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Transcript of the Meeting  
of the  
Commission on Health Care  
Facilities in the 21st Century

Held on Thursday, October 12, 2006  
NY Marriott Hotel  
525 Lexington Avenue, Stuyvesant Room  
Borough of Manhattan

1 Meeting convened at 10:00 a.m.

2 P R E S E N T:

3 Statewide Members

4 STEPHEN BERGER, Chairman

5 CRAIG A. DUNCAN

6 MARK KISSINGER

7 ROBERT R. HINCKLEY

8 HOWARD T. HOWLETT

9 DARLENE D. KERR

10 RUBEN JOSE KING-SHAW

11 LEO BRIDEAU

12 PETE VELEZ

13 TERESA SANTIAGO

14 BISHOP JOSEPH SULLIVAN

15 PATRICK LEE

16 DR. ALBERT SIMONE

17 BUFORD SEARS

18 G. NEIL ROBERTS

19 ROBERT GAFFNEY

20 KRISTIN PROUD

21 Commission/DOH Staff

22 DENNIS WHALEN

23 DR. DAVID SANDMAN

24 MARK USTIN, ESQ.

1                   CHAIRMAN BERGER: I'd like to call to  
2                   order the 13th meeting of the Commission on Health  
3                   Care Facilities in the 21st Century, and I'd like to  
4                   ask the Executive Director, David Sandman, to begin  
5                   the meeting with a progress report.

6                   DR. SANDMAN: Good morning, Mr. Chairman.  
7                   I'm pleased to make this report on progress since  
8                   our last meeting.

9                   Last week Governor Pataki announced that  
10                  the federal government had approved New York State's  
11                  request to join in a partnership to reform and  
12                  restructure the State's health care delivery system.

13                 Specifically, the federal government has  
14                 approved a new five-year demonstration entitled the  
15                 "Federal-State Health Reform Partnership," commonly  
16                 known as F-SHRP. The goals of this reform  
17                 partnership are to promote the efficient operation  
18                 of the State's health care system, consolidate and  
19                 right-size New York's health care system by reducing  
20                 excess capacity in the acute care system, shift  
21                 emphasis in long-term care from institutional-based  
22                 to community-based settings, expand the adoption of  
23                 advanced health information technology, and improve  
24                 ambulatory and primary care provisions.

25                 Under F-SHRP, the federal government will

1 invest up to \$1.5 billion over five years. The  
2 federal investment is conditioned upon the State  
3 meeting a series of established performance  
4 milestones, and generating savings sufficient to  
5 offset the federal investment.

6           These performance milestones are as  
7 follows: First, with respect to the Commission on  
8 Health Care Facilities in the 21st Century, the  
9 State must indicate that there are no state  
10 statutory impediments to implementation of the  
11 Commission's recommendations and that steps have  
12 been taken to implement the recommendations. By  
13 July the 15th, 2008, a final report on  
14 implementation of the Commission's recommendations  
15 is required.

16           Second, the State must increase its  
17 Medicaid fraud and abuse recoveries. The first year  
18 of the demonstration requires development of an  
19 audit plan to increase recoveries. Specific dollar  
20 recovery targets have been established for years two  
21 through five, starting with \$250 million in annual  
22 recoveries for year two, and increasing to \$644  
23 million in recoveries for year five.

24           Third, the State must implement a  
25 preferred drug list for Medicaid.

1           Fourth, the State must implement a  
2           program to increase the number of currently  
3           uninsured but employed New York residents with  
4           private insurance coverage.

5           Fifth, the State must implement a program  
6           to create a single-point-of-entry for Medicaid  
7           recipients needing long-term care, in at least one  
8           region of the state. And conditions pertain to ADA  
9           compliance, programmatic changes and baseline data  
10          reporting.

11          With the exception of the targets for  
12          audit recoveries, failure to meet these milestones  
13          results in termination of the demonstration and a  
14          loss of your funds.

15          The \$1.5 billion in F-SHRP is in addition  
16          to the State's \$1 billion allocation for the HEAL-NY  
17          program, and in combination, these represent vast  
18          and unprecedented sums for the purpose of system  
19          restructuring.

20          Beyond the F-SHRP developments, we  
21          continue to supervise discussions among parties who  
22          applied under the Commission's voluntary rightsizing  
23          protocols. We continue to meet with hospitals,  
24          nursing homes and many other interested parties.

25          And, as always, we remain engaged in an

1 active outreach and communications program with  
2 various constituencies.

3 So, in summary, Mr. Chairman, we are  
4 making good progress and remain on schedule with our  
5 work. Thank you.

6 CHAIRMAN BERGER: Thank you very much,  
7 David. It has been a very important couple of weeks  
8 for the Commission, and for the State of New York.

9 What we would like to do now is follow-up  
10 on our last session. In our last meeting we talked  
11 about reimbursement issues related to the acute care  
12 system. And what we promised we would do is now  
13 take a look at some of the reimbursement issues that  
14 are related to long-term care.

15 DR. SANDMAN: Thank you again,  
16 Mr. Chairman.

17 At our last session we did focus on acute  
18 care reimbursement. And this morning I'm going to  
19 talk about nursing home reimbursement, as well as  
20 other types of non-institutional care models that  
21 comprise the spectrum of long-term care services.

22 For all types of health care, it remains  
23 true that we largely get what we pay for. The  
24 Commission's enabling statute specifically provides  
25 for the Commission to make nonbinding

1        recommendations with respect to reimbursement and  
2        other broad policy issues.

3                    This morning's presentation will cover  
4        Medicaid spending on long-term care services. I'll  
5        describe the way in which Medicaid currently pays  
6        for nursing homes, review major reforms enacted in  
7        our most recent State budget, talk about alternative  
8        payment approaches, and also talk about the broader  
9        ideas for expanding the availability of long-term  
10       care options -- describe the way that Medicare talks  
11       about alternative payment programs and also talk  
12       about broader ideas for expanding the availability  
13       of long term care options.

14                   Medicaid spending on long-term care  
15        services is massive. Across all long-term care  
16        services, New York spent nearly \$12 billion in  
17        fiscal year 2005, and just over half of that was  
18        spent on skilled nursing facilities.

19                   New York State actually has one of the  
20        lowest proportions of nursing facility spending to  
21        total long-term care spending, just over half,  
22        meaning that New York is among the highest among the  
23        states in supporting non-institutional options. For  
24        example, Medicaid also supports programs such as  
25        long-term home health care, personal care services,

1 medical daycare, and some assisted living.

2 A major aspect is the Personal Care  
3 Program that provides home attendants to assist with  
4 activities of daily living, such as bathing and  
5 feeding, but it does not provide much clinical care.

6 In 2004, New York State spent \$2.2  
7 billion on this program, with most of those  
8 expenditures in New York City.

9 Focusing just on nursing homes, Medicaid  
10 is the dominant payer by head and shoulders. As we  
11 talked about in our session last time, on acute  
12 care, Medicaid is an important payer among many.  
13 But, for nursing homes, Medicaid really is the whole  
14 ball game.

15 It pays 78 percent of all nursing home  
16 days in New York State. In total, New York spent  
17 \$6.2 billion in fiscal year '04 on nursing  
18 facilities alone, about 15 percent of the State's  
19 budget.

20 By any measure, New York State leads the  
21 country in its spending for skilled nursing  
22 facilities. New York spent over \$2 billion more  
23 annually than the next highest state, in total  
24 dollars. New York spent more than 11 percent higher  
25 than the next highest state on spending per nursing

1 home resident.

2 New York has the highest total number of  
3 nursing home residents, despite ranking No. 3 among  
4 states in total number of citizens ages 75 and  
5 older. New York state spent more than any other  
6 state on a per capita basis for nursing facilities.

7 Finally, spending on nursing facilities  
8 continues to increase, although the rate of growth  
9 has been moderating over recent years.

10 The way that New York's Medicaid pays for  
11 nursing homes is enormously complex, mind-boggling.  
12 But it's also a very traditional model. It's  
13 similar to what most other states use.

14 Essentially, we pay on what's called a  
15 "facility-specific" basis, utilizing the facility's  
16 costs and circumstances to determine payment levels.  
17 Each skilled nursing facility in New York State gets  
18 paid a daily rate for each day that the resident  
19 spends in the facility.

20 That daily rate is expected to cover all  
21 room, board and care services, including nursing  
22 care, meals, housekeeping, therapies, recreation,  
23 medical care and supplies. Up until this year, the  
24 daily rate was also to include pharmacy costs, but  
25 Medicare Part D now covers that for

1 Medicare-eligible residents.

2           The calculation of the Medicaid daily  
3 rate is, again, complicated, but simplifying it a  
4 bit, it is based on four general buckets of  
5 expenses: there are direct costs, there are  
6 indirect costs, which are subject to peer group  
7 ceilings -- the peer groups being free-standing or  
8 hospital-based, and those that are over or under 300  
9 beds -- there are capital costs, which are passed  
10 through directly to Medicaid, and the fourth bucket  
11 is non-comparable costs which must be approved by  
12 the Department of Health, and which are also passed  
13 through and added onto the daily rate.

14           The daily rate is the sum of these four  
15 buckets, with additional technical adjustments to  
16 determine the final facility daily rate.

17           As I mentioned before, all of these  
18 calculations are based on the facility's costs, and  
19 up until very recently, the facility's cost was  
20 determined in what we call the "base year." The  
21 default base year for all facilities in the State  
22 had been 1983, more than 20 years ago.

23           Some facilities, namely those that have  
24 undertaken significant capital renovations,  
25 expansions and replacements, as well as those that

1        have changed ownership, could utilize a base year  
2        from the time of their capital projects or turn  
3        over.

4                    Another key element in the daily rate  
5        calculations is the case mix. All residents are  
6        categorized according to the intensity of their  
7        service needs, and the resulting mix often  
8        determines the payment.

9                    Putting it all together, there is a vast  
10       range of Medicaid daily rates throughout the State,  
11       and they vary more with facilities and less so with  
12       the type of residents that are cared for within  
13       them. The median for the State is probably between  
14       \$150 and \$175 per day. That same range widely  
15       across the State, from as low as \$90 to as high as  
16       \$325.

17                   This year's budget enacted a series of  
18       major reforms to nursing home reimbursement. It  
19       left the basic paradigm of facility specific pricing  
20       intact, but made a lot of important technical  
21       changes and updates. First, the base year of 1983  
22       was obviously woefully outdated.

23                   Clinical advances, technology  
24       expansion, more rapid resident turnovers, and many  
25       other changes have transformed the expense structure

1 of just about every facility in the State. Thus,  
2 all facilities, will be re-based to a 2002 base  
3 year, phased in over four years. And, after that,  
4 facilities will be re-based every five to six years.

5 This reform also adds some equity to the  
6 system. Previously there was uneven access to base  
7 year updates, and the "carrot" of updating the base  
8 year was encouraging capital expenditures and  
9 facility turnover that may not have been necessary  
10 otherwise.

11 Going forward, no further facility  
12 specific re-basings will be allowed. Going forward,  
13 we will also transition from a resident  
14 classification system of 16 categories to what is  
15 generally thought of as the "next generation  
16 classification system." Utilized by Medicare and a  
17 number of other states, it includes 53 categories  
18 which can better distinguish among resident types  
19 and their associated costs.

20 And, finally, there will be per diem  
21 adjustments for early dementia in low-scoring  
22 categories, dual diagnoses of cognitive and  
23 behavioral issues, and bariatrics or high  
24 body-mass-index. It includes 53 categories that  
25 could distinguish between resident categories and

1       their costs and finally dual diagnoses of cognitive  
2       and behavioral issues.

3               Previously, without a special care unit  
4       or special payment rate, these types of individuals  
5       could be very difficult to place in a nursing home  
6       facility and would sometimes linger in hospitals for  
7       an unnecessarily extended period of time.

8               Even with these important reforms, the  
9       basic payment paradigm is unchanged; namely, we will  
10      continue the "facility-specific" pricing model,  
11      calculating the daily rate for every facility based  
12      on the facility's cost, peer group, and the average  
13      of its residents' case mix.

14              A flaw of facility-specific payment means  
15      that the same individual with the very same care  
16      needs could cost Medicaid very different amounts,  
17      depending solely on which facility admits the  
18      resident, even if they're all side-by-side  
19      facilities within the same county.

20              There are alternatives to consider, none  
21      of which are perfect. Some states have adopted  
22      resident-based pricing, where each resident is  
23      regularly assessed and scored. Each score gets  
24      associated with a specific payment level and  
25      reimbursement is then matched to the care needs of

1       each individual.

2                       Thus, nursing facilities have fewer  
3 reasons to shun high-need residents, because they  
4 receive higher payments for individuals that need  
5 more service. While resident-based pricing does  
6 offer advantages, there is not yet established a  
7 direct correlation between case mix payments and  
8 quality of care.

9                       In theory it is also possible that this  
10 system can discourage the rehabilitation of  
11 residents that would then result in lower payments.

12                      Another option that exists in a few  
13 states is "flat-rate" payment, which really follows  
14 the concept behind managed care's capitated payment  
15 approach. Nursing home daily rates are set in  
16 advance, independent of an individual facility's  
17 cost or the actual resident mix, and they are  
18 typically based on the cost experience of all  
19 facilities in a very large geographic area, such as  
20 the whole state of California, for example.

21                      Since providers are at risk financially,  
22 there are incentives to operate more efficiently.  
23 And, at the same time, there are incentives to skimp  
24 on quality. This system creates incentives for  
25 facilities to admit lower-acuity residents who need

1 less care, since they receive the same payment,  
2 regardless of the time and the resource investment  
3 needed for the resident.

4 For all the complexities of nursing home  
5 reimbursement, it is critical to remember that  
6 nursing homes are only one part of the long-term  
7 care continuum.

8 To create a future system where the right  
9 person is served in the right setting, at the right  
10 price, we have to think beyond the walls of the  
11 nursing home.

12 The range of home- and community-based  
13 services includes the long-term home health care  
14 program. This program is often known as "Nursing  
15 Homes Without Walls."

16 They offer health care and support  
17 services to disabled and chronically ill who are  
18 medically eligible for admission to a nursing home,  
19 but who choose to be maintained at home.

20 We have certified home health agencies  
21 which provide care and support services to  
22 individuals who, for the most part, have home health  
23 care needs for a limited duration. CHHAs, as they  
24 are known, provide nursing home health aide  
25 services, and they provide a range of other

1 services, including physical and occupational  
2 therapy, speech pathology, social work and nutrition  
3 services.

4 The Adult Day Health Care Program  
5 operates in a day center with a specific number of  
6 slots per day. Like the Home Health Program, each  
7 individual receives a care plan specifying the  
8 number of days they should attend the center, along  
9 with the services to be received while they are  
10 there.

11 We also have a small Medicaid Assisted  
12 Living Program. Like private-pay assisted living,  
13 this program provides room, board, housekeeping,  
14 personal care and nursing services to nursing home  
15 eligible individuals.

16 There are currently only 4,200 ALP beds  
17 allowed in the State, per an administrative cap on  
18 the program.

19 Medicaid Assisted Living may be a more  
20 viable alternative to nursing home care for some  
21 individuals. Home care and day care do not provide  
22 24-hour supervision. And if an individual requires  
23 that and does not have a family caregiver able to  
24 take responsibility in the off hours, the  
25 out-of-home placement is necessary.

1                   However, nursing facility care may be too  
2                   intensive for their actual care needs.

3                   Finally, there is a managed long-term  
4                   care program for individuals enrolled. Medicaid  
5                   pays a per member, per month payment, and this is a  
6                   fairly small program.

7                   Expanding the spectrum of long-term care  
8                   service options is an important objective. There  
9                   has been clear movement out of nursing homes and a  
10                  shift towards non-institutional care. Many trends  
11                  could only further strengthen this shift.

12                  Patients prefer to be served in their  
13                  homes and communities, when possible. And this  
14                  preference is going to be especially true of future  
15                  generations of health care consumers. The Olmstead  
16                  decision further requires that care be provided in  
17                  the most integrated setting possible.

18                  Progress in medical treatment and  
19                  technology enables older New Yorkers to live longer,  
20                  in a less restricted setting. And a series of  
21                  federal efforts are further stimulating a shift  
22                  towards non-institutional care.

23                  But there do remain important questions  
24                  and challenges to be considered. For example, is  
25                  there an adequate work force to support such a

1 shift, such as, is there an adequate supply of home  
2 care attendants?

3 Are there enough informal and family care  
4 givers, and what types of supports will they need?  
5 Costs also remain a huge open question. Many people  
6 believe, and virtually everybody wants to believe,  
7 that non-institutional care is cheaper than paying  
8 for nursing homes. But the jury is still out on  
9 that. The evidence base is still fairly thin.

10 There are certain economies that result  
11 from congregate care arrangements, and we do still  
12 need further evidence that home and community  
13 services would be cost neutral or less costly than  
14 institutional care.

15 So, with that, Mr. Chairman, we are open  
16 for questions.

17 CHAIRMAN BERGER: Yes, Albert?

18 DR. SIMONE: I got a -- I guess a concern  
19 -- I've got a couple of concerns and then a  
20 suggestion to alleviate them, maybe. Something that  
21 David said, you know, sometimes the purpose seems to  
22 be to take care of the patient, but, yet, the  
23 incentive seems to be to maximum revenue.

24 So you maybe don't admit certain patients  
25 when you try to not maximize revenue. It is a

1 concern that one would think that when people need  
2 health care, the caregivers would be caring and  
3 sensitive to their needs. And the statement that,  
4 "Well, you know, we sacrificed a little bit of care  
5 because it was too expensive or we could make more  
6 money doing something else."

7 That really disturbs. I don't know if  
8 they rely on the caregivers and the management is  
9 maximizing revenue.

10 So the suggestion: Is there some way to  
11 provide incentives for quality care, somehow  
12 measured -- we need some measurement, and that way  
13 -- you talk about daily rates or patient rates,  
14 maybe you get a higher rate per patient or per  
15 patient day if there is some metric that says you  
16 really are providing a higher quality than the  
17 standard -- just to provide for incentives, for  
18 quality care as opposed to, you know, balancing the  
19 budget.

20 That's one idea. The other one -- and  
21 this is a personal experience -- I never was in a  
22 nursing home in my life until my mom became ill.  
23 And I didn't know. I came from out of state and  
24 shot into the hospital and two or three doctors said  
25 she has to go to a home, no question about it.

1                   Doctors know that -- to put her in a  
2                   nursing home was the worst decision we ever made.  
3                   And the home care comes up and you talk about she  
4                   could have done that --

5                   The concern is, where are these doctors  
6                   coming from that they did not recommend what would  
7                   have been the best thing -- they caused my mom to  
8                   suffer and die earlier. They caused her to suffer,  
9                   because of that recommendation.

10                  Where are they coming from, in terms of  
11                  the education of doctors? It seems to me that these  
12                  kinds of options should be part and parcel of  
13                  everything, they need to make the right  
14                  recommendations.

15                  I love doctors, they save lives, but in  
16                  this case there was damage done. So those are the  
17                  two concerns. And there a couple of suggestions.

18                  MR. VELEZ: I am concerned specifically  
19                  as to what this presentation is supposed to  
20                  accomplish. Specifically with taking, literally  
21                  taking a historical perspective on reimbursement, in  
22                  terms of long-term care, all of the components of  
23                  long-term care, what recent laws have accomplished  
24                  or hopefully will accomplish in 2006 or 2007, and  
25                  some of the challenges still are facing long-term

1 care. But, are we in a position to go beyond, based  
2 on all your knowledge, come up hopefully with some  
3 recommendation, like a guide of reimbursement going  
4 forward?

5 DR. SANDMAN: Yes. As I said at the end  
6 of the presentation, the Commission's enabling  
7 statute specifically provides for the Commission to  
8 make nonbinding recommendations on broader policy  
9 issues, such as reimbursement and regulations.

10 So this background briefing at the  
11 request of members is to authenticate what currently  
12 -- any issues identified are some of the alternative  
13 options to explore.

14 MR. VELEZ: So we have not gotten to the  
15 point to talk about the recommendations we would  
16 make?

17 DR. SANDMAN: Some of these options could  
18 lead to potential recommendations. For example,  
19 actually just throwing out, would New York State  
20 want to explore a random-based pricing on some sort  
21 of small demonstration basis?

22 CHAIRMAN BERGER: I think we are trying  
23 to lay out sort of where we are and see if we do  
24 come up with recommendations. We have always said  
25 that we would like to, as we talk about, you know,

1       our model recommendations, to see where some of the  
2       -- well, if we could make recommendations to the  
3       policy issues that would, in fact, be supportive of  
4       the direction one goes.

5                   But recognizing that some of these areas,  
6       particularly reimbursement, is going to require an  
7       effort probably as long and as extensive as what we  
8       have dealt with on the institutional structure. It  
9       requires probably a group similar, spending some  
10      time thinking about it.

11                   And I think that it is, given how much of  
12      the long-term care budget is pure state dollars, is  
13      pure Medicaid, as you begin to look to change that  
14      pattern and that system. Some of it are things that  
15      we have talked about, the whole notion of the single  
16      point of entry is a recommendation that we made and  
17      the State now is going to implement -- that it's not  
18      just a Medicaid-based structure, it is a structure  
19      to make available to all people in the state,  
20      whether they are paying for it or not paying for it,  
21      a source of information so they can make judgments  
22      and weigh the doctor's recommendation versus  
23      alternative services.

24                   And, you know, part of this is the people  
25      have to participate in these judgments. This is

1 going to be a complex working out of the system.  
2 But I will tell you that there is no way we can  
3 solve this problem by making an assumption that  
4 we're just going to -- if somebody does a "higher  
5 quality job," we are going to pay them more. I  
6 mean, that's part of the whole thrust here, is that  
7 we have got to find ways, inside the system, to move  
8 dollars towards a higher quality of performance, not  
9 just add. This State --

10 MS. DEVINNY: Has the Medicaid drug  
11 program removed the barrier for admission of high  
12 drug cost patients -- patients with high drug costs  
13 -- because I know for the nursing home -- what do  
14 you know?

15 DR. SANDMAN: I do think it removed some  
16 of the pressure.

17 MR. KING-SHAW: It's just an observation.  
18 One of the things -- perhaps it's a matter of  
19 opinion -- is that the whole nursing home,  
20 particularly the long-term care infrastructure, is  
21 woefully underfunded, given the expectations of  
22 quality. It would be enormously expensive to give  
23 nursing homes enough money to pay the types of  
24 salaries at the level and the benefits to attract  
25 the kind of people we want taking care of our

1       elders.

2                   So we do get to a great extent what we  
3       pay for, but I think it's an open-ended debate  
4       whether the people in the State of New York would be  
5       willing to pay a lot more and the sources to finance  
6       the kind of quality everybody demands.

7                   There is a further understanding that  
8       there is just not enough money to get what we want  
9       out of this. This is a starting point. The other  
10      would be -- now, I would be cautious to recommend --  
11      often what you get, the criteria for quality that we  
12      discourage in nursing homes from taking the very  
13      patients we are most concerned about.

14                   And if the concern is we're going to end  
15      up with an inpatient population or a resident  
16      population that's going to make you look bad on the  
17      scores, then you don't want to take them.

18                   And the other thing I would say is that,  
19      we are going to ask questions about quality and  
20      reimbursement at the end. I can say that is  
21      particularly dangerous if you apply that to a long  
22      term care setting and finally, there is quite a lot  
23      of data and reporting that nursing homes have to  
24      look at, so having to create yet another reporting  
25      or data set that would cost more money will

1           exacerbate much of the pressure they have today.

2                     CHAIRMAN BERGER: Neil.

3                     MR. ROBERTS: There's certainly a lot I'd  
4           like to say, but I won't take too much time.

5                     I'd like to first say that my parents  
6           spent the last years of their life in a nursing  
7           home. It was the right decision, it extended the  
8           quality of their life. So there's just another  
9           point of view on that circumstance.

10                    The problem that nursing homes has had is  
11           not to make more money, it's to lose less. And when  
12           you're in that sort of decision-making process, you  
13           end up doing all the right -- making decisions that  
14           are Machiavellian, but realistic.

15                    I think that David did a fine job, but  
16           one of the things that's missing, is some of the  
17           drivers in long-term care that aren't Medicaid that  
18           are changing the face of reimbursement: the  
19           private-pay marketplace, assisted living, continued  
20           care retirement communities, even, to some extent,  
21           social model day care, which are really not factors  
22           in costing Medicaid money, but are taking out of the  
23           system the people who can pay their own way.

24                    And, lastly, we are trying to move --  
25           everything you say and everything you have seen is

1 moving towards a more social model of care. At the  
2 same time, New York State doesn't seem to -- a layer  
3 on top of everything, incredible requirements for  
4 care, and that costs a lot of money.

5 So I always tell people I have never seen  
6 a resident who I cared for, in the facilities I ran,  
7 who would have traded the semblance of some risk for  
8 a little bit more sense of making their own  
9 decisions. And I think we need to move into an  
10 environment where our surveillance process and our  
11 regulations recognize that is what people want to  
12 do. So there are other drivers out there that will  
13 affect this that haven't been talked about, because  
14 I don't want to take too much time to talk about,  
15 but I just wanted them included.

16 CHAIRMAN BERGER: Kristin.

17 MS. PROUD: It has been several years  
18 since the assisted living program has been created.  
19 What is the status of discussions about either  
20 raising the cap or removing the cap altogether?  
21 What kind of setting from the Health Department has  
22 been done to look at the cost savings on having an  
23 in-house based program versus the traditional  
24 program?

25 DR. SANDMAN: Your question addresses the

1 Department. We ask Dennis to address that.

2 CHAIRMAN BERGER: Knowledge is a  
3 dangerous thing, Mr. Whalen.

4 MR. WHALEN: There are some studies --  
5 I'm taking a look at cost. There are certainly  
6 differences in the population in facilities, if you  
7 compare assisted living to skilled nursing facility.  
8 So that is a major issue.

9 The decision on the cap has really been  
10 fiscally driven. The Department has continued to  
11 recommend expansion in these alternative levels of  
12 care. But that gets rolled into budget discussions.  
13 And when fiscal calculations are made, if they're  
14 able to add a number of slots, will add this much  
15 expense to the system. They don't seem to progress.

16 Now, you also make the argument that by  
17 expanding the alternative levels of care you may  
18 have individuals going into those settings who  
19 otherwise would be in a more expensive setting of  
20 care.

21 That has not been an argument that has  
22 been particularly effective in the legislative or  
23 budgetary arenas. But I think it's one we'll  
24 continue to see.

25 DR. SANDMAN: Just to add onto that. I

1 think that typically the place to be -- the fact  
2 that you make the other options available rather  
3 than transfer nursing home residents to lower levels  
4 of care, people would crawl out of the woodwork and  
5 certain other people create expenditures. There is  
6 evidence from other states; it is limited.

7 But, in Minnesota, for example, we did  
8 find, in fact, that the expansion of options did, in  
9 fact, decrease nursing home utilization and costs.  
10 There is far from a mountain of evidence as of yet,  
11 but there is a body of evidence.

12 CHAIRMAN BERGER: Mark.

13 MR. KISSINGER: You know, I sort of  
14 follow up on two of the issues that David raised  
15 here. On the work force issue there are both the  
16 para professional issues and professional issues --  
17 actually limits what would be a woodwork effect very  
18 much.

19 The other big issue you've heard here is  
20 really, most of the long-term care is done by family  
21 in the form of support. And the State system, we  
22 have to do all we can to further emphasize -- that  
23 is really the normal attempt of the care that is  
24 given.

25 CHAIRMAN BERGER: Craig.

1                   MR. DUNCAN: Just to pick up on what Mark  
2 was saying. Work force issues are paramount and  
3 they impact all the way up the line. You can't get  
4 somebody out of the hospital unless they have home  
5 care. You can't get home care started unless you've  
6 got a personal care aide or home health aide.

7                   And, if it's a question of resources, in  
8 terms of having people available, it's also a  
9 question of reimbursement, being able to pay people  
10 enough to make that an attractive position to work  
11 in.

12                  CHAIRMAN BERGER: Leo.

13                  MR. BRIDEAU: It strikes me as a  
14 difficult task for us to make a recommendation, any  
15 recommendations that make a whole lot of sense,  
16 except the recommendation for more study and more  
17 data. I am struck by, in each of these alternatives  
18 to institutional care, what we have around their  
19 effectiveness and their impact on cost of care or  
20 time is principally anecdotal.

21                  And even with a few studies, giving us a  
22 little bit of information, programs, as long as they  
23 have been in existence, the level of evaluation  
24 that's been done still falls short, helping us to  
25 understand how you get a handle on this whole

1       problem.

2                   And when you look at the demographics  
3       that we are facing, we're watching a steamroller  
4       coming down the hill as the population ages. As we  
5       look at some of the other demographics, the eroding  
6       structure in the home and the increasing inability  
7       to care for older people in the home, and life  
8       expectancy going on much longer, we better get an  
9       answer to these questions of what approaches to care  
10      will work, from both a quality standpoint and a time  
11      standpoint, because the realities that Dennis  
12      referenced aren't going away. And so I hope that  
13      comes out as a recommendation of this Commission,  
14      that there be, very quickly, a serious study.

15                   And some money has to go into funding the  
16      evaluation and research of these models, so we don't  
17      rely on policy or anecdotes.

18                   CHAIRMAN BERGER: Albert.

19                   DR. SIMONE: Just quick. I do want that  
20      one statement to stand, so, with all due respect to  
21      my colleague on the right, there was a statement  
22      made, "you get what you pay for," which implies that  
23      if you pay more money you get better quality. And  
24      that may be the case in a particular institutional  
25      setting and from a particular institution, but you

1 can make that same statement, "you get what you pay  
2 for," and then the question is "are we?"

3 I thought that's what we were all about.  
4 If we take the total amount of money we are spending  
5 across the state, are we getting the quality and  
6 variety of services that we should get from that  
7 amount of money?

8 CHAIRMAN BERGER: Craig.

9 MR. DUNCAN: One of the things that  
10 strikes me is -- and it's not you, I think you did a  
11 wonderful job and you captured all the particulars  
12 -- chronic care management. Very specifically, we  
13 have an area of further emphasis and conditions,  
14 like congestive heart failure, that there is home  
15 care -- they may avoid cost on the up end with  
16 emergency rooms on the low end, the inappropriate  
17 populations and institutionalizations.

18 So that is a whole area, chronic care  
19 management, that I think we should really talk  
20 about.

21 CHAIRMAN BERGER: Mr. Hinckley.

22 MR. HINCKLEY: I really want to echo what  
23 Leo said. I think what we are looking at is some  
24 really broad and very difficult issues, and it does  
25 need further study. But I do think it is incumbent

1       upon us to provide the next Governor and the Health  
2       Commissioner with guidance.

3                    You know, we are looking at a system  
4       where we're sitting on significantly old housing on  
5       the institutional side. And they will be facing a  
6       number of CON applications et cetera, to rebuild and  
7       renovate this. So I think we could provide guidance  
8       to the next Governor and Health Care Commissioner.

9                    Our thinking, is in terms of how you  
10      rightsize that. You know, right now we give more  
11      reimbursement for institutions with 300 beds or  
12      more, it just seems irrational to me.

13                   I don't think you get better quality with  
14      300 or 500 beds or whatever the size is. I think we  
15      really should look at a way to incentivize owners to  
16      come to a smaller size, where you get better quality  
17      and more personal care. And, again, take care of  
18      some of the issues we had in terms of occupancy.

19                   CHAIRMAN BERGER: Bishop Sullivan.

20                   BISHOP SULLIVAN: This is on the  
21      beginning presentation with the federal \$1.5  
22      billion.

23                   Do we have a comfort level or what is the  
24      comfort level that we could meet those expectations?  
25      Is that the target that we think we can hit?

1 DR. SANDMAN: I think the expectation is  
2 -- I mean, New York State will be able to achieve  
3 all of those milestones, obviously, in the last  
4 budget. We got the legislature to vastly expand the  
5 office of the Medicaid Inspector General, putting  
6 strips on Medicaid cards -- so the tools are new  
7 tools to make those recoveries. They are being put  
8 into place.

9 It is also important to note that the  
10 barrier to meet those recoveries do not result in  
11 the total termination of F-SHRP. In the worst case  
12 scenario, New York State would recover zero dollars,  
13 it would lose half a billion dollars. But New York  
14 State would still receive a minimum of \$1 billion.

15 BISHOP SULLIVAN: And if the money that  
16 we are able to save was reinvested -- so it is that  
17 plus the billion and a half --

18 DR. SANDMAN: Correct. As well as,  
19 obviously, the billion dollars that the State has  
20 invested from the beginning.

21 CHAIRMAN BERGER: The assumption,  
22 frankly, is, and I believe this, that if you  
23 implement -- when we go through through this process  
24 and we're done, we believe that the savings will be  
25 there to match federal dollars, and to create

1 exactly what you are talking about, investment  
2 dollars.

3 And I don't want to miss the point, we  
4 have talked a lot about reinvestment in the acute  
5 care system, but the fact of the matter is, that  
6 among the other issues, you will only ultimately  
7 change institutional framework on long-term care  
8 when you start investing in technology on long-term  
9 care as well.

10 You will eliminate -- you will solve some  
11 of the labor issues. The labor issues get solved if  
12 you can do distance monitoring with people at home.  
13 It will solve institutional needs. It will tie into  
14 some of the recommendations I hope you will make  
15 about outpatient availabilities in certain  
16 communities. It will reduce all kinds of  
17 institutional needs over time.

18 And that is where we ought to be  
19 reinvesting dollars over the next five to ten years.  
20 That's where you will change the core of the system.  
21 Neil.

22 MR. ROBERTS: I don't know if there is  
23 room for this in our report. If I was enlightened  
24 yesterday to how could I bring down cost in  
25 long-term care, I would invest in senior housing,

1           because -- people, you can bring down the cost.

2                         Ironically the people who sponsor that at  
3           the moment, the federal government, don't agree with  
4           me.

5                         CHAIRMAN BERGER: I think -- by the way,  
6           we will talk -- part of the reason for this  
7           discussion is to trigger amongst us what kind of  
8           recommendation we want to make in the report.

9                         Some will be closer to the restructuring  
10          recommendations we ultimately will make, but knowing  
11          this group, some will be a little farther away. But  
12          I think that we do have them in, I think Bob is  
13          right, that part of what we have to do here is meet  
14          our statutory requirement and take a look at the  
15          excess capacity, to free that up and reinvest it  
16          back, but also to make recommendations to the State,  
17          to the next administration, to the next Health  
18          Commissioner about the next two and three and four  
19          stages that have to take place over the next ten  
20          years.

21                         I think that is all very important. Some  
22          will be more specific. Quite frankly, I think some  
23          of it will prove to be more general, because it is  
24          going to need some studying, like solving the  
25          reimbursement issues.

1                   Pete, you need the mike.

2                   MR. VELEZ: I know that. You know, only  
3                   making an assumption going forward, because there is  
4                   nothing concrete at this time. Additional studies  
5                   have to be done -- however, if the intent is to try  
6                   to reduce cost so you can reinvest into the system,  
7                   you know, the moment bureaucracy takes over and uses  
8                   those dollars and not reinvest those dollars, we  
9                   have to give them the opportunity, so we could  
10                  identify some basic principles.

11                  So now there is a full prospect -- so we  
12                  could be making consideration for potential future  
13                  reimbursement. If we leave it blank and just make a  
14                  statement, I don't, I don't think the bureaucracy  
15                  will be supportive of what we want.

16                  CHAIRMAN BERGER: I think that is a fair  
17                  comment. We will try to come together and see if we  
18                  can make more specific, but yet reasonable  
19                  suggestions -- I need to word it carefully -- more  
20                  specific as opposed to absolutely specific in those  
21                  areas.

22                  Any other comments? Thank you.

23                  For the record, the next meeting date  
24                  will be November 20th in this room. It will be the  
25                  last meeting of the Commission. It will be the

1 meeting at which we will make a final  
2 recommendation. Mr. Hinckley.

3 MR. HINCKLEY: Mr. Chairman, I move that  
4 we enter executive session to address in detail of  
5 the medical, financial, and credit history of  
6 particular general Hospitals and nursing homes that  
7 may be the subject of commission recommendation for  
8 restructuring, resigning, close consolidation and  
9 conversion.

10 AUDIENCE SPEAKER: As we go into  
11 executive session we hope that --

12 CHAIRMAN BERGER: Excuse me. Excuse me,  
13 Judy. There are rules and guidelines and you know  
14 better.

15 AUDIENCE SPEAKER: I do know better and  
16 that is why I am --

17 CHAIRMAN BERGER: All in favor.

18 (Time Noted: 10:50 a.m.)

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C E R T I F I C A T I O N

I, ELLEN SANDLES, a Shorthand Reporter  
and Notary Public, do hereby certify that the  
foregoing is a true and accurate transcription of my  
stenographic notes.

I further certify that I am not employed  
by nor related to any party to this action.

ELLEN SANDLES