and less expensive people and as long as they balance
18 each other out in the final analysis and remain --
19 remain -- excuse me -- maintain overall cost
20 neutrality, that is okay. So, it's an aggregate cap
21 not an individual cap, in this particular waiver.

22 As we're moving along and
23 implementing that - and it should be up and running,
24 assuming all the federal approvals, this spring - we

1 H.C.F. Commission, 1/12/06, Albany, NY
2 are also, at the same time, working with aging and
3 have staff dedicated to the overall restructuring
4 that was referenced in the interim working group
5 report.

6 The waiver that we have to ask for
7 to support this larger effort is a more complex
8 waiver. It's known as the 1115 waiver, and it's the
9 same thing that we used to put up our managed-care
10 program in the health department, the Medicaid
11 managed-care department. Much more complex waiver.

12 What we intend to do with that
13 waiver -- and sometime affectionately referred to as
14 the mega-waiver -- is to fold in all of those waiver
15 programs I mentioned a minute ago. So, we'll be
16 taking that care-at-home program, and the
17 long-term-home-health-care program, and candidly this
18 brand new waiver program that we're putting up, this
19 nursing-home-transition-and-diversion-waiver program,
20 and asking to have them all melded into one waiver.

21 We also intend, in that waiver, to
22 take all of those state-planned services that are
23 operated outside of a waiver, and bring all of those
24 state-planned services into this waiver. So, if

1 H.C.F. Commission, 1/12/06, Albany, NY
2 fold in all of the people that need long-term-care
3 services in New York State, it will be, obviously,
4 for persons of all ages. It will -- also in this
5 waiver, we're looking to close the
6 Medicaid-eligibility loopholes. The closing of those
7 loopholes does not come without alternatives. We
8 know that if those loopholes closed, people have to
9 have other ways to plan for their futures and much of
10 that work has already begun and much of it is already
11 on the streets.

12 Last session, if you all remember,
13 there were provisions to change the New York State
14 partnership for long-term care, and how we provide
15 long-term-care insurance in the state of New York.
16 I'm pleased to say that those policies are now
17 available in the state of New York at --
18 opportunities where people can buy what they need a
19 cost that they can afford. So, rather than using a
20 state-planning technique and sheltering income and
21 resources from -- from you, we will have opportunity
22 for people to protect their income and resources, but
23 by doing it through the opportunity to -- excuse
24 me -- purchase long-term-care insurance in the -- the

1 H.C.F. Commission, 1/12/06, Albany, NY

2 amount that meets their needs.

3 In this waiver, again, I said it
4 before and I apologize if it's marginally repetitive
5 here. It will be all of our Medicaid state-planned
6 services will be in this waiver, all of the waiver
7 services that are existing in our waivers today. We
8 do not intend to take the long-term-care program --
9 the long-term-home-health-care program waiver off
10 the -- the market, if you will, and get rid of the
11 services. We intend to bring in all of the services
12 of that waiver. We're not going to eliminate; we're
13 going to make it more robust; okay? So that people
14 are able to get, based on their strength-based need
15 determination, what it is they need to -- to
16 accomplish their -- their goals and be able to -- to
17 live in -- in New York.

18 I think the last thing that I just
19 want to mention to you is the last page of your
20 handout here. It has a number of websites, that if
21 you want to get additional information about what
22 Neal and I have spoken to you about this afternoon,
23 that's available there. Additionally, in your
24 handout is just some real quick thumbnail take-away

1 H.C.F. Commission, 1/12/06, Albany, NY
2 sketches of the point of entry, the
3 nursing-home-transition-and-diversion waiver, and
4 this overall restructuring waiver.

5 MR. BERGER: Thank you. Thank you,
6 Betty.

7 Thank you, Neal.

8 Now, are there any questions from
9 members of the Commission before we go on?

10 Ruben.

11 MR. KING-SHAW: I -- I -- actually,
12 I just have one. Ruben King-Shaw.

13 Given the unstability of fifteen
14 million dollars that's attached to the Medicaid
15 program, what kind of conclusions to the planning are
16 you going to be working with, through this process?

17 MS. RICE: Well, I can -- I can
18 tell you that we have taken a look at the activities
19 that are going on in Washington and what has been
20 proposed. And candidly, most of what's in there
21 absolutely fits in with what we're doing into this
22 program, with the closing of the eligibility
23 loopholes. It's the kinds of things that we
24 reference in our proposal here. It's totally

1 H.C.F. Commission, 1/12/06, Albany, NY
2 consistent with what's being proposed at the federal
3 level. So, I think that at this point our analysis
4 shows that -- that we're a pretty good lock step to
5 move forward with -- with where we are and what we're
6 doing back here.

7 BISHOP SULLIVAN: To me it sounds
8 too good to be true. I mean, it's so conceptually
9 sound. It's the thing everybody in social service
10 has always objected to, the categorical way of doing
11 business. This is such a -- a -- I mean, the hope is
12 that there is the resources to do what we're really
13 planning to do, because to me, this is the only thing
14 that makes sense; it's the right way to move; it's
15 the one that, I mean, will really take all the
16 mystification, on a daily basis for families who are
17 trying to get help. So, I -- I mean, I just -- I --
18 I've been around a long time in this business, and
19 this to me is the first rational construct that
20 really -- really, really gives me some hope.

21 MR. BERGER: Thank you.

22 MS. RICE: Thank you. Can I just
23 say that -- that -- that we do have resources behind
24 this. We have been very fortunate that through --

1 H.C.F. Commission, 1/12/06, Albany, NY
2 through -- through the governor's office, that both
3 in aging and in the health department, that we
4 actually have people dedicated to work on this right
5 now, and we're not being distracted with the other
6 government activities that we do to keep our
7 day-to-day programs going, so it's really very
8 encouraging.

9 MR. BERGER: You know, the Bishop's
10 comments -- I mean, one of the reasons when the task
11 force made a recommendation on this, the original
12 task force, we did it -- it was that it was -- it
13 was -- it was -- the -- the Neal -- Neal's sort of
14 confusion chart, that's a confusion chart which
15 exists regardless of wealth, age, race, geographic
16 location, to this day. And following your entry
17 about understanding how to manage in a long-term-care
18 system when you have somebody -- usually somebody
19 aged, but it can be anybody in the family, is just
20 such a onerous burden by -- on the most
21 knowledgeable -- on the most knowledgeable people.

22 So, that's -- I mean, this --
23 and -- and there's more, because we've got enough, I
24 think, with what we've talked about right here today.

1 H.C.F. Commission, 1/12/06, Albany, NY
2 But -- but the reason behind it was, it should be --
3 it should be available to all people, people who can
4 afford to purchase the services, and people who
5 are -- who are dependent will not. But in order --
6 it's there to create a new way of looking at this
7 problem.

8 I want to thank both of you for --
9 for speaking -- let me -- I'm sorry. Krisin -- I'm
10 sorry.

11 MS. PROUD: Just following up on
12 Ruben's question about the federal funding, in light
13 of the -- the Medicaid cuts that are contemplated in
14 Washington. Your presentation also mentions federal
15 funding for non-Medicaid services, Meals on Wheels,
16 those kinds of things for higher-income recipients.
17 What do you think the likelihood of -- of those
18 federal funds would be in the coming years,
19 particular as, in New York, we are seeing a much more
20 rapidly aging population than many states. Do you
21 think that there's likelihood of additional federal
22 monies for those services, or -- or reduction in
23 federal support for those kinds of services?

24 MS. RICE: I have to be honest. We

1 H.C.F. Commission, 1/12/06, Albany, NY
2 presented this to C.M.S. and the federal agency on
3 aging a couple of years ago. And while it was a
4 couple of years ago, they are very, very interested
5 and they have also -- they have also hired staff that
6 are dedicated to working with us, on putting this
7 waiver together. So, I think from where -- where I
8 sit in the Medicaid program, that C.M.S. is very,
9 very interested, and candidly, provided additional
10 resources. Everybody in this room some day might be
11 eligible for Medicaid, you know, whether --
12 whether -- whether we believe that or not. So,
13 take -- keeping people away from the -- the -- the
14 more robust programs by providing less expensive
15 services, really helps Medicaid. And I think that
16 that will drive into part of our cost and channel the
17 argument with C.M.S. when we will put that forward.

18 MR. BERGER: Ruben.

19 MR. KING-SHAW: This is a good
20 time. I was there a couple of years ago when this
21 came in. So, I can personally attest to the fact
22 that it's a very popular waiver down at C.M.S.
23 Still, I think the presumption, always with these
24 types of waivers though, is that the savings will

1 H.C.F. Commission, 1/12/06, Albany, NY
2 come in the in-patient, if you will, nursing-home
3 experience. That would suggest that somewhere in the
4 state's thinking would be a reduction in the bed need
5 for nursing homes, which goes right to one of the
6 core issues in front of this Commission.

7 It will be interesting when this
8 Commission pursues its work and the tough decisions
9 be -- get made, whether, in fact, your state, whether
10 your agency is prepared to make those decisions
11 around reducing the need for nursing homes, and thus
12 nursing-home beds and potentially nursing homes.

13 But I think if -- if the logic were
14 to play out the way you present it, then the
15 unavoidable conclusion is that the savings will be in
16 reduced nursing-home beds, and potentially --
17 potentially enough savings in nursing-home beds to
18 afford the kind of expansion of the Medicaid program
19 to service segments of the population we don't
20 currently qualify for it.

21 MR. BERGER: Yeah, I --.

22 MR. KING-SHAW: I -- I think it's a
23 big savings.

24 MR. BERGER: Thank you. Since --

1 H.C.F. Commission, 1/12/06, Albany, NY
2 since -- since you've now basically taken over the
3 agenda, do you want to --.

4 MR. KING-SHAW: Sorry.

5 MR. BERGER: No -- no. You've
6 got -- this is a man who's got a plane to catch, so,
7 you do understand.

8 But in fact, one of the reasons we
9 asked-- we asked Neal and Betty to make their
10 presentation when they did on the agenda is that this
11 Commission is responsible for looking at the
12 institutional structure in the state. And one of
13 the -- one of the parts of our responsibility is the
14 long-term-care system and the nursing-home system.

15 And that is now the next item on
16 the agenda. Having -- having this as a lead-in for
17 some of the ways you have to change looking at the
18 delivery system, looking at -- at the -- you know,
19 how you -- how you provide services, and how you look
20 at the range of services, the next piece for us in
21 thinking about long-term-care facilities that exist
22 in the state.

23 And I'm going to ask -- I'm going
24 to ask our executive director to now take over and

1 H.C.F. Commission, 1/12/06, Albany, NY
2 --- take over and take us to the next stage of the
3 long-term-care discussion.

4 And I want to thank -- I want to
5 thank Neal -- I want to thank Neal Lane and -- and
6 Betty, for -- for being here with us today.

7 DR. SANDMAN: Thank you, Mr.
8 Chairman.

9 I too would like to thank Neal and
10 Betty, as well as Ruben, for their discussion. It
11 helps point up the presentation.

12 I'm going to share with you today a
13 new analysis, in regard to identifying geographic
14 areas. It may represent good opportunities to shift
15 long-term-care resources and help to further the
16 availability of a continuum of care services.

17 To begin, New York State has a
18 massive nursing-home system, by its count. There are
19 a total of six hundred and sixty-six licensed nursing
20 homes statewide, about twice as many nursing homes as
21 there are hospitals in the state. Collectively our
22 nursing homes have more than a hundred and twenty
23 thousand beds, and nursing-home capacity has actually
24 increased over the past decade. The total number of

1 H.C.F. Commission, 1/12/06, Albany, NY
2 nursing-home beds grew about eleven percent between
3 1994 and 2003.

4 It's also a very costly system:
5 Eleven billion dollars per year in total operating
6 expenses by nursing homes. And most of that money,
7 of course, is public funds. Here in New York State
8 seventy-eight percent of all nursing-home-patient
9 days are paid for by Medicaid.

10 Many of our nursing homes are
11 struggling. This picture shows nursing-home
12 occupancy rates over time, and while they are
13 certainly enviable compared to those of our
14 hospitals, the trend is steadily downward. And the
15 optimal occupancy rates for a nursing home is much,
16 much higher than what it is for a hospital. To view
17 it another way, the number of empty beds in New
18 York's nursing homes has been steadily rising. It's
19 increased by more than five thousand beds since 1994.
20 And it's particularly worth noting that this is
21 consistent with national trends, despite the fact
22 that the nation's elderly population has grown in the
23 past quarter century, the number of nursing-home
24 residents in the U.S. has declined steadily since

1 H.C.F. Commission, 1/12/06, Albany, NY
2 1993.

3 Based on those trends, it's not
4 surprising that a growing number of our nursing homes
5 are in fiscal trouble. The number of nursing homes
6 losing money has been steadily rising in New York
7 State, and by 2002, for the very first time, the
8 majority of our state's nursing homes had operating
9 deficits, and this is particularly true in some
10 regions of the state. And the percentage of nursing
11 homes in financial trouble keeps rising.

12 A lot of that turbulence has to do
13 with changes in the nature and the sources of
14 long-term care. There has been a movement out of
15 nursing homes and a shift towards noninstitutional
16 care. One big driver is the rise of consumerism, and
17 changes in patient preferences. Many people shun
18 institutional care. They simply do not want to be in
19 nursing homes. Studies have repeatedly found that
20 older adults prefer to receive care at home rather
21 than in an institution, by very large margins.

22 For example, a 2004 survey of
23 A.A.R.P. members in New York State found that only
24 three percent would prefer to have their needs met in

1 H.C.F. Commission, 1/12/06, Albany, NY
2 a nursing home. And another study found thirty
3 percent of seriously ill individuals over age seventy
4 report that they would rather die than to receive
5 their care in a nursing home. This preference of
6 noninstitutional care will be especially true with
7 future generations of health-care consumers.

8 And another driver is that the
9 current rate of growth for Medicaid spending is
10 unsustainable. New York's Medicaid spending on
11 long-term care has risen by fifty-four percent since
12 1997 in our state. And our counties simply cannot
13 afford those levels of expenditures.

14 Third, as Betty said, the legacy of
15 the 1999 Olmstead decision is making itself felt, the
16 supreme court decision that requires that care be
17 provided through the most integrated setting
18 possible.

19 And fourth, there are a serious of
20 federal efforts under the umbrella of the New Freedom
21 Initiative, that are further stimulating a shift
22 toward noninstitutional care. For example, C.M.S.
23 has been giving grants to states that support states
24 to do things like develop single-point-of-entry

1 H.C.F. Commission, 1/12/06, Albany, NY
2 systems, as well as to foster nursing-home-transition
3 programs, which funds things like making
4 modifications to one's home so that it is more
5 accessible to them.

6 The challenge for us was to
7 identify areas of the state as likely to present good
8 or even the best opportunities to appropriately shift
9 the long-term-care resources out of institutional
10 settings and into home- and community-based settings.
11 And we identified four core elements that may point
12 us toward those opportunities.

13 The first is where the number of
14 existing beds already exceeds the calculated need for
15 nursing-home beds.

16 The second is where beds are being
17 used sub-optimally. And what I mean by that is where
18 beds are being used by patients whose clinical-care
19 needs could most likely be met through alternative
20 settings.

21 The third is where existing beds
22 are simply not occupied by anybody.

23 And fourth, the areas of the state
24 where alternatives to nursing-home care may be less

1 H.C.F. Commission, 1/12/06, Albany, NY

2 than optimal.

3 We began the analysis by using New
4 York State's official bed-need methodology, and what
5 people who are into this kind of stuff often refer to
6 as 709.3. Unlike the hospital-bed need methodology,
7 which is very out of date, the nursing-home-bed-need
8 methodology was last revised in 2004, after a very
9 extensive developmental and public-comment process,
10 and it uses a planning target year of 2007.

11 It is complicated. The need
12 methodology is based mainly on the projected numbers
13 of older people in each county, as well as on the
14 likely degree of dependency for activities of daily
15 living in that population. And activities of daily
16 living, or A.D.L.s are everyday things like
17 day-to-day dressing, eating, walking.

18 The formula then apportions needs
19 between the need for nursing-home beds and need for
20 noninstitutional services like home health or
21 assisted living or supportive housing. So, it gives
22 us, on a county-specific basis, an actual projection
23 of needed nursing-home beds. Which, as this
24 illustration shows us, it can be less than, greater

1 H.C.F. Commission, 1/12/06, Albany, NY
2 than, or equal to the number of beds that exist.

3 Using the planning year of 2007,
4 the good news is that on a state-wide basis, the need
5 and the supply of nursing-home beds are basically at
6 a equilibrium, there's a mismatch of -- of less than
7 one percent, which we know looks great. In that
8 three-little-bears terminology, it's just right, how
9 many beds we've got.

10 But underneath the state-wide
11 total, there's a lot of geographic maldistribution.
12 On the surface many counties have too few beds; many
13 other counties are over-bedded. But that's also kind
14 of a surface impression. And what I'm going to show
15 is that when we account for other considerations, the
16 picture starts to change. And just as importantly,
17 the challenge is not simply moving beds around on a
18 map of the state as if they were interchangeable
19 chess pieces. The real opportunity is to think
20 creatively about where we can constructively move
21 some resources out of institutions and into home- and
22 community-based settings.

23 To do so, we examine how the
24 existing beds are -- are being used. And -- and we

1 H.C.F. Commission, 1/12/06, Albany, NY
2 look at the type of patients who occupy those beds.
3 All nursing-home residents in the state are scored
4 using a system known as RUGS or resource utilization
5 groups. The lowest scoring residents generally have
6 fewer A.D.L. limitations. They require the lowest
7 intensity of care, and there are a considerable
8 number of low-acuity patients. They are the
9 so-called P.A.s and P.B.s in our nursing homes.
10 State-wide fourteen percent of nursing-home beds are
11 occupied by low-acuity residents. These are the
12 patients who may be excellent candidates to
13 transition out of nursing homes and into other
14 settings where their needs can be met.

15 And in fact, that's really what the
16 nursing-transition-and-diversion programs around the
17 country are trying to accomplish. It's what our own
18 waiver will embark upon, as we heard from Betty a
19 little while ago.

20 To be conservative, we assumed that
21 only half of the P.A.s and P.B.s were suitable
22 candidates to be shifted out of nursing homes, and
23 that the other half should or had to remain in a
24 nursing home for any variety of reasons. Once we

1 H.C.F. Commission, 1/12/06, Albany, NY
2 adjusted the bed surplus numbers to account for these
3 low-acuity patients, the number of excess beds
4 increases.

5 So, what we've done at this point
6 is to highlight counties around the state that had at
7 least a hundred and twenty-five excess nursing-home
8 beds, once we've applied the low-acuity adjustment.
9 And the counties in orange began to emerge. What we
10 see is that they're pretty well distributed across
11 the state. They're not just clustered in one or two
12 regions. There -- there are opportunities, you know,
13 really across the state and on -- on the flip side,
14 there are many, many counties that remain gray, as
15 well.

16 The next question we asked is
17 whether the existing beds are in demand. And then we
18 looked at county-level average-occupancy rates.
19 What's striking is that there are counties that might
20 seem to have a deficit of beds, and yet they have
21 pretty low use of the beds that already exist, which
22 might reflect patient preference. Patients do vote
23 with their feet, whether it's for acute-care services
24 or for long-term-care services. And so, we've

1 H.C.F. Commission, 1/12/06, Albany, NY
2 highlighted counties with an average occupancy below
3 ninety-four and a half percent.

4 We chose that threshold because
5 ninety-five percent is the target at which nursing
6 homes qualify for bed-hold cases. It's something for
7 them to shoot for. It's a crucial occupancy
8 percentage for a nursing home. It determines their
9 own finances, and we gave them a cushion of half a
10 percent off that. I would note, however, that we're
11 kind of liberal in this regard. The bed-need
12 methodology in entities like SHRPC actually impose
13 even more stringent standards, wherein they will not
14 consider applications for additional beds if the
15 county does not have an occupancy rate of at least
16 ninety-seven percent.

17 The standards being used are
18 actually a little tougher than what we're using as
19 analysis. This method -- and again, the highlighted
20 counties are those with relatively low occupancy
21 rates. And once again, they are pretty well
22 dispersed across the state.

23 The next way we approached this was
24 to examine the availability of noninstitutional

1 H.C.F. Commission, 1/12/06, Albany, NY
2 resources. And we all know that long-term care is
3 comprised of a large array of care arrangements that
4 can include adult day services, home health, managed
5 long-term care, adult day-care facilities, assisted
6 living, C.C.R.C., and finally, nursing homes.
7 Sometimes people whose needs do not require being
8 institutionalized, end up in institutions simply
9 because there are no alternatives available to them.

10 As I mentioned, one of the really
11 useful things about the D.O.H., the methodology, is
12 that it accurately -- actually calculates, for every
13 county, the total need for long-term care. It
14 apportions some of that need to nursing-home beds,
15 and the rest is considered a need for
16 noninstitutional services, and can quantify that need
17 just as well.

18 What we did was sum up all of the
19 existing noninstitutional resources, including
20 home-and community-based slots, as well as various
21 types of supportive housing, and then we calculated
22 the simple difference between the need and supply of
23 noninstitutional services. Most counties did have at
24 least some unmet need for noninstitutional services,

1 H.C.F. Commission, 1/12/06, Albany, NY
2 and because counties vary so considerably in their
3 populations, obviously we wanted to convert those raw
4 numbers into percentages, just for differences of
5 counting styles.

6 In the counties where at least
7 fifty percent of their need for noninstitutional
8 services was not met, that's highlighted. Sorry, the
9 third map. Again, you see a distribution of
10 highlighted counties, but there is also more of a
11 pattern here in that they do tend to cluster more in
12 upstate and rural counties, which, you know, comports
13 well with our understanding that home- and
14 community-based services do, of course, tend to be
15 more available in the urban areas.

16 The final step was how to do we put
17 this all together; all right? What happens is that
18 certain areas emerge with possibly good
19 opportunities. And if a county had been highlighted
20 for at least two out of the three reasons, either
21 because they have a surplus of beds in light of the
22 low-acuity adjustment; they have a low occupancy of
23 their existing beds; or they have a high degree of
24 unmet need for alternatives to nursing homes, then

1 H.C.F. Commission, 1/12/06, Albany, NY
2 these counties were highlighted, and they may be
3 worth examining further as good places to shift
4 resources from nursing homes to home- and
5 community-services, and more supportive housing.

6 This map is the result of the
7 summary analysis. And again, it kind of takes us
8 where we started to see that in each of the six
9 regions that comprise the state, there are counties
10 that may be opportunities and they are existing and
11 they have -- are in every part of the state.

12 Having identified those possible
13 areas of opportunity, of course this is the time for
14 certain caveats. Actually resources are very hard,
15 very complicated, and there are many other factors
16 that need to be considered.

17 First, is there enough accessible
18 and affordable senior housing available? Is there an
19 adequate work force to support such a shift, such as
20 home-care attendants? Are there enough informal and
21 family caregivers? What types of supports are they
22 going to need if they're going to be responsible for
23 some of the care that gets shifted?

24 Costs do remain a huge open

1 H.C.F. Commission, 1/12/06, Albany, NY
2 question. I thought Betty's discussion on aggregate
3 cost neutrality was excellent. Some people believe,
4 and virtually everybody wants to believe, that
5 noninstitutional care is cheaper than paying for
6 nursing homes. But the jury is still out on that
7 question, on a limited basis, somewhat, and there are
8 certain economies that do result from our work and
9 care arrangements. So, we can't automatically assume
10 this is a cost we will share. Of course we need to
11 keep that in mind as well.

12 Additionally, the official bed-need
13 methodology that serves as our starting point is
14 based on current practice patterns, looking into the
15 future, and into the possible impact of certain
16 trends developed with these conclusions, although I
17 would suggest that they just -- probably only further
18 strengthen the need to shift resources.

19 For example, progress in medical
20 treatment and in technology have enabled older New
21 Yorkers to live longer in less restricted settings,
22 as evidenced in the quality nursing-home-occupancy
23 rates. And though the population is gradually aging
24 with the boomers, as Neal showed us, the development

1 H.C.F. Commission, 1/12/06, Albany, NY
2 of home- and community-based care could very easily
3 keep pace with that trend as that generation turns
4 away from nursing homes as a preferred alternative.

5 What the analysis does is give the
6 Commission -- it kind of wraps a way to think about
7 geographic areas of opportunity, and focus our
8 efforts. New York State is so big, so diverse, so
9 complicated, it's sometimes hard to know how to get
10 started. This helps us to identify smaller areas for
11 analysis. As always, the numbers are a starting
12 point. They're not the end point. There's a great
13 deal of local and regional knowledge that has to be
14 brought into this process to help us interpret the
15 numbers as we find them, and use those numbers most
16 effectively.

17 And concluding thoughts, very
18 importantly, this presentation has focused on where
19 we might find opportunities to shift resources. But
20 in doing so, we must not lose sight of the fact that
21 an appropriate number of nursing homes will always be
22 needed. They are a bedrock of our long-term-care
23 system. Our most frail, our most vulnerable
24 patients, with the most acute needs, will continue,

1 H.C.F. Commission, 1/12/06, Albany, NY
2 now and in the future, to be cared for by nursing
3 homes. And as part of this balancing act that we are
4 engaged in, it's equally crucial to fiscally
5 stabilize needed and high-quality nursing homes that
6 are such an important part of our care delivery
7 system.

8 And with that, I'll give it back to
9 the chairman.

10 MR. BERGER: Thank you, David. I'm
11 going to praise -- I was just going to praise this
12 one person. You don't think that's a problem?

13 MR. DUNCAN: I think the -- having
14 lived through, I think, four or five iterations of
15 709.3, it's -- it's, I think, refreshing to see the
16 comprehensive look that you've taken with it.

17 Now having said that, I've got two
18 questions. One is -- and particularly talking about
19 the additional considerations. I think you
20 recognized the issues and the final points. But it's
21 a couple of questions with this, on a process.

22 Is this -- where do you go from
23 here in establishing the numbers and really looking
24 the fact that rural areas face very different issues

1 H.C.F. Commission, 1/12/06, Albany, NY
2 than they do even in some of the suburban areas in
3 this region. How is this brought back up to a point
4 where someone says, this is the number, this is the
5 distribution? What is the process that we're looking
6 at?

7 DR. SANDMAN: I think the next step
8 is we are sharing reports with our RACs, whose input
9 is absolutely critical. We were fortunate that some
10 of our members as well, talked to us, and looked at
11 the order drafted and -- and said, almost like you,
12 this is totally sound, you know, and elegant, but I
13 know this area, and I know there's a lot of other
14 stuff going on, and that's exactly the kind of
15 feedback that has to be brought into the process in
16 the RACs. That's their value to us. So, we'll share
17 the analysis with the RACs; they'll look it over --
18 gives them places to look and define this and so on.
19 That's what we propose as the next step.

20 MR. DUNCAN: Is there a -- is there
21 an intent to have these numbers stand as the numbers
22 that the RAC react to, or is it, again, a view of the
23 appropriate redistribution resources within that
24 region?

1 H.C.F. Commission, 1/12/06, Albany, NY

2 DR. SANDMAN: They -- they do not
3 need to react formally to us. It's meant to be a
4 more informal method.

5 MR. DUNCAN: Thank you.

6 MR. BERGER: Neil.

7 MR. ROBERTS: The discussion that
8 Neal Lane led, and then this discussion, depends so
9 much on the term "county," that --

10 MR. ROBERTS: -- that I'll --

11 (Discussion among members)

12 MR. ROBERTS: -- say the obvious,
13 and I've said this to the staff already: The county
14 boundaries really are completely artificial. And the
15 county I'm most familiar with, Saratoga County, from
16 a medical point of view and those who are familiar
17 with the Northway will appreciate my -- will
18 understand what I'm saying, there really are three
19 counties. There's exit twelve south, there's twelve
20 to sixteen, and there's sixteen north. And they
21 really focus on three different medical regions.

22 And within that, the distribution
23 of nursing-home beds, as one example, is very uneven.
24 There are none in the northern section. There are

1 H.C.F. Commission, 1/12/06, Albany, NY
2 gobs of them in the center section, and there are a
3 relatively modest number in the southern section.
4 So, there's levels of subtlety here and my discussion
5 with -- if I had a question for Neal Lane it would be
6 the same thing. I mean, there's -- county is a
7 completely arbitrary thing and doesn't relate to
8 reality.

9 So, that's why we have the RACs, is
10 the answer you're going to give me, and I appreciate
11 it. But it really is critical that this be looked at
12 very -- deeper than this, and I -- but I
13 appreciate -- I reiterate, like Craig said, there's
14 a -- there's a direction that this offers, which is a
15 good thing.

16 MR. BERGER: Pete, did you have a
17 question?

18 MR. VELEZ: Yes. I was just -- and
19 again, I want to say that, you know, the data -- I'm
20 looking at the presentation on line and the data
21 is -- is certainly very targeted and very
22 informative.

23 My -- my -- my question, David, is
24 this a -- a strategic direction that will be

1 H.C.F. Commission, 1/12/06, Albany, NY
2 entertained? And specifically I think you'll find
3 some regions that can benefit in the shifting of
4 resources primarily to H.T.D. and supported housing.
5 Are you putting this on the table just for the
6 discussion, or do you feel, okay, that we can begin
7 to focus exclusively on those regions that you have
8 alluded to, that have the potential of taking the
9 next step?

10 DR. SANDMAN: If -- if I understand
11 your question, Pete, we're not looking for any formal
12 level or adoption of any sort, but -- but these are
13 the counties to focus on. It is meant to be a tool
14 for analysis and discussion and talk with the
15 Commission and the RACs.

16 MR. VELEZ: I heard half of your --
17 are -- are you saying that further analysis should
18 come, you know, before you could -- you could sort or
19 recommend to the RACs that this is not -- it's just
20 the region?

21 MR. BERGER: I think what we're
22 saying is that we'd like to hear the other way, Pete.
23 I think we'd like to hear back from the RACs whether
24 this information, from their point of view, is

1 H.C.F. Commission, 1/12/06, Albany, NY
2 sensible and drives us in a direction which we could
3 then consider.

4 MR. VELEZ: Okay. Thank you.

5 MR. BERGER: Leo.

6 MR. BRIDEAU: Steve, I -- I -- I
7 also agree it's a very nice piece of work and it's a
8 great starting point for discussion with the -- with
9 the RACs. I'm wondering if there isn't a piece of
10 work we ought to be doing simultaneously with that,
11 given that institutional restructuring has pretty
12 long implications and with the trend data that we saw
13 around the aging of the population, how are we going
14 to do some scenario building while we're talking to
15 the RACs and take a look at this five years out, ten
16 years out, and fifteen years out, and get a sense of
17 what are the possible outcomes.

18 And again, it's a -- it's a -- it's
19 a crap shoot, because you have so many variables
20 you've got to adjust for. But again, as our chairman
21 has said, this is not an exact science, it's
22 judgment. And I think if we apply judgment to some
23 of those elements and try to create a set of sort of
24 optimistic and pessimistic scenarios, just to get a

1 H.C.F. Commission, 1/12/06, Albany, NY
2 sense of -- of what's the range of possibilities
3 we're dealing with five or ten years out.

4 DR. SANDMAN: And -- and I do --
5 Neal, shake your head if I have this right. I do
6 believe that D.O.H.'s plan is also talking just
7 beyond the 2007 planning year; right?

8 MR. LANE: Yes, we're -- we're
9 required to.

10 MR. BERGER: Right. I mean, one of
11 the -- one of the tests you've just given everybody,
12 Leo, which is what makes this so very complicated, is
13 one of the things David said and we'll talk more
14 about it next month as we look at the health trends,
15 is seventy-five -- today's seventy-five is not
16 yesterday's seventy-five; and today's sixty-five is
17 not yesterday's sixty-five; and tomorrow's
18 eighty-five is not yesterday's eighty-five. So, in
19 modeling need, we're going to have to make some very
20 wide assumptions about the changes that -- the -- the
21 demographics are creating new age bundles. But the
22 needs of people inside those demographic cohorts is
23 very different than it would have been once before.

24 And while I think you're right, we

1 H.C.F. Commission, 1/12/06, Albany, NY
2 do have to do some modeling and make some
3 assumptions, we all know that we're going to -- that
4 these -- they are pure assumptions, and we're going
5 to have to spend some time talking about the reality
6 for those assumptions, given the changes that are
7 taking place in people's lives.

8 I -- I think it's fair to do it,
9 but I think we have to understand that's what we're
10 doing.

11 Kristin.

12 MS. PROUD: Steve, I would just add
13 also -- and -- and I think this ties into the
14 presentation that was made by Betty earlier. To the
15 extent that part of the undertaking is to -- to start
16 to educate people at younger ages and start to help
17 shape behaviors, we need to build those things in as
18 well. And one of the pieces was the long-term-care
19 partnership and encouraging the purchase of
20 long-term-care insurance, and those things which have
21 been going on for a while, to the extent that efforts
22 really, solidly, get put behind that at local levels,
23 where that may make a bigger difference than some of
24 the state-wide efforts that have been going on for a

1 H.C.F. Commission, 1/12/06, Albany, NY
2 while. Then those could be very positive assumptions
3 in some of the models that we would work on, as
4 opposed to some of the other assumptions that are
5 going to add costs, unfortunately.

6 MR. BERGER: I mean, in -- in the
7 original task force, we spent a great deal of time
8 talking about the issue of long-term-care insurance,
9 the reason it hasn't taken. One of the reasons, very
10 honestly, that we made recommendations about
11 loopholes in the -- in the Medicaid system was to
12 create both -- both sides, both the carrot and the
13 stick, for creating a real long-term-care insurance
14 program in the state, which would be beneficial
15 across the board. But I think it is -- over the long
16 haul, it's got to happen, because it's very important
17 for -- for people's futures.

18 And -- and David made the point
19 early on, if you look at what is the growth in the
20 cost of -- the Medicaid growth cost on long-term
21 care, what we do understand, it's just not
22 sustainable over time. And so, you've got to have
23 changes in the system if you're going to take care of
24 people, and that's part of what this entire

1 H.C.F. Commission, 1/12/06, Albany, NY

2 discussion is really about.

3 Any other comments?

4 Mark.

5 MR. KISSINGER: I just want to echo
6 people's -- I just want to echo people's statements
7 about the -- the work of the task force staff. I
8 thank them for that. I think it's a great starting
9 point for our discussions.

10 And I wanted to caution people that
11 we do have a -- a very extensive home- and
12 community-based system in the state, and it's a great
13 base to grow upon. So, I want to make sure that we
14 all understand that -- that we have a great base to
15 start from, and we -- we can build on that.

16 I have a specific question about
17 some of the data, and if we could go maybe offline
18 and talk to us about the actual -- the actual
19 background documents that you used, at some point,
20 maybe in a further communication to the task force,
21 that would --.

22 MR. BERGER: Okay. We can do it.
23 We just thought it would be -- well, you know, it's
24 really that we got too deep into the day in here.

1 H.C.F. Commission, 1/12/06, Albany, NY

2 MR. KISSINGER: Right.

3 MR. BERGER: It would -- it would
4 be difficult.

5 Are there any other comments on
6 this piece?

7 DR. SANDMAN: I -- I would also
8 thank the -- the staff. They did a great deal of
9 work.

10 MR. BERGER: Mr. Hinckley.

11 MR. HINKLEY: We talked a lot
12 about -- about the alternatives to nursing-home care.
13 And you know, David rightly point -- pointed out
14 that, you know, the backbone of care now and in the
15 future will be an appropriate number of nursing
16 homes.

17 I think we need to have a
18 discussion as well about what the -- what the nursing
19 home of the future will look like, and how we can go
20 about helping facilities get there. Because, you
21 know, we're sitting on -- when I say we, the -- the
22 facility owners are sitting on significantly aged
23 housing stock, and -- and there will have to be
24 changes going forward. And I think we have to -- to

1 H.C.F. Commission, 1/12/06, Albany, NY
2 come up with some ideas that will help -- help them
3 modify and -- and -- and renew their stock to help
4 support our overall agenda.

5 MR. BERGER: Yeah, there -- there
6 are a number of changes taking place, frankly, in
7 terms of what we used to call nursing homes all over
8 the country. There are physical changes, there are
9 program changes. They -- they've taken place in this
10 state as well. If you look at the population, if you
11 look at -- at some of the activities that now take
12 place, they're -- I will tell you, they are not the
13 same as they were fifteen years ago, and they're --
14 they're dramatically different.

15 I think, in the same way -- I
16 think -- I think Bob, you're right. Mr. Hinckley has
17 pushed us when we talk about acute care. He's asked
18 the same question on the acute-care side, and he
19 continues to ask that. And I think it's the right
20 question for him to ask, because while we can't truly
21 predict, we've got to create -- I think we've all
22 set -- we've got to create some models and
23 flexibility so that as change takes place -- and I
24 think we have to think about it in terms of looking

1 H.C.F. Commission, 1/12/06, Albany, NY
2 at what are the -- you know, what are going to be
3 some of the services, options, available in the -- in
4 the long-term care.

5 And by the way, the only
6 disagreement I have is the backbone of long-term
7 care, in the state of New York and most of this
8 country, remains family care at home. We shouldn't
9 forget that. It's a very important piece.

10 But -- but the answer is yes, I
11 think that's a fair thing, and I think we've got to
12 look at it and try to -- try and do something on it.

13 Bishop.

14 BISHOP SULLIVAN: Just a -- just a
15 question. Experience, I think, in the state shows
16 how much reimbursement methodologies really drive the
17 way we take care of people. And -- and the issue
18 will be, here -- I mean, this seems to be much
19 more -- you know, it's open to everybody. You either
20 have to pay or the government pays, but -- but I
21 think we've got to give a lot of attention to what is
22 the methodology of financing the system, because that
23 will shake the way the system actually functions.

24 MR. BERGER: By the way, I -- I

1 H.C.F. Commission, 1/12/06, Albany, NY
2 think that it's obviously, in the long-term-care area
3 where -- where Medicaid and the state provide such an
4 overwhelming amount of -- of the funding, it's
5 fundamental. But I would argue, before we're done, I
6 think this body is going to have to talk about
7 broader issues of reimbursement as it affects both
8 the acute-care as well as the -- as well as the
9 long-term-care system. And that even though it is
10 not directly in our mandate, it is -- to make
11 recommendations in those areas, but if we want to
12 shape the care, then you're right. You know, it
13 follows the money. There's no change to that. That
14 hasn't changed, like water going downhill. That has
15 not changed.

16 Any other comments?

17 Let me -- let me take a moment to
18 try to talk to the members of the Commission about, I
19 think, where we are at and the process for the
20 next -- next period of time.

21 David had -- David, in his progress
22 report, has talked about the -- the -- the stage
23 we're at, where we have now had, we have the -- the
24 six RACs around the state have come together, five

1 H.C.F. Commission, 1/12/06, Albany, NY
2 have had organizing meetings; the sixth will have a
3 meeting this week. And several are actually into
4 their second meeting and now planning for public
5 hearings, and they're planning to begin to meet with
6 people in the local community.

7 Whether you're talking about the
8 acute-care system or you're talking about the
9 long-term-care system and -- and very much to do with
10 Neal's point about counties -- or not counties --
11 health-care delivery does not necessarily fit in the
12 map, and it doesn't -- by the way, it's true in
13 long-term care and it's also true in -- in the -- in
14 the hospital-based systems as well.

15 But we're now at the point where,
16 to make -- to make the template -- the template that
17 we discussed with this Commission, you know, at the
18 end of last year, a -- a reality, we really are at a
19 point where we're dependent upon beginning to hear
20 back from -- from the RACs. Because it is the field
21 information that now does exactly what Mr. Roberts
22 does -- did -- did for us in terms of -- terms of
23 describing a health-care-delivery system based on
24 exits on -- on the thruway. But we need a lot more

1 H.C.F. Commission, 1/12/06, Albany, NY
2 of that data. The -- the RACs, I know, are really
3 the environmental staff. They're -- they're a check
4 on what's happening in each community. And as they
5 meet and talk with people, they will -- they will be
6 able to put, you know, sort of flesh and blood onto
7 what our series of statistics and numbers, which --
8 which we -- we have -- we have generated. Our
9 executive director continues to point out, if this
10 was just a mental exercise, he wouldn't need the
11 Commission, he'd just need a computer, and it is not.

12 And so, I would expect that over
13 the next sixty days or so, David, what do you think?
14 Over the next sixty days, you know, in some places a
15 little faster, some places it will take a little
16 longer, some of the regions are bigger, some will
17 take more time, we will begin -- we will see the RACs
18 starting to have meetings, starting to have
19 conversations, and talking to people in their
20 community, holding public hearings, and then
21 beginning to feed back to us a sense -- you know,
22 starting to put shape and color onto some -- onto
23 some of the structure that we're -- we're trying to
24 deal with at that point. And we'll -- you know,

1 H.C.F. Commission, 1/12/06, Albany, NY
2 the -- the Commission will then be able to focus
3 on -- on the matrix that we've created, and begin to
4 put some reality onto it.

5 We have distributed material to all
6 the RACs. All -- all the RACs have material. The
7 RACs are not there to duplicate, you know, the
8 functions of -- of -- of the staff or to create data
9 networks. The data for the RACs is background. What
10 the RACs -- the RACs are there, and have been
11 appointed, to be -- they're our people who are from
12 communities, who understand health care in their
13 regions, and can bring to us critical judgments that
14 we need, that turns -- that -- that, you know, that
15 turns pieces of paper into something -- you're
16 starting that exercise. We're going to -- we're
17 never going to -- we're never going to get away. But
18 it's very real here.

19 MR. ROBERTS: Until I find
20 something on you.

21 MR. BERGER: Until you find
22 something on me, absolutely.

23 But it's very real. And so, that
24 is where I see, you know, our spending a good -- a

1 H.C.F. Commission, 1/12/06, Albany, NY
2 good part of our time over the next -- over the next
3 several months. I have suggested, so that -- I've
4 said -- I've said to people who've asked me, the RACs
5 have the ability to meet with people. They can meet
6 in public; they can meet in private. They have --
7 they have a wide range of -- of ability. They
8 will -- you know, regional members, this Commission
9 will probably be invited to -- to -- to meet with --
10 to meet with some of the RACs, and sometimes they
11 won't be.

12 But the decision-making process
13 will be come -- will come at this level, to the full
14 members of the Commission. But the RACs have a
15 free -- have -- have a very wide mandate to gather
16 information to help us shape -- shape our decisions.

17 And I would expect that that would
18 be -- that will take a good deal of the staff's time
19 and a good deal of activity managing over the next
20 sixty days at least, and probably -- and probably a
21 little longer.

22 David, any --

23 DR. SANDMAN: No.

24 MR. BERGER: Mark?

1 H.C.F. Commission, 1/12/06, Albany, NY

2 All right. Any -- any other
3 questions, comments?

4 Kristin.

5 MS. PROUD: I -- I just have one
6 question which goes back to our hospital-framework
7 discussion of the last meeting, but it -- it relates
8 to some of the things that we just talked about here
9 with respect to the long-term-care system and trying
10 to model trends and make assumptions, you know,
11 educated assumptions about needs and that sort of
12 thing.

13 And do you -- at some point, can we
14 go back to that framework and have a discussion about
15 which elements of that framework will allow us to
16 factor in the need for emergency preparedness? I
17 mean, those kinds of things certainly is -- the --
18 particularly the acute-care system in the state has
19 evolved over the last many decades. The idea of
20 being prepared for certain emergencies has changed a
21 great deal. Whereas before maybe it was more about
22 being prepared for certain public-health emergencies
23 and epidemics and that sort of thing, that's still
24 the case, but also it has -- there -- there are

1 H.C.F. Commission, 1/12/06, Albany, NY
2 certainly things with respect to other emergencies
3 that were not foreseeable before that now
4 unfortunately we need to be a little bit more
5 prepared about.

6 I know that nursing homes are also
7 involved in that, but -- perhaps to a lesser degree,
8 but you know, all of these facilities are being asked
9 to have their own emergency preparedness plan and
10 disaster preparedness plans, and I'd like to talk at
11 some future point about what -- whatever action or
12 recommendations the Commission makes will factor in
13 the need for that kind of preparedness.

14 MR. BERGER: Well, one of things
15 we're going to need is things like this, like setting
16 things -- everybody setting things up. And part of
17 what we're going to do at the next session is we're
18 going to talk about the long-term health-care needs,
19 and we're going to -- the staff has been working on a
20 paper, of which this -- you know, this is -- this is
21 certainly -- certainly part of it.

22 And one thing we might do is, as
23 soon as that paper is sort of ready as a draft to
24 circulate to the members, so we can talk about at the

1 H.C.F. Commission, 1/12/06, Albany, NY
2 next meeting, we might circulate it and then get some
3 questions back from people who have some things that
4 they think we ought to talk about, and we can use
5 that -- we can use that sort of as a baseline for
6 talking about -- to see whether we're covering
7 health-care needs and health-care issues at the next
8 meeting.

9 And if you have any particular
10 questions, send them to David first, so he has to
11 rewrite the damn thing again.

12 MR. ROBERTS: I'd like to make one
13 suggestion on how we look at health-care particularly
14 as finance -- regarding financing. We talk about
15 cycles of care, and we tend to keep -- put people in
16 cycles and they tend to stay there.

17 But there's also cycles of finance,
18 and if you layer on top of the list of care services
19 the list of how people pay for them and what options
20 are available in -- in that pay system, you end up
21 seeing three different systems. You've got one that
22 has community-based Medicaid; one that has
23 institutional-based Medicaid; and one that has
24 private pay. And what's available to those people in

1 H.C.F. Commission, 1/12/06, Albany, NY

2 long-term care varies tremendously.

3 For example, the reason so many
4 Medicaid people end up in nursing homes is that's all
5 that's available on an institutional basis. But on
6 the other hand, most private-pay people don't see a
7 value in medical-model daycare, at least from my
8 experience.

9 So, I think one of the things that
10 we might want to ask staff to do is look at how
11 people pay for this, and what choices that sort of
12 pushes them into, and do we like that? I'm not
13 saying it's bad or good, just what -- what -- what
14 does it tell us about our system, and should it be
15 adapted?

16 MR. BERGER: I think that's fair.
17 That's -- that's partly why so much time is spent,
18 whenever you try to do something, on creating a
19 waiver list. That's exactly why.

20 MR. ROBERTS: Yeah. I don't know
21 if the waiver addresses that.

22 MR. BERGER: I'm not sure it
23 addresses that. But -- but that's what you sort of
24 have to do to break the financing cycle. I think

1 H.C.F. Commission, 1/12/06, Albany, NY
2 it's a very good point.
3 Any other comments? Anybody?
4 If there are no other comments, I
5 would take a motion to adjourn.
6 FROM THE MEMBERS: So moved.
7 MR. BERGER: Thank you.
8 (The hearing concluded.)
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24

1 H.C.F. Commission, 1/12/06, Albany, NY
2 I, Caleb J. Miller, do hereby certify that the
3 foregoing was taken by me, in the cause, at the time
4 and place, as stated in the caption hereto, at Page 1
5 hereof; that the foregoing typewritten transcription,
6 consisting of pages number 1 to 85, inclusive, is a
7 true record prepared by me and completed by
8 Associated Reporters Int'l., Inc. from materials
9 provided by me.

10

11

Caleb J. Miller, Reporter

12

Date

13 rcjm/tcww/plah

14

15

16

17

18

19

20

21

22

23

24

