
Mark Hennessey: We are here today for a meeting of the Continuing Care Retirement Community Council, I'm Mark Hennessey, I'm the Chair of the Council. I'd like to call to order the meeting of the CCRC Council and welcome members, participants and observers. A couple of pieces of housekeeping, just to remind Council members, staff and the audience, this meeting is subject to Open Meetings Law and is broadcast over the Internet. Webcasts are accessed at the Department of Health's website which is www.health.ny.gov. The on demand webcast will be available no later than 7 days after the meeting for a minimum of 30 days and then a copy will be retained in the department for four months. Just a couple of suggestions and ground rules to help make this a successful meeting. Because there is synchronized captioning, it is really important that people state their name the first time that they talk so that the captioning people can capture the names. We also want to make sure that people speak one at a time, its really important so we're not speaking over each other to make it accessible for folks that will be reading the words on the video. I'll keep my eyes out for anybody who wants to speak in the Council. You can raise your hand. Please don't wave your hand, just raise it and we'll keep track of who needs to talk and we'll call upon people in the order that the hands are raised. I've been told there's not going to be a public comment period because we haven't had anybody who's wanted to discuss things today or signed up for discussing things. So we wanted to remind people that these microphones are hot; that means that any noise on the table, shuffling of papers, things like that will be a problem. So, please let's try to refrain from that. the other thing I'd request is if anybody in the room has a cell phone with the ringer on, please silence it at this time, it will be very helpful. And as a reminder, for people in our audience, there's a form that needs to be filled out upon entering the meeting room which records your attendance at the meetings. It's required by the Joint Commission on Public Ethics in accordance with Executive Law § 166. The form is also posted at the Department of Health's website which is again is www.health.ny.gov. In the future you can fill out the form prior to the Council meetings if you so desire to save a little time. We want to thank you for your cooperation in fulfilling our duties as prescribed by law. So, since we're not going to have public comment today, no one signed up for public comment, the first agenda item is approving the transcript from the last meeting of the Council which was the May 15, 2018 meeting. the transcript contains the discussion that we had and will serve as minutes for the Council Meeting as authorized by the Council's bylaws. Before we make a motion to adopt the transcript, does anyone have additions or changes they would like to be considered? Okay I don't think that's the case. So at this point, I'll make a motion to call a vote on the adoption of the transcript. May I have a motion to adopt the transcript from the May 15, 2018 meeting? Moved by Council Member Barnett. May I have a second? Council Member Stubblebine. Any discussion? Okay now let's take a vote on it. All in favor say aye.

(Chorus of ayes) any opposed. Okay, the minutes are adopted.

Next item agenda item is that we're going to have a guest speaker here today. The Council expressed a desire to hear directly from representatives of CCRC programs. We've had a couple of folks come and talk to us. We're fortunate today to be joined by representatives from Woodland Pond at New Paltz CCRC and the Summit at Brighton CCRC. Woodland Pond at New Paltz CCRC is an Article 46 CCRC located down the Thruway in New Paltz. Michelle Gramoglia, did I do that correctly?

Michelle Gramoglia: Gramoglia.

Mark Hennessey: Gramoglia, President and CEO of Woodland Pond is here today to speak with us about her community.

Michelle Gramoglia: First I'd like to thank you all for having me. I'm always pleased to see that we have the ability to access you and Mike was kind enough to say that I could have quite a bit of time. I'm going to try to keep my comment brief but informative. I did provide some material in advance which you may have in your packet; an economic and social benefit report which is a multi-page document. And then a press release related to LGBTQ issues. I think that its important for the context of the comments that I'm going to make that you understand just a little bit about the structure of Woodland Pond. So, Woodland Pond opened in September of 2009. We were financed through our local county IDA and we were entirely bond financed. So that puts Woodland Pond in a relatively unique position because we had basically all of the finance that were used to build the community were borrowed and predicated on an initial financial model that was based on the market conditions at the time; the housing market and those kinds of things. And because of some significant contraction of the housing market and the economy right when we were coming online, we actually had a delayed period of opening. So Woodland Pond has had a protracted period to fill the community. We are now full with waiting lists but in addition to offering all the services an Article 46 community offers, we do have that added layer of all of the requirements of our bond documents. We have a significant number of covenants and we've had to restructure that a few times commensurate with financial challenges of filling early. So I think it's important for you to know that. I'm certainly happy to answer any questions if you have them.

So Woodland Pond, we are, as you mentioned we're in the Hudson Valley. We do not really have any technical competition right in our primary market area so Glen Arden which is in Goshen, New York is slightly outside of our primary market area and then Kendall on Hudson is the next closest. So we don't have any direct competition with true Article 46. We have a look alike community that's similar. So one of the things that we encountered early on is our community as a whole, which has a significant penetration of age and income eligible seniors, very significant penetration of IBMers, really a significant amount of IBM in Ulster and Dutchess County, many colleges. So there are plenty of age and income residents really had absolutely no concept of what a CCRC is. So, in addition to the contracted housing market, we also had to do a significant amount of community education as to why would any senior want to do this and trust live savings into a not-for-profit that has no track record, no history? It's a significant decision. And not only life savings but also my health and wellness for the rest of my life. So we've done a lot of that in our community now. We're going on 9 years being open in September, people really get and understand this concept. So at Woodland Pond we offer independent living, of course, and as I said, we're in a waiting list status in a number of our unit styles there. In our case we see waiting list status actually for our larger units which I think is different than some of the other communities. We offer assisted living, special needs assisted living, memory care unit, skilled nursing and we also have a very, very significant outpatient rehabilitation program. So Woodland Pond has a higher than typical Medicare book of business. So we do not qualify for any of the low utilization, cost reporting for Medicare and I'll talk about

that in a few minutes. When we talk about, I know you asked for comment on what do you mean when you say you're over regulated? What do you mean when you have regulatory challenges? I'm trying to give you a picture of what Woodland Pond offers so you can understand what we're doing. The community as a whole and I'll get to some of those concerns in a few minutes, the community as a whole is thriving. We take our not-for-profit status very seriously and we take corporate compliance very seriously. We have a very thin work chart so at Woodland Pond, I'm the Executive Director and CEO, and then I have 6 department heads. I do not have a number 2; I have a 3-person finance team. I have an administrator and a director of nursing but we try to keep overhead costs as low as possible so that the cost of our salaries and things go into direct resident services and care. And we run, right now salaries and employee benefit costs are our number one cost on the P&L. We run about \$10 million between employee salaries and then benefits and next in line compared to that is our interest expense. Woodland Pond has a very, very significant interest cost because we were fully debt financed. So we're running about \$4 million a year in interest expense. It's very, very significant. So we have a very thin financial model, even more so than some other communities, so it's very critical that we are able to keep our pipelines full, keep that Medicare business, because it very heavily subsidizes independent living, and for us its definitely a puzzle.

One of the things that I started doing a number of years ago as part of the education process was we started preparing the economic and social benefit reports that I've included for you. And I don't know if you've had a chance to look at it. I'm not going to go through it in great detail but this is something that Woodland Pond has a pilot so we have a payment in lieu of taxes arrangement with our local municipalities and it's a 20-year pilot which is quite lengthy. Our IDA assisted with having that to be negotiated but it grows. So the first year it was I don't know \$200,000, it goes up to over a million and a half in a few years. But the pilot oftentimes is rife for controversy. You know municipalities, people are either opposed to or appreciate pilots and the constituents want to know why should Woodland Pond or any other entity that wants a pilot qualify? So we started using this partially as a tool for that to explain to people, just for New Paltz, not talking about our whole economic area or the state, here's what Woodland Pond is bringing to New Paltz. So we were able to identify and we do this every year. How many residents are coming new into the zip code and what's their buying power? The US Government has great statistics on non-housing buying power that seniors bring. You can put very easy numbers to this. You can see here we're talking about significant spending. And I think it might be helpful actually for this Council to understand if we did an analysis like this for how many people we're bringing into New York State, because I can tell you, many of our residents are coming from out of state. Many lived in the area, worked, retired to the south for example or to other parts of the country, Arizona, and now that they really are in need of services, they're coming back. So they weren't in our zip code roles in New York State prior to being a resident here in New York. So I think it may be helpful if we did an analysis to see how much business are we bringing back into New York? Because there is significant spending power there.

We talk about employment, and then use of local businesses. That's something that Woodland Pond puts a great focus on, our strain on municipal assets and how we're performing favorably to what was expected. The pilot contributions, but for Woodland Pond, I think the most significant piece of this report to me that tells you most about Woodland Pond, is we are

completely embedded with our community at large. We see ourselves as being something that should be an assistant to the community. So we make our meeting rooms available. We are constantly partnering with local schools of art or colleges. We offer many internships and externships. Any kind of opportunity. We very rarely say no when somebody comes through the door and I think that that's really helped to create an appreciation of Woodland Pond in the community as a whole. One of the things that we do very routinely is we're a center for emergency services, whatever. So if there's an emergency, we'll make bedding areas available for the local fire, police, emergency responders, we'll provide meal service. They hold meetings and trainings at our facility. We're really trying to be a community resource. I think that that really shows that it's a partnership.

One of the other things that I included for you in a press release that we issued that got picked up by a number of local and regional publications. We place a great emphasis at Woodland Pond on inclusivity. It's challenging to enhance, I will be very honest with you, very challenging at least in the Hudson Valley to enhance diversity in the way of when you think about racial diversity, because there's such a focus on age and income eligibility. Like you're pulling from a pool of people that have to qualify demographically so CCRC's as a whole find it very challenging to become racially diverse in certain parts of New York State, certainly and in other parts of the country. So you will find, if you visit certain CCRC's, actually most in the country tend to be demographically similar. It's hard to enhance diversity because people have to be age and income eligible and you've got to have that demographic. So Woodland Pond doesn't want to just have one type of resident, we want to be inclusive, we want to be a community that is open to all that are interested and qualified. And where we really see that taking hold is in the LGBTQ population. Twenty-five percent of my leadership is a member of the LGBTQ community. We are friendly for all LGBTQ and we're now the first CCRC in the country to be nationally recognized for our skilled nursing facility as a Human Rights Equality leader, and that means a lot to us. This has come to us over time and we want to be a safe haven for people that feel they've been in a marginalized community. That's not to say we're excluding anyone that isn't LGBTQ but we see this as being something that's very important to us. So, generally speaking, I think that we're doing a lot of really good stuff at Woodland Pond. In addition to the general CCRC of Article 46, that is keeping folks off the Medicaid roles. If you really look at what we're doing here, we're bringing people in, we are taking on the risk of the finances because you know, most of our people take the fully refundable model, so we're taking on the financial risk and responsibility. We're keeping residents off the Medicaid role. So I think we're doing a lot for New York State. I think that there's a lot that can be done, partnerships and just a lot of good. And I would love to see a day that we could maybe find some concessions for our communities that are bringing so much life enrichment and really helping keep the Medicaid roles lower in our communities, doing such good care on some of the regulatory stuff. I'm just going to stop there before I kind of go into a list of some regulatory things that you might just want to be aware of. Does anybody have any questions or comments?

Council Member Laible-Kenyon: Can you explain a little bit more about, forgive my ignorance, how it helps keep people off the Medicaid role? I just don't know that.

Michelle Gramoglia: Yes. So in New York State and I assume Medicaid works the same in other states but I don't have experience there, so I'll explain to you how it works in New York. So in New York State if you are in need of a higher level of care as you age, so let's talk about assisted living or skilled nursing, so a nursing home, typically the folks that you see in nursing homes are on Medicaid. They have exhausted their assets and the state is funding their care. In order for that to happen, and for you to qualify for Medicaid, what needs to happen is that you apply for Medicaid participation, you need to have exhausted basically all of your assets. I think that the number this year that you can keep is like \$14,000 and a car. You otherwise have to have expended all of your assets including selling your primary residence, if you've transferred assets to your family or to others in the last 5 years, the state can require you to be made whole before they'll pay. And so most seniors in New York and there are a good percentage that pay privately for care either in their home or in a facility, but the vast majority of folks that are in institutionalized senior living, senior services, assisted living or skilled nursing in New York State long-term are on Medicaid, which means the tax payers are funding their care. In the CCRC model, for an Article 46 Community, the residents take their assets and in Woodland Pond's case we have some that are independently wealthy but most of our residents are people that worked hard, they saved money, the value of how they paid to come to Woodland Pond mostly came from the value of their home, so they've sold their home and they've got let's say a few hundred thousand dollars, they pay us an entrance fee, right now at Woodland Pond it's somewhere between \$350,000 and \$500,000 depending on which unit size you take, and we have made a contract with them that when they pass, 90% of that will be refundable to their estate. Now there are some other alternative models that you can use but they've invested their life savings in us. They have the option of buying with Woodland Pond a life care contract which basically is a long-term care insurance which mitigates their process if they go into the higher levels of care. But we are saying to the State if we've signed up as an Article 46 Community, we will never put these people on Medicaid. So if they run out of all of this money and let's say they can't pay their monthly service fee, Woodland Pond is required to allow them to use that 90% refund which would eventually go to their children or whatever for their car at Woodland Pond and if they truly exhausted everything, that refund is gone and their assets are gone, we have committed that we will never, these residents will never go on Medicaid.

Council Member Laible-Kenyon: So after they've spent everything down, at the end of the day, no matter even if it's an A, B or C contract, no matter what you're still...

Michelle Gramoglia: We only have A and B so I don't want to speak to the others but in our contract language there is a clause that says, you will not, your residency will never be terminated for inability to pay. And we are unable to get our residents that are in Type A and B for the most part onto Medicaid. There are some exclusions; if there's a spouse that still needs support and there are some nuances to it, and there is some legal precedents being set in certain Type B contracts, but Type A which is where you're buying the life care, unless there's been mismanagement or willful hiding of the assets, which we will have to legally pursue to prove, we're basically saying, these people will never go on Medicaid. Woodland Pond, the other Article 46's are taking the financial risk. What we do and I'm sure it's the same at the other communities, is we do a financial vetting process for residents before they come in to make sure that we think that their assets will sustain them throughout their life at Woodland Pond based on

actuarial life expectancies, but ultimately we take the risk and we're saying that these residents will not be on Medicaid.

Council Member Laible-Kenyon: Do you know what the percentage of individuals that would be put at, that sort of put you at risk? So do you know how many people are even at risk of going to Medicaid?

Michelle Gramoglia: So, Woodland Pond, we're 9 years in and we have none. But we have no on that we're subsidizing at this point. We have a very risk averse financial approval though so we may and I don't know the statistics we do turn people away for not having sufficient finances upfront. So we're pretty risk averse at that front end.

Council Member Laible-Kenyon: So how are you keeping people, I'm sorry, how are you keeping people off of Medicaid if you don't have anyone at...

Michelle Gramoglia: Because all of these folks are...

Council Member Laible-Kenyon: If you don't have anybody at risk yet. Am I asking the right question?

Michelle Gramoglia: If these residents stayed in their primary residence and did not come to an Article 46 Community, they would be required to spend down all of that cash. So the money that they've paid us now is secure and towards their care, but if that was not the case, they would be required to spend every single penny of that towards their care first and then Medicaid would pick them up eventually. And the going rate, private paid skilled nursing in the Hudson Valley right now is \$15,000 a month. So even if you have \$250,000 if you're paying privately \$15,000 a month, goes very quickly. So we're keeping these people off the Medicaid roles. Any other questions before I go on?

Council Member Davis: Council Member Davis. When I do marketing events, I tell people the CCRC has two components; you're providing housing healthcare and insurance. That's why PSS is a the table. If everything is planned correctly, we become the insurance product that pays for the higher level of assisted living and skilled and therefore people don't spend down and get on the Medicaid roles. The likelihood is, partly to your question, if somebody spends all their money at the racetrack and they can't pay the monthly fees, the CCRC can drawn down the entrance fee. Now those entrance fees will last for many years because the monthly fee is relatively small to the interest fee so the likelihood of somebody spending everything is not great. At the end of the day because of the benevolent aspect of a not-for-profit, we could do the same thing you did, we could never put anybody out on the street. But it's unlikely that that would happen. But the beauty of a CCRC is the insurance component. It protects people from going on Medicaid, it protects the state from increasing the Medicaid role. So it's a wonderful product if all of it works. And congratulations, we opened in 2010 I know exactly what you faced. People do want to sell their homes 90% of the time to use the proceeds of that home for the entrance fee. I'm just curious, you mentioned you restructured several times, how many times did you actually structure _____?

Michelle Gramoglia: So we, I use the term restructuring, we're getting into details, we refinanced for interest rates only twice, so 2014. When we were initially financed, we had 5 tranches of debt so we had some fixed rate debt and we had some variable rate and some adjustable rate. And in 2014 our bondholders provided us the opportunity to fix the rates on the remaining variable rate debt that we had, I'm sorry adjustable. So at that point we still had adjustable rate debt that was adjusting every single day to market and they said this is too wild, this is too hard for you to plan for, we're willing to allow you to fix out the rest of the debt that's not fixed. So that happened in 2014. And then in 2017, commensurate with what may have been the sun setting private activity bonds that was being proposed at the federal level, the bondholders again came to us and said we're actually willing to let you bring all of your rates down. So we took this whole thing out to market and we were able to find rate favorability to the extent that in the mid 20/30s we were able to reduce our debt service annually by \$1.2 million. So in both cases it was interest rate it was not principal.

Council Member Davis: Did you have to go through a formal bankruptcy procedure?

Michelle Gramoglia: No.

Council Member Davis: Did this require approval of all your investors?

Michelle Gramoglia: No, in this case we needed majority approval of the bondholders to wave call protection. But because we weren't doing anything with principal and we never had an event of default, we never missed an interest or principal payment this was not a bankruptcy, this was an interest rate reduction. Basically refinancing.

Council Member Davis: The other thing I would comment on and I think there's a number of reasons to do social benefit programs and statements like you did not only for pilots but also to maintain a not-for-profit status of CCRCs, these are always good things to do because the higher risk some would say look at these places, look how high end they are, the services they provide and these really not-for-profit driven organizations. So I think the extent that you're doing these social benefit programs benefits that as well.

Michelle Gramoglia: I would be happy to share this template with all of our member communities if anyone is interested. Once you start doing it, you have the template its just pulling HR reports and its quick. So I'd be happy to share it.

Just in terms of the regulation, I don't want to belabor this but because we have such a robust book of Medicare business which we will not leave to the side, and I'll be honest, even if it was not as costly as it is, us having such high performing, so we've been 5 star rated for Medicare/Medicaid services for the last 7 years, clean surveys always with very minor tags if any for assisted living, and for skilled nursing. The ability for us to rehabilitate our residents when they break a hip, have a surgery, both on an inpatient and outpatient basis, absolutely allows us to keep our residents in independent living longer, there's no question about it. So we would not divest of this. So I think I mentioned, we do about 2 ½ million dollars worth of Medicare business annually which is a lot. About \$30,000+ a month on outpatient and the remainder in

inpatient. We are also required to actually take in as a direct admission two skilled nursing Medicaid residents, a certain number of them. That's one of the requirements of Article 46 so that we're not only offering our services just to the folks that can afford to come in under contract, we have agreed that we will take a certain number of Medicaid residents to assist the facilities that are heavily Medicaid and we need to take those in, which is completely fine. The way it's handled at Woodland Pond is that every room is private, every room is not assigned to a Medicaid room or a Medicare rehab room or a private pay room, or a resident room. Every room is the same; somebody could be a Medicaid one day and the next day it's private pay at \$15,000 a month. Our staff do not know what the payer source is at all and we do that on purpose. We want somebody that's on subsidy to be treated exactly the same as somebody that's paying us \$15,000 a month or a contract holder which is paying less. But that being said, there are significant requirements in New York State because we are a Medicaid participant. So between the Department of Financial Services requirements because we are an insurance company, which includes, of course, the annual insurance blanks. So the financial reporting, the interrogatories which includes significant amount of operational information, what's changed from last year? Do you have new agreements? So on and so forth. We also have a full Medicare cost report which is dozens of exhibits of every kind of different way to slice up your pie and how you're spending your resources, and a Medicaid cost report, audited financial statements that have to happen at the beginning of the year, and because we are debt financed and we have so many covenants, we've got significant bond reporting requirements and continuing disclosure that has to happen all the time.

I did an analysis in preparing for this meeting; 90% of my director of finance's time since February 1st has been strictly related to regulatory requirements. So first the audit of the financials which now, for us, because of the cyber security requirements under Medicare CFR and Medicaid requirement, I'm sorry DFS requirements, now includes a significant cyber security audit and corrective action plan so that happens up through mid April, and then the insurance blanks get done. Immediately following that her entire time, 90% of her time is spent on the Medicare cost report. Now immediately following that the Medicaid cost report, and this year we are also subject to the triennial department of financial services audit which is required because we're part of DFS. So she, I don't know now this compares and it's transparent it's on our 990, she makes about \$125,000 a year at assumed 6 months 90% of her time that's \$65,000 of our costs because we have a very thin team. It's basically her that can do this because all the pieces tie together and loss of productivity. It's a significant cost. All of these things have to be audited now because they're full cost reports. So in addition to our audit fee with the audit firm, the cost reports also have to be audited and certified too so audit costs for us range about somewhere between \$60,000 and \$90,000 depending if we have to have a new actuarial comprehensive study which this year we do which is one of the contingencies of our 2017 refinancing. To me the bigger issue outside of the cost though is I don't have a director of finance for all that time. I don't have somebody that is able to analyze our cost patterns. So that's kind of getting picked up by me. I'm reviewing the payroll reports now every 2 weeks and doing the position-by-position analysis which is critical for us because that's our biggest P&L item, that's \$10 million a year out of \$23 million, somebody's got to be looking at that and understanding if there are trends why are there trends? If we have overtime why is there overtime? So I've lost my Director of Finance every year for the last 5 or 6 because we've done

more and more Medicare and Medicaid business. I've lost her expertise. I'm not going to back fill that so its something there's vacancies there so I feel like there's opportunities that are being lost from just a pure management perspective. We also just to give you a little bit of perspective on special type events, in 2016 when Woodland Pond was initially created, we were part of a hospital based healthcare system in the Hudson Valley which is now called Health Alliance. In 2015ish Health Alliance decided that they were going to be going down a patch to try and focus on community-based health ultimately which resulted in them affiliating with Westchester Medical. While that was going on, Health Alliance and Woodland Pond which has no other senior living with the exception of a critical access based nursing home in Delaware County, they have no senior living. So Westchester was not interested in having a CCRC. They have really no senior living anymore. They used to have a skilled nursing years ago. Health Alliance didn't want it. We really didn't want to be part of Westchester and its hard to be a senior living facility that's parented by a hospital corporation. Very, very different operating concepts. So it made sense, our Boards unanimously approved separating and ultimately we did get all of the approvals that we needed to have this be done in a very, what I understand to be a very fast period of time which was 4 or 5 months from November of 2015 to March of 2016. We had to go through, now our IDA had to be the first level of approval after the Board's unanimously approved it. So both parties said, we're good. That wasn't enough though. So we had to go through our IDA which ultimately has authority to make these approvals. We had to go through our bondholders. We had to go through FIPIC, Marrow for public health council FIPIC I'm sure you're aware of that down in Manhattan and we had to go through the Department of Health for the Assisted Living Facility so we had to get approval for the skilled, we had to get approval for the assisted living, we had to get approval by DFS, I'm sure you approved it somewhere along the way. Conceptually, I think there was no one that had any issues with this. But the way it works, if you don't get on the FIPIC agenda by a certain date you're getting delayed and if there was a way that there could be a single entity or part of the state that could say, we're going to take this on and we'll get feedback from, like let's say its DOH which is what we're recommending in the CCRC Revitalization Act. They can get signoff from the IDA. They can get signoff from DFS. They can get signoff from the ALR, they can get signoff from SNIF but they're the point person so that there's one review. And then if its needed to then go to FIPIC or go to all these other places, you know that would be a great relief on some of the strain for some of these things. Similarly when we did the 2017 refinancing of the debt, the financial feasibility study which we spent \$90,000 to have performed as a requirement of the bondholders, reanalyzed our entire primary market area. They did a full market analysis. They did a full financial feasibility study from scratch. It all came back that this was going to be financial feasible for us Woodland Pond was going to be fine, it was going to save us \$1.2 million within the next 5 or 6 years. It seemed like a no brainer. We didn't have to go to FIPIC for that but we had to get approval by the IDA, the bondholders, DFS, DOH, and this was something that didn't seem questionable at all. I mean we had an independent report that said, yes, if you can get these rates this community is just going to strengthen financially. So if there was a way to streamline the approval process, it would just make these things seem like they're all positive and very little downside, it would be great for our communities to just be able to continually strengthen and thrive in my opinion.

Council Member Laible-Kenyon: Can I ask a question? We don't know that we'll ever really be able to really separate between the IDA approval and DFS and DOH but we can certainly try and consolidate stuff that's directly in our hands in some way or at least talk about it. Is it possible for you to give us just a list, you were talking about those financial reports that you have to do; the ones that go to DOH, DFS and you know the monthly cost reports, can we have a list of all of the reports that you have to. Again, I don't know if there's anything we can do with that but it's worth taking a look at.

Mark Hennessey: Just to specify, you're asking for a written list.

Council Member Laible-Kenyon: A written list.

Michelle Gramoglia: Absolutely I would need to do that not sitting here. I wouldn't want to take the time and who would I give that to?

Mark Hennessey: You could give it to Mike, Mr. Heeran.

Michelle Gramoglia: Alright can I have a week? Is a week okay?

Mike Heeran: Whenever you get it ready, I think that's fine. Get those ready, send that to me and I'll forward it to the Council.

Michelle Gramoglia: That's fine. I just want to make sure it's comprehensive because I was just talking about the big things but I know there's probably other things in there too.

The last thing I just want to mention because it's new and it's quite cumbersome, cumbersome to Woodland Pond due to the fact that I will be adding because of the compliance requirements to my payroll, and I have not added a position to my payroll, it's a significant position other than nursing or wait staff since we've been full. So this is a new management level position although not supervisory, basically a Risk and Compliance Manager. It's unavoidable at this point. We've been able to handle regulatory compliance with my Corporate Compliance Officer which is also my Director of Human Resources until now. But because of the HIPAA security requirements of the CFR that came out for Medicare, that and the new cyber security requirements of DFS, we simply cannot do this without a full-time person watching corporate compliance, cyber security. We outsource our IT function, we have since the inception because we've always wanted the redundancy of support 24/7 instead of just a guy that's like in a room there Monday through Friday. We really wanted to have the continuity of care because we're on a fully cloud based EMR for our skilled nursing facility. We need to be able to be computing all the time so we've always used a third part firm and they're excellent. They're heavily focused on the security of our systems. We're constantly investing in that. If you look at our capital investments for the last four years, the bulk of it has gone into computing systems and security over our systems, redundancy. That's how much of an issue it is for Woodland Pond. But we simply cannot do this as a part time job anymore. The self-auditing that needs to be done, the constant monitoring of the systems. I mean you would think that we were a multinational bank because the requirements are the same for a huge, the DFS requirements for cyber security because we're a

DFS required covered entity, the requirements for our cyber security program are exactly the same for us as they are for the largest insurance company in New York State and any other covered entity under DFS. And we do very minimal amount of, we don't even accept credit cards at Woodland Pond. So I mean the risk to Woodland Pond is basically anything that's in our electronic medical record and all of that's covered by HIPAA and very tight. I have to add, and right now the going rate for this position without benefits is \$75,000 in the Hudson Valley. So I will be adding \$75,000 cost plus benefits to be able to comply with these requirements. And I could say cost vs. benefit, you're only getting 2 ½ million in, in Medicare and then I have to have the Medicaid people, I'm not allowed to not have the 4 Medicaid's that I have. It puts all of these requirements on. So this will be an added position. Its just important for you to know some of the real costs. And when we're talking about a thin financial model at Woodland Pond as it is, not-for-profit status we like to take any additional cash that we have and put it right back into the residents. This is something that really takes assets away to the tune of even this particular person that we have identified will require benefits close to \$100,000 a year. That's all I was prepared to talk about. I know oh my goodness, I'm sorry I went on and on.

Mark Hennessey: Council Member Davis.

Council Member Davis: Just one general question more for DOH, you're talking about Medicaid census, clearly in my mind when you open a CCRC you need a certain percentage of Medicaid in your nursing home based on the county utilization does that requirement continue after 7 years?

Mike Heeran: You cannot discriminate by payer source.

Council Member Davis: You need a percentage of Medicaid in your nursing home after the 7 years. You're now servicing your community.

Mike Heeran: For your outside admissions you're not supposed to, by Public Health Law, discriminate by payer source.

Council Member Davis: Do you need a certain percentage in the nursing home?

Michelle Gramoglia: The way we understand it to be and maybe you can correct me is that as long as you are taking direct admits, and you're within your required number of direct admits, a certain percentage of that should be a mix of every payer source. So you operationalize it based on your, you look at how many direct admits you are allowed to have or many that you are required to have and then a percentage of that always has to, in the way we've always understood it, is it has to be considered to be Medicaid. So we have a number in mind that tells us, okay we'll be safe with X number of Medicaid's, maybe we've been interpreting that wrong, but that's always been the way, we've always expected that we've got to have a certain percentage of our direct admits need to be considered to be Medicaid if there are candidates that need a bed in our region.

Mike Heeran: I don't know if you're referring to the Medicaid access issue that's where I'm pausing and I'll look to Tracy Raleigh because I wasn't aware of what you are referring to.

Tracy Raleigh: So this is Tracy Raleigh, I'm the Director of Planning Licensure and Finance at the Department and you know I think what you're describing is our expectation of the CCRC community in terms of having its admission policy, there are direct admits from the community going on that's its representative of the community. To you question Jim and we'll take that back, we're not that strict requirement that's imposed when you're coming before the FIPIC for a nursing home Article 28 project is not directly imposed on a CCRC community. But I think the expectation is that if they are directly admitting from the community that it is representative of the pair mix of the area.

Council Member Davis: Perhaps as the nursing home matures and you have less outside admissions, I would assume the number of Medicaid residents you need to take at any given time could go down proportionate.

Tracy Raleigh: Right. We'll go back and verify that but I believe that's accurate.

Mark Hennessey: Any other questions from Council Members?

Michelle Gramoglia: I appreciate the time and I'm sorry that I went on so long.

Mark Hennessey: Well thanks for all the information, we appreciate it.

Michelle Gramoglia: Thanks and I'll get that list. Thank you all.

Mark Hennessey: The next item on the agenda is a presentation by the Summit at Brighton at CCRC out of Rochester. The purpose of Summit's presentation is really two-fold. First, they're going to introduce us to their CCRC and second to discuss their interest in offering a new CCRC care at home product at the CCRC. I think we have Debbie McIlveen who is the Senior Vice President of Finance and the CFO, and Susan Busse, Senior Vice President of Housing. They are here today to discuss the CCRC and their plans to explore a CCRC care at home contract offering. There is a concept paper that was handed out I should say was distributed to all the Council Members before the meeting, feel free to refer to that during the presentation. And, thanks for being here today, we appreciate it. And I just again remind you please state your name first before you speak the first time if you wouldn't mind.

Susan Busse: Good morning, I'm Susan Busse so I'll start us off. Just an overview here. we're getting the table of contents. We're going to introduce the program and then walk through the different so financial overview and then overview of the program.

So jus to start off with the Summit at Brighton is a CCRC. We offer 3 levels of care, we're a 90 unit independent living community with 60 units of assisted living and 16 units of memory care. And you can see the timeline there between 2015 and 2018 that we've stabilized our occupancy so it's pretty high. Runs at a fairly high rate.

Debbie McIlveen: Good morning, I'm Debbie McIlveen and I'm the CFO and I've been here since the beginning of time so when we opened in 1998 and I'm still here heavily. So we have had some financial challenges. In 2009, you already heard the previous speaker talk about the occupancy challenges, we face the same things. Fortunately now you can see our occupancy has come up. In 2015 we actually had a loss of about \$560,000, that's turned around. Our occupancy now are in the mid 90s to high 90s. We actually have 55 people on our waiting list. New marketing strategies that Susan implemented that's turned around. We had a gain in 2016 of about \$250,000 and 2017 it was a gain of \$723,000 and we're pretty much right on target in 2018 to have about a \$700,000 gain.

We've actually started to put money back in to our property updating a lot of the resident rooms, the common spaces and all that and still have been able to maintain a days cash on hand 187 and probably right about 175 if we were to look at it today. The debt service ratio beats our covenants set by the bank so we feel our financial status has been much improved.

Just quickly talk about the actuarial highlights that we had. We just as required finished our actuarial report from 2015 through 2017. The valuation date which was 12/31/17 we had a funded status of 106% and really what that tells us is that our future revenues will more than adequately cover our future expenses. So the target is 100, 105 is above so we were at 106 and you can see that the last time we did this our funded status was only 84%. So there's been much improvement. In the liquid reserve that just says that our assets will cover our expenses, was 40.5 as compared to 19.5 3 years ago. So, there's been improvement as a result of that.

Susan Busse: So the concept evolution for life care at home is it's a CCRC without walls. It began in 1990 in Pennsylvania with a Type A life care pricing model. It's an entry fee plus monthly fees guaranteed for future care. And the programs offer a package of services for people who want the CCRC concept but they really want to stay in their own homes. So it's keeping them at home as long as possible.

There are currently approximately 30 life care at home programs operating across the country. In our research the Summit at Brighton reached out to two communities that are currently in operation; one was Longwood at Home that's in Pennsylvania. They started their program in 2002 and they have over 450 participants, and the Jewish Home in Fairfield, Connecticut, they started operations in 2011 and they have over 100 participants at this time.

As far as member eligibility goes, so it's the same as a CCRC, it's page 62. we still have the same requirements for the at-home product as we do as coming into our CCRC. Applicants would have to be medically qualified and financially qualified. So our medical director would have their piece and then the financial department as well.

So the overview. Members enroll when they're healthy. They pay an entrance fee and its based on their age as well as the options that they choose in exchange for future care, similar to that of the CCRC. So if the member experiences a change in their health, so we're probably enrolling people who are very healthy and they don't need anything right away, when they have a need, they would contact the Life Care At Home coordinator and arrangement for services based on

their personal needs. And the care could be daily and it could possibly be lifetime, depending on what they need.

The typical member utilization. So initially Life Care At Home, the program will include the items you see below; care coordination, programs at the CCRC which would mean the ability to come on campus for planned events, that type of thing. So being part of a community. Companion care, transportation coordination, handyman services, housekeeping. So services that would keep people independent and in their homes. So we anticipate the first few years that this will be the biggest utilized piece.

And then the Life Care At Home contract will also include access to healthcare, managed access on a temporary basis, while the contractor has needs. So what they would be able to access to on our campus is adult daycare, we have a physician house call service, so they could have house calls, skilled nursing care, transitional care which would be short-term rehab, assisted living including the enhanced level that we have, outpatient rehab therapy and memory care, that will be available. If the life care member determines that they no longer wish to live in their own home and they do want to come into the CCRC, they would have to apply but they certainly could have that option as well if they so choose. And then we will also establish geographical limits so as far as where the member, we'll serve a radius of clients so we probably will have a primary and secondary market which we do so that we will be able to access our clients as quickly as possible. And we will contract with at least one other adult care and skilled nursing provider so that in case we can't accommodate their needs, out clients can be accommodated.

And this is just a general, its an example of a member profile. So this is a potential member who might join the Life Care At Home program. So John, he's 75 years old, he's a widower, he is in relatively good health. He lives in his own home and he's able to care for himself. He became a member of the Life Care At Home program and he choose the all-inclusive plan and we'll get into the plans a little bit later, 100% coverage with 0% co-pay. He required a hip replacement and was immediately discharged from the hospital. So he didn't get that 3 day stay following the surgery. John went to rehab services at Jewish Senior Life and followed by Home Care and therapy in his own home until he was fully recovered. All of the care and therapy that he received post surgery was covered by the Life Care At Home option he choose when he joined the program. So those services were there for him when he was ready for them.

Debbie McIlveen: So, the Life Care at Home just was approved by the CCRC Council in 2014 in New York State. We've really been looking at it for the past year. One of the reasons we want to do that is we feel we're pretty well situated in order to provide all the services that go along with Life Care At Home. And as I mentioned before, we have 55 people on our waiting list. We are looking at ways to expand. We only have 90 units and when you compare us to some of the other organizations, that's pretty small. So a couple of reasons why we want to look at Care At Home. We think there's a market opportunity and Clifton Larson Allen confirmed that for us and we also think that this allows us to help more in the community but for us to be seen. It's also a theater for some of our other services. We have a nursing home, I'm probably getting ahead of myself but I'll come back to that in a minute. But we are requesting, and I know there's the regulation that says, the number of Life Care At Home would be limited to the

number of independent apartments, we would ask to go beyond that because we are a small community and we believe that the marketing analysis supports that we can go well beyond that. So we would be asking at the appropriate time for up to 150 slots.

The marketing analysis I just mentioned, it shows that just in the primary market, we could pick up between 55 and 173 members, and then in the secondary market which is still well within a reasonable range, anywhere from 20 to 120 more. So Rochester Community could support our program and without causing any real reduction or any reduction at all in the CCRC occupancy. Because again, there's a differentiation between the people that would pick Life Care At Home, they really want to stay at home where those 55 people on our waiting list they really want to come into the community, they don't want to remain in their home. So this gives them an option and it gives us the opportunity to approach people that say, "Hey, I really like the concept of CCRC but I don't want to live in a community like that, I want to live in my home." So we also did a telephone survey as a part of this. We had them look at what their potential long-term care needs and it's hard. I know that as I'm aging I'm starting to think, oh which am I going to prefer, probably because of where I work but I can now have an option, I can stay in my home or I really can go to some place nice like the Summit.

So, Jewish Senior Life is our parent organization and the Summit at Brighton and Wolk Manor that Susan and I have been talking to you about has 90 apartments, Wolk Manor has 60 apartments and as part of the Wolk Manor license, we have the lodge, a memory care unit, that has 18 beds and then the Jewish Home of Rochester which we're affiliated with has 328 beds. So you can see, even with our existing CCRC, we have plenty of capacity to add Life Care At Home under our umbrella.

The services available at Jewish Senior Life, we've been pretty progressive with our staff and our CEO at the lead. We have outpatient rehab. We have a program specifically for that. We have transitional care. We're expanding from 68 beds to 88 beds. We're undergoing a campus renovation for Jewish Home that involves expanding our transitional care. We will be adding a neurobehavioral unit. We have over 200-bed long-term care, and one of the things we're most proud of right now is that we just opened 108 greenhouse beds. So a greenhouse bed, it's a different way to provide long-term care. Instead of being on your typical nursing home unit, we now have a greenhouse home which has 12 beds and its considered a home. There's common space, everyone eats at a community table. The staff is really a lot more involved. It's not run by a head nurse manager, it's really run by the residents and the staff on that unit. That's been very well received and we actually now have people waiting to come into our nursing home. So that's been very helpful. We have some of our CCRC people are now asking when they need skilled nursing, "Can I go to the greenhouse instead?" We have an alternative there too as well. And that's the nice thing about our campus; you're going to have alternatives. You can either go into the tower, the typical SNF care or you can go into the greenhouse.

We also offer physician house calls. We have physicians on our staff that go out into the community. We serve several of the people in the CCRC but this fits perfectly into the idea of Life Care At Home. We already have those services and those systems in place. We have a companion, one of our only for-profit corporations, Companion Services, that's operated under

the Jewish Senior Life umbrella and we have 84 slots in adult daycare so we can offer that service as well.

So, again this is all preliminary and thank you for helping us go through this. With our investigations that we've talked to the other places that Susan mentioned and talking to our actuary also, these seem to be prevalent. This would be the way that we would, at least preliminary, look at offering the contracts; an all-inclusive rate where there would be no co-pay and 100% coverage for authorized services, home health aides. Now Home Health Aide is one of the, we're not certified Home Health Aide but we would look to contract that. All of the other services would certainly be under our umbrella. This is the only one that we would contract. But for us, that's a great way for collaboration too with other organizations in the community. So that's a plus to us. One of the things under the All Inclusive that I think we're going to talk about later and we've had some conversations is, what's the limit? And we'll talk about the risks there.

A security plan, a 15% co-pay and again, we haven't had our actuarial study done, we wanted to wait and see what the expectations of this Committee and Department of Health and Department of Financial Services would be but this would be the things that we would explore in the authorized service of 30% co-pay for facility services once you needed assisted living or nursing home care.

And another option would be the co-pay 30%, I'm sorry a 50% co-pay for all those services. But, again, this is preliminary and we haven't really investigated the numbers wise.

A possible fee schedule – again, these are just ranges that we're starting with and until we get the actuarial study done we won't know for sure, but the all inclusive and entry fee might range from \$40,000 to \$75,000, a monthly fee of \$500 and then they go down in recognition of the out-of-pocket expenses the member would have. Security plan 30 to 60 and then the co-pay \$20,000 to \$40,000 and a reduction in the monthly fee is appropriate as well.

Mark Hennessey: Council Member Davis

Council Member Davis: Just one question about this slide. You're talking about age adjusting in a CCRC as I'm sure you know the only age requirement is 62, entrance fees remain the same. How will you age adjust each person that comes in?

Debbie McIlveen: So the one's that we've looked at and this is an option that we would have and we certainly can discuss this more, but for specifically the one in Connecticut that we looked at it was adjusted I'm going to make up a number by \$500 for every 5 years of age. They did it based on an increment; we don't have to do that. but that was a way that they felt they minimized their risk because the person, as we age we all need more services. So the \$75,000 entry fee was more appropriate for somebody who was 85 or 90.

Council Member Davis: We group them in some incremental level.

Debbie McIlveen: Yes, that's how they did it. So that would be an option for us to look at.

So, ways to minimize the risk and as the CFO this is always one of my concerns as well as everyone else's. Susan mentioned the application process, it would be the same. The medical evaluation, we have a medical director associated with our CCRC. We would look for input from this group as well but typically what we do is we look for someone to live independently anywhere from 2 to 3 years. Their financial application, you talked at length about keeping people off of Medicaid roles, what we're looking for here is that somebody's not only going to be able to meet the requirements of our Life Care At Home but also that they are going to be able to stay in their home because that's part of what they wanted to do. We would meet the reserve requirements established by DFS. And the way we understand that is that this program Life Care At Home would be looked at as part of the CCRC. So, while we've shown where we meet the reserve requirements now in our covenants, we would continue to meet those including the Life Care At Home.

Actuarial reviews and updates – they have to be done every 3 years. We would follow that same schedule with Life Care At Home. And just as we do in the CCRC, we require annual proof of Medicare coverage, property and auto insurance so that there's no risk should there be any liability that occurs and would negatively impact them.

We believe that this would have a significantly favorable impact on our existing CCRC. We talked about that we're small 90 units, so our overhead, Susan's and my salaries, only now gets spread over the 90 units but also the Wolk Manor units, this would allow us to add 150 slots and we really don't have to add much overhead at all. There are no property costs, we can assimilate those positions into our organization, and for the majority of this, there really is only 1 or 2 other FTE's that we would have to add; the Care Coordination obviously, but everything else we already have the systems and the people in those systems. So it would be little to no overhead really that would be added. And, the fact that the Life Care members At Home may need assisted living for a short period of time or have to come in to our transitional care or maybe use our adult daycare, that all enhances the occupancy and the utilization of the services that we already have. And makes it easier for the members themselves so the Life Care At Home. We're a small, relatively small community in Rochester. People know Jewish Home. People know Jewish Senior Life. People are well aware of the Summit and Wolk Manor so it's not going to be a big stretch for somebody to join our program. And we talked about the 55 people on the waiting list. Not all of those will come into life care as I mentioned because some people really do want to move to the campus and don't want to stay in their own homes but we feel that overall this is just going to help all of our organization.

So our next steps, the way we see it we're looking for input from all of you. If we get a favorable response from the CCRC Council to continue with our explanation, we would engage the actuary and once we know specifically what DOH, DFS, and the Council would want we can proceed with that.

We would submit our application and actuarial report. And we've actually started to look at the draft of the Life Care at Home contract based on, and we do offer and we probably, we're so

excited about Life Care we probably didn't go into as much detail on our existing CCRC, but we do offer the three types of contracts in our CCRC. We do offer the A, the B, and the C. So, we've started to develop a Life Care at Home contract based on the contracts we have and also in conjunction with the other facilities we've been talking to in Connecticut. They seem to follow similar ideals I guess.

We would meet with the CCRC Council to obtain our Certificate of Authority if you would grant it. And then we would also, and I kind of switched those, we've already started to have Susan talk to some of the Summit residents preliminarily saying that this is a program that we want to look at. And we would go back to them with more specifics and details and share with the financial impact and the results that the actuarial evaluation proved. Probably in November or December. And then we would hope to roll out this Life Care Program in the first quarter of 2019.

Council Member Hennessy: So, do we have any, thank you by the way, just for starters. Do we have any questions from the Council Members? Council Member Laible?

Council Member Laible-Kenyon: Council Member Laible-Kenyon. Can you talk a little about the caps so that they would be weekly, monthly, lifetime caps and what would happen once someone exhausted those caps? Like for home care for example.

Debbie McIlveen: The things that we've been looking at is that, again, we will be able to answer that better once we look at the actuarial study and know what ranges of age people might be entering. But some of the opportunities and options that we have, and again I'm not sure how these will fit and you'll probably talk more about it. But some of the organizations that we have, have a lifetime cap. So, once, I'm going to use round numbers, once the members hit \$500,000.00 they become responsible. That's all spelled out in the contract. Or if you remain in your home and you start to utilize more than what it would cost to care for you in the nursing home. So, say it's \$550.00 a day. If you are using \$600.00 a day of service in your home we would pay up to the \$500.00 or give you services up to the \$500.00 and then the member would pay \$100.00. But these are all different options that I think we have to discuss more but there are several options that we can structure it within the regulations. But I think we as a group have to talk about that a little more.

Council Member Hennessy: Council Member Barnett?

Council Member Barnett: I was glad that you mentioned that you already approached the residents because I was surprised when I read that was not going to be until you were almost ready to open that you were going to discuss it with the residents.

But also, how much Home Health Care, I mean how many hours of aids would go to the homes? Have you? You have to establish a time that they can have. They can't have around-the-clock Home Health Care Aide.

Susan Busse: So, they...

Council Member Barnett: You have that within your facility they can get care.

Susan Busse: Right.

Council Member Barnett: But this is somebody going to the home.

Susan Busse: Right.

Council Member Barnett: And you have an amount of time that the person would be spending there?

Susan Busse: So, we would have a care coordinator and an interdisciplinary team determine, they would meet with the member, determine the need, and they would get whatever care they needed. So, if they needed 24/7 for a few weeks and then tapering it off we would set the hours and times with the member.

Council Member Barnett: It wouldn't be until they evaluated the situation.

Susan Busse: Right, we would have to find out there's a need and then we would assess the situation and put services in place.

Council Member Hennessy: And these home care, I'm sorry, Council Member Hennessy. These home care services will be provided by a licensed Home Care Services agency?

Susan Busse: Yes, yes.

Council Member Hennessy: Okay.

Susan Busse: Home care service.

Debbie McIlveen: That's the one service that we don't offer on our campus. So, that's the one where we would collaborate with one of the two Home Health Care agencies in our area.

Council Member Hennessy: Okay. And how, overseeing services that are provided in a facility, and I know there's more than four walls but let's just call it a four-wall facility, is one type of thing. Overseeing services that are being provided in a disparate sort of situation is different. How are you going to accomplish the task of overseeing those services as they're provided in people's homes?

Susan Busse: Well in speaking with other communities that interdisciplinary team has got to include the home care agency as well so meeting regularly, weekly, as often as needed so that we're all communicating the same. We know the situation and the needs of the client or the member. So, it's going to be a lot of really good communication.

Debbie McIlveen: And I think critical to this is the care coordinator. That person is going to be responsible for taking care of each of the members.

Susan Busse: Right.

Debbie McIlveen: And we already have some experience with this. We have a companion program that we really in some cases we become the care coordinator. Even though it's unofficially and we just provide the, we know what the resident's needs are. And if we see that the resident's health declined, maybe we suggest to them hey maybe you come to our physician house calls or let our physician come out and see you. Or we can go take them to their physician and be part of those conversations. We can't do hands on care but we certainly can coordinate other things for them. So, we already have some experience doing that a little bit.

Council Member Hennessy: And what kind of system do you use? That's kind of the question that I'm asking. What kind of system do you use to track Individual A as receiving these services. It's basically the care manager who's responsible for documenting all of this, right?

Susan Busse: The care coordinator.

Council Member Hennessy: Care coordinator, sorry.

Susan Busse: Yes, they would be the primary person coordinating all the services.

Debbie McIlveen: And probably what we'll use, we haven't really gotten into that nitty-gritty.

Council Member Hennessy: Sure.

Debbie McIlveen: That's next month. But what we have an extensive electronic medical record system.

Council Member Hennessy: Okay.

Debbie McIlveen: That we use for all of our systems with the exception of companion care. But that easily could be adapted to do this. I haven't talked to IT yet, but I think so.

Council Member Laible-Kenyon: Do you have a standard assessment that you plan to use to determine if someone is eligible?

Debbie McIlveen: It would be the same and Susan could probably talk more about the details. It would really be the same as what we use for the CCRC because the risk is relatively the same.

Council Member Laible-Kenyon: [Inaudible].

Susan Busse: They'd submit their medical records and application, health application and financial too, so.

Council Member Hennessy: Council Member Davis?

Council Member Davis: Just a few questions. I think you'd be an ideal organization to do this. You have a good track record and you have a lot of other things on the campus that I think could make it work. So, from a concept standpoint the thing that always concerned me about this was are you competing against yourself? I know you mentioned specifically there are some people on your CCRC waiting list who are interested in this.

Debbie McIlveen: Who may be.

Council Member Davis: Who may be. How comfortable are you that this will not become a more attractive? People want to stay home most of the time, we all know that. Will this end up being something where you're competing against yourself to fill your CCRC department?

Debbie McIlveen: The possibility always exists. But it's very, we're the only CCRC, there's one in Buffalo, I don't believe there's one in Syracuse. So, we have a pretty wide primary market. But we really are, with a waiting list of 55 and I know that can disappear in a minute, what happened in 2009. But our product is so strong right now and we are the only life care. And with people's investments coming back in line and there's more to protect, the fact that they can, not lose all of their life's work I think is important. There'll always be people who want to come into the CCRC.

And I think as people age they don't want to stay in their home. But there are people that hey, I'm still relatively healthy but maybe I have a stroke when I'm 80, or whatever. But I want to go back home. We see a lot of people in our CCRC that don't want to move on even though we offer them that continuum of care. Can I guarantee that we won't impact that, our CCRC occupancy? I can't, but I think from our marketing study and what we've heard from our people there's enough to make both of the programs work.

Council Member Davis: From the Pennsylvania and Connecticut experience is that they didn't face competing against themselves?

Susan Busse: So, I just want to add to that that we did speak with many other providers. And basically, what everyone said right up front was don't expect this to be a feeder for your independent living. That's not the intent of the program. The intent of the program is to have people remain at home.

So, when we spoke with other providers beyond the two that we talked to, they were all kind of saying that there's a small percentage of people taking advantage of the services at any given time. It's not like everyone is using all of the services. So, it's a smaller percentage because we are attracting a younger person who's more active. They're going to use the services kind of on-call, on-demand. And there will be a small percentage of people who may want to move into the CCRC. But really these are people who want to stay home. It's a different product.

Council Member Davis: I'm more concerned with people who would have come to the CCRC and now will choose the Life Care at Home option.

Susan Busse: You know the people who are choosing the CCRC and on our waiting list really want the socialization of a community. That's what they want. I see very few people veering from that. They're coming to be around others. And the Life Care at Home model really is staying in your own place, so.

Council Member Davis: Just a few more questions. So, when you first built the CCRC you sized the assisted living and the skilled nursing on an actuarial basis to take care of the existing community. This could potentially, I assume, represent an overhaul of assisted living skills. I know you talked a little bit about contracting with other places but. Alright you're already shaking your head no.

Debbie McIlveen: Well no I just, our organization's a little bit different. We were a nursing home first. In many cases the CCRCs came and had a nursing home component. We actually have 328 beds of nursing home care on our campus. The Summit actually contracts with the Jewish Home to purchase it. And when we sized the assisted living, you're right, back in 1998 we started out with 30 units. But it became evident to us pretty quickly that we needed more. So, we actually have 60 units of assisted living. And our occupancy as you can see is pretty high at 95, 96%. But we believe we have the capacity to meet the needs of the Life Care at Home people that we would add.

Council Member Davis: Just a couple questions related to the report that you distributed. On page six at the bottom it says Life Care at Home contract will include access to the following healthcare services that may be accessed on a temporary basis. [Inaudible].

Debbie McIlveen: So, assisted living. I'm not looking at...

Susan Busse: Yeah.

Debbie McIlveen: So, the idea is that they remain, their permanent address always remains at their home. So, if I, the example that Susan gave, when somebody maybe had a stroke or needs a knee replacement they would come into transitional care. But the intent no matter where they are on our campus is that they return home because that's the premise of the Life Care that would be the contract.

Susan Busse: Right.

Council Member Davis: What if somebody needed long-term care in your skilled nursing facility?

Debbie McIlveen: This is where those limits are going to come into play.

Susan Busse: Right.

Debbie McIlveen: Because if they need permanent placement in the nursing home that's fine, that's covered here. But that's where when we go with the actuary we're going to have to talk to them about that. Because the idea is that they remain in their home and that these facility services are really temporary.

Council Member Davis: As you know those temporary situations very often become permanent.

Debbie McIlveen: And that's why we need to look at the limits and the caps.

Council Member Davis: Fair enough. And then on page seven there's a section permanent transfer to a CCRC facility. Maybe I'm just not following this. The very last sentence, the member does not qualify either medically or financially for the CCRC the Life Care at Home coordinator would assist the member in finding the appropriate on campus services prior to terminating the contract. I'm not following that. Why would the contract be terminated?

Debbie McIlveen: So, Life Care at Home again is based on the premise that I'm going to live in my home. If I change my mind and want to come into the nursing home then in our mind that Life Care at Home contract ends.

Council Member Davis: [Inaudible].

Debbie McIlveen: As long as, well I don't know. This is where I, we're going to have to talk about this. Because the idea is that, and what we talked about with the place in Connecticut was, as long as the person returns to their home the Life Care Contract at Home is in place. When they choose to come into the CCRC or let's say they make that choice... I'm going to go back on this a little bit. If I'm in my home and I want to come into the CCRC on the independent side. Absolutely you would have to pass the medical and that.

Susan Busse: Right.

Debbie McIlveen: If it gets to the point where now I'm at a higher level of care I wouldn't qualify for the CCRC and I need permanent care, or I want permanent care in the nursing home. I think that's where we have to talk. Because I don't know how we would. I don't think we know yet how we handle that.

Mike Heeran: Mike Heeran from the Department of Health. When we worked on the Care at Home bill with the legislature and the governor which is who passed it and signed it, the intent was to cover the person throughout. And if they need long-term care they were supposed to receive either long-term care at the CCRC or an affiliated organization. It's supposed to be, it's actually outlined in the contract how that's covered, is I think what you're struggling with and having caps on it. But it was the intent that somebody could still move through the continuum just like a CCRC. So, it's not just temporary. It's long-term placement. But the coverage of it I think is, I don't want to speak for you, but I think is what you're struggling with and if there's limits on that coverage.

Debbie McIlveen: Well, and I think we need to look at how we write those contracts. Because it very clearly says permanent placement in their home. So, I think we have some work to do on that.

Council Member Davis: Because my understanding of the intent of the legislation is this is to do everything a CCRC would do. Therefore, permanent placement in a nursing home would be possible, so.

I mean look, you're the first guys to do it. We applaud you and we hope it works. Because some of us would like to do it. But I think there's some issues here that's being presented in this report relative to the legislation that has to be resolved.

Council Member Hennessy: Any other questions from Council Members?

Council Member Laible-Kenyon: I had a question but it might have been asked while I was gone. I apologize. But it kind of goes along with what we were just talking about. So, I'm not sure now if you necessarily would have the answer.

It was sort of who would be given preference. So, if you have 300 people in the community and they're all sort of aging through and if the intent is to have it be like a CCRC and you continue all the way through and provide that care even to skilled nursing. So, who would be given that preference if you have [inaudible] that you have three people in the community who are looking to go in? Maybe someone from the assisted living looking to go in. Is there like a hierarchy, or?

Susan Busse: We would have to weigh their needs just like we do now. And determine who needs to move when and ensure services are in place to keep them safe.

Council Member Laible-Kenyon: And then you have the contract with the other facility as well if necessary.

Debbie McIlveen: In our existing contract, our CCRC contract now, allows if we're not able or we don't have the accommodations or we can't provide the level of care that they realize they might be in another nursing home until we can do that.

Council Member Hennessy: If there are no other questions I'd thank you for coming here today and for talking to us about this concept. You may want, you can leave the table, but you may want to stick around. We're going to have a discussion that might be pertinent to what you presented here today.

Susan Busse: Thank you.

Debbie McIlveen: Thank you all.

Council Member Hennessy: Thank you very much for coming today.

And so, at this time we thought it would be helpful for Mr. Heeran of the Department of Health to review the highlights of a presentation he gave to the Council back in March on the CCRC Care at Home proposal. After his presentation we'll open up the conversation to Council Members so the Department can solicit guidance from the Council and factors to consider when faced with reviewing CCRC Care at Home applications. Mr. Heeran.

Mike Heeran: Okay, I'm going to go through a deck of slides that were actually presented to you back in March, to the Council. I'm going to kind of skip around because we've gone over a lot of this before. I'm just going to skip through. I think we've pretty much talked about what Care at Home is. I want to get right to the requirements. Focus on those.

So, under Care at Home it can only be offered by an existing CCRC. This is the case with Summit at Brighton. I just wanted to stop here and add that Summit at Brighton, in their presentation, is more like the CCRCs we recently approved the two instead of the traditional CCRC which is a self-contained campus that offers its own skilled nursing and assisted living. They actually have separate skilled nursing and they actually have a separate incorporated assisted living which is oversized. So, they are a little different but they are an Article 46 so they do qualify.

And again, they talked about the financial reporting as well. Jump a little bit here.

So, the application requirements that we're looking to establish and we talked about. They have to submit a business plan that includes the services to be provided, the market to be served, and fees to be charged. You see they've done some work on that. A copy of the Care at Home contracts to be used. And the actuarial study then includes the Care at Home contracts demonstrating the impact they will have on the community.

I think in here I just want to talk about some of the things I think we're learning as a group. DFS and DOH have had meetings with the two providers that Summit mentioned as well. And we're trying to learn more about actual providers who offer Care at Home. But the crux of the application is going to be the actuarial study and the contracts. I think that's going to be probably from our perspective the heavy lift. Because that's going to be really what determines if this is feasible.

The communities we've talked to were able to have an actuarial study done and able to meet that actuarial study. So, they were operating within that study. So, it's going to be important for us to make sure we're comfortable with that study before presenting it to the Council because that's going to be important for the success for the Care at Home product. They have to follow those assumptions.

And again, contracts. This is going to be the law was established with the lateral requirements I'm going to go through. Those requirements and law are going to be tested for the first time in a contract to see if we can meet them. So, that's going to be challenging, I think, from a legal

perspective. Of can we have contracts develop that meet the requirements of the law and work in a way that meets the law actually in a contract.

And again, there's market feasibility study, you saw they've done some work on that as well. That needs to demonstrate that there's a market for this product. They have to notify the residents that they're doing this. And again, they've talked about that and they've put that in their timeline. And they have to meet all the requirements that are established by Department of Financial Services.

So, I'm going to go through some of the requirements that are in the Public Health Law. And I think this gets to what Council Member Davis was talking about. Continuing care at home contract is a single contract to provide a person with long-term care services and supports based upon the person's needs and coordinated by a case manager, which shall include services provided to the person in his or her residence and services of the community's nursing facility, adult care facility, or affiliated facility.

So, as Council Member Davis pointed out, the question that was raised was is it just temporary services as mentioned, or long-term care services? And I believe when we did this the intent under the law was to cover long-term care services as well.

Although the communities that we spoke to that offer it, this type of resident is very dedicated to their home. That's why they choose this product. And there's a very low incidence of them moving into the long-term care part of the CCRC. It's a little different than a regular ILU resident. So, I believe the numbers we heard were usually less than 10% that actually take advantage of a long-term care aspect of a CCRC. So, it is a little bit different flavor of a resident versus a regular ILU resident in that these people are very dedicated to their home, want to stay in home.

And this model we've heard from numerous care home providers is there's a care coordinator or care manager that really works, that's the crux of the model is you get that service. And that person works with not only the contract holder but the family to put services in place to keep the person independent and living a home longer. So, you have somebody there working with that contract holder to keep them independent and living in the home. And that seems to work well to keep the person out of needing long-term care services. At least that's how they manage that risk.

Contract, there's a 4608 of Public Health Law, Section 20 gets into some of the details of what's required. And I want to go through some of them right now so you're comfortable with them.

There has to be a statement describing the circumstances under which a contract holder may move into a campus. Either in the independent living through to kind of go to a regular CCRC contract or how they move onto the adult care facility or a nursing home. And that could either, that's going to have to be through the contract, it's the Care at Home contract itself.

A statement as to whether and under what circumstances transportation will be provided to contract holders. We've heard from some that it could be emergency transportation, non-emergency transportation. So, what exactly is covered as far as transportation goes has to be described in the contract.

A statement, again this was brought up earlier as well, a statement describing the mechanism for monitoring continued Care at Home. Contract holders, I believe Mr. Hennessy started talking about that, so there has to be a mechanism in place to how they keep track of what's going on at Care at Home. And again, in the model itself it's really that care coordinator who does that and arranges for services and is in contact. So, our understanding is that that person would be involved, say if the person/contract holder needed services they would help arrange to put them in place. If they were in the hospital they would work with that person in the hospital to get follow-up services either at home or temporary services at the community.

The contracts have to have a statement by which that describes priority access. I'm going to be forthright here, I think this was an error when we did the chapter amendment. I think it should have said as we heard Council Member Laible say, this says access to ILUs but I believe we meant access at the time to the higher levels of care. But as the law reads right now it says if there is competition between ILUs between a Care at Home member who wants to convert a contract, I guess, to a regular contract or somebody on a waiting list. They have to describe how priority would be determined between those two people, different contract holders.

The contracts also have to include the statement of describing the applicable geographical limits of the Care at Home contract services. This is really what we call portability. And this is, we've heard different aspects of this from different other communities in other states and how they handle this. But the contract has to state if these services that are being provided can be provided outside of the geographical area, if there's limits on that. How they could access covered services should they leave the area like go to Florida for the winter, things of that nature. So, that has to be described in the contract.

And a statement describing any applicable policy that would entitle a continued care contract holder to select an adult care facility or skilled nursing facility placement in a facility that's not part of the CCRC itself.

Okay so, and I do want to point out a couple things that were mentioned before I move on to the next steps. In the Summit's presentation they referenced the fact that there's limits on a CCRC's number of contracts that they can offer in Care at Home. That was something that we put in as like a security measure. And it's not, what's required is if it's initially it can be set either at the number limited to the number of independent living units or it can be set above. We put in a safeguard into that law that states if they come in with a number below and they go to exceed that and are approved by the Council. So, they're at 90. So, if they're initially approved by the Council or apply for 50 and we approve them at 50. If they went above 90 they would have to, or some other amount, they would have to come back to the Council. So, it wouldn't be under the Department's discretion they'd actually have to come back to the Council.

And the reason for that is capacity. And it's really not applicable to Summit's case because they have enough capacity because they serve contracts through a regular nursing home. But for a regular community, I'll use Kendall at Hudson as a good example. They have certain resources that need to be kept available for their current ILU residents. So, we wanted to have some sort of safeguard in the law that says if a community comes in and says we're only going offer a few contracts, it's not going to impact the services to the ILU residents, it's fine. We wanted to have that mechanism in there as a safeguard to say if they do that and then decide to all of a sudden have a lot of contracts that could impact ILU residents that's the mechanism where they have to go back to the Council. So, we do think under the law it's allowed that we could approve someone at Brighton to exceed that number to go up to 150 as long as the Council took that all into consideration at the time.

So, the Council does have the power and authority under 4602(2)(j) to develop guidelines for the applications for Care at Home. And we're looking today for some feedback now that we actually have, we've talked about this in the past, but we actually have now a potential application being considered. And they've given us some ideas. And hopefully we can get some feedback on the materials that the Council thinks is necessary to approve an application. What would you like to see in that application?

Oops, hang on a minute. Here we go.

So, in some of our discussions and research that we've been doing in the next two slides I've tried to outline some key elements that we think would be in a Care at Home application. And we'd like to get your feedback on these.

The actuarial study pricing and financial impact analysis are very key. It would be key for us to present to you.

They'd have to demonstrate capacity to serve Care at Home contract holders so they'd have to show that they would have the resources to serve them. For example, they'd have to describe how they're going to provide homecare services. What type of homecare agency they're going to sign with. Care managers, I think we like to see more about the care coordination aspect. Who's going to be conducting that? How many are they going to have? What role do they play?

Target population to be served and the geographical limits of that population. And demonstrated demand for the services within that area.

Contracts that meet the requirements of Article 46, Section 4608. Again, I think this is going to be a challenge going forward as this is going to be the first product offered under this model and we'll have to see how the contracts work. And it's probably going to be a lengthy period of time to do that.

I think the most important thing I've heard through communities who have either taken on this model and I've actually talked to a CFO of a community who looked at this when she worked in another state and they decided not to take on this model as risk.

So, how does the CCRC manage risk of the Care at Home product? And I've listed out here some of the items that I think are applicable to that and we've heard that today as well. Do they put limits on services? Lifetime limits we heard today. Caps on care. Other communities have talked to us about daily caps on care and services.

They have to maintain adequate reserves. This is more of a traditional insurance product so to speak. So, again they're prepaying for care and they have to maintain adequate reserves over time so that when the Care at Home resident actually needs the services there's money there to pay for it.

The qualification requirements become very important. Both medical and financial. Again, the communities we talked to were successful because they had an actuarial study done and they are achieving or staying within that actuarial study model. So, that's crucial for anyone who's working and doing the admissions and qualifying these people that they're making sure that they're working within that model. If they stray too far from that model there could be consequences.

The number of contracts offered. You don't want to be too small but again you have to be to a certain point, to a certain size to mitigate risk. They've asked for 150. Again, anything smaller from my understanding could be problematic for them to manage the risk. And again, even with that the portability of contracted service becomes an issue as well. What other services are you allowed to access outside of the CCRC? What happens if they move temporarily? How are they allowed to get services as well? Getting care coordination is very difficult. You have a care coordinator out of Rochester and you're living out of Florida.

Some other elements that we've been kicking around are core services to be offered, optional services, and services to be offered with a co-pay or at a fee-for-service rate need to be considered and discussed. We, I don't think we're anticipating a co-pay type arrangement. So, when it was presented to us I think that may be a challenge. And again, in a traditional CCRC model you don't see to co-pay type arrangement. So, how we manage that within the structure of the law and there are certain areas we're going to be checking are concern as well.

How will they manage care management and care coordination and how it will be implemented? We've also heard about not only homecare being in issue but hospice and palliative care. Again, these are residents who want to stay in their home and may choose to stay in their home until their passing. So, hospice and palliative care have to, should probably be discussed as well.

How will entrance fees be advertised or refunded? Again, they presented entrance fees here but the discussion has to occur of if they are going to be a refund model. We heard from some communities that have some refund models. Or whether they're just going to be advertised over time. In the industry I think 48 months is the standard for advertising an entrance fee and a non-refundable contract. And again, if there is refunds how will they be refunded and what will trigger the refunds.

And then how does a CCRC ensure a stratified population in the product to manage demand for services and contract turnover? Again, how are they going to manage this population? You don't want to create a bubble so to speak of people who will be demanding services all at once. So, how are they going to manage their initial enrollment? How will they keep that contract turnover going and that population stratified so there's not the risk of some adverse bubble of demand on services occurring. Especially with other CCRC models where they actually have to provide services from within in a limited community and capacity.

So, those are some of the things that we were thinking about. DFS and Department of Health when we were listening to all this. But we'd like to hear some of your thoughts on some of these issues.

Council Member Hennessy: So, as Mike pointed out in the slides they've got, actually is it possible that we could throw the last two slides up again?

Mike Heeran: Sure.

Council Member Hennessy: And I know you all have them in front of you as well so you can refer to those but really what we want to have at this point is a discussion by Council Members of any ideas you may have about this list, it being maybe longer, maybe changed in certain ways. So, we'll open it to discussion for any of the Council Members and we'll go one by one if that's helpful. Council Member Laible can you?

Council Member Laible-Kenyon: Yeah, you touch on a lot of really great points here. I was glad to see there are things I was also thinking about. Just some additional things. Well, we mentioned the cap whether it be a daily or that I think it would be important establish that.

Also, is there an appeal process? As you know this is much more like, this is an insurance, you know, plan essentially. So, what would the appeal process be if somebody wanted additional homecare hours and it was being denied what does the denial process look like?

You touched on the care management a little bit. What is the ratio of care managers to Care at Home members?

And what would the ongoing oversight and audits look like? There's one, you can do a survey of a nursing home but what would this look like? There has to be, and who's doing that essentially?

Mike Heeran: So, for the survey process this is technically part of the CCRC product so it would be subject to...

Council Member Laible-Kenyon: But it's going to be very different.

Mike Heeran: ...The triennial review. So, we would have to incorporate some aspect into the triennial review. There's the DFS, it's heavily right now DFS does it under an MOU for DOH

but it's a heavy financial review and programmatic review as well. So, we could incorporate some requirements with the Council's input on what we could do during that review.

Council Member Laible-Kenyon: I would probably reach out too to just managed care on that. I mean a lot of what the oversight would be would be very similar.

Mike Heeran: But again, the purpose of this discussion and of the Council when we receive the application is there's things we can do when it's approved to put conditions in place on that approval, or put things on the books so to speak, on how this will be managed. So, if there's, if we can look to managed care, if you can actually assist us with that, pointing us in the right direction of how we monitor that. I think that's input we would like to hear.

Council Member Laible-Kenyon: And then you might want to look at a more standard, I don't know if there even is a standard qualification tool but just something so it's standardized across the board. Because let's just say this grows beyond one CCRC you might want to have everyone using something similar.

Mike Heeran: Yeah. I will want to hear as part of the application process I think we'll want to see what they're using for qualifying. I did, for example, my understanding is, and I've not talked to Summit at Brighton about this. But in most other states the person doesn't, where it's different from a regular CCRC is, they don't use their home or the value of their home to qualify. So, that portion, the value of the home, is taken out. So, it's other resources. So, I think we have to be clear about what resources...

Council Member Laible-Kenyon: Medical too.

Mike Heeran: Oh, medical too? Okay.

Council Member Laible-Kenyon: Yeah, medical too.

Mike Heeran: For both I think they're...

Council Member Laible-Kenyon: Yeah, for both. Yeah, of course. And then just out of curiosity for the homecare would it be licensed or would it also include consumer directed? Just out of curiosity.

Mike Heeran: The law states it has to be, the homecare has to be licensed. It has to be licensed homecare. So, if you give me a minute.

Council Member Laible-Kenyon: Just as a comment or aside. I think it's a really great program and I wish you guys luck in getting started.

Mike Heeran: We can get back to it. I can look up the law. But I believe when the law was passed there was a requirement in there that homecare had to be appropriately licensed, I believe on Article 36, so.

Council Member Hennessy: Council Member Stubblebine.

Council Member Stubblebine: I also have a lot of questions about how the homecare services would be rendered. And particularly with the contract. If there are limited licensed homecare providers in the area and lots of times people, sometimes they have acute needs and you never know when it's going to come up, and you try to have a home health aide come, they are not always immediately available. So, how would that be structured within a contract with the licensed home health agency to determine that there would be availability to meet someone's needs? If someone was on one of the 100% plan and they had an immediate need for home health care but the licensed agency didn't have anybody available for the next week or so how is that going to be handled? And how would that look within the contract that Brighton would have with the home health care agency?

I agree with a lot of these other questions were things that I was also thinking. I guess the other question that I had was what would the transition or the conversion look like if somebody was going to, you know obviously everyone has the intention of wanting to stay at home but sometimes illness, injury cognitive decline, for some reasons it's going to necessitate moving into a long-term care situation or a skilled nursing facility. What does that conversion look like and what happens to the entrance fee for the Life Care at Home? Is that something that gets taken into account and rolled into this new contract or is that refunded, forfeited, or somebody has been doing it for a number of years? I guess I would be curious to see what that would look like as well.

Other than that, again, I think it's great and I think that Brighton is really thinking through this very carefully. And I think that it would be great. I'm originally from the Rochester area. I think this would be awesome for Rochester. So, other than that those were my two questions that were top of mind.

Council Member Hennessy: Council Member Davis?

Council Member Davis: Just a couple comments and a question. Is homecare a requirement of Life Care at Home? To provide that service.

Mike Heeran: I think they just have to detail what's covered. I don't think we required it.

Council Member Davis: So, it is optional? That's my understanding. So, if [inaudible] it doesn't mean they can't do this.

Also to you question about standardization. There is no standardization of qualifications now for CCRCs. [Inaudible].

The regulations themselves are they very prescriptive or do they allow this Council to kind of set a template for this first application in terms of co-pays and limited stays versus.

Mike Heeran: So, how Care at Home came about was through law. There are no regulations for Care at Home. So, Care at Home was passed back in 2014 by the legislature and signed by the governor. And as passed it had some challenges, the language. So, we had to work on it, what was called the chapter amendment to the law, to create the language you see here before you today. And we try to put as much as possible in there to make this workable.

But again, there's some flexibility with the Council and the Council has some powers that can help us put things in place as far as what needs to be in an application. And give us some guidance on what we need to see as far as regulations to manage this as well. I think the application process you have authority, as I pointed out, I don't know the law number. But you have the power to establish the application process itself. So, you could build it into that. And again, you do have some power, I believe, through adding conditions to approval to put on some other requirements as well that might be missed in the law.

So, there is ways to kind of set the template but we will be doing that here. We'll be setting precedent if an application comes forward. So, we're trying to think of all these things ahead of time. We want this product obviously to be successful if it goes forward. And to be available to seniors in this state as a viable option if they have the resources to pay for their care and want this type of product for long-term security in their healthcare. So, again, whatever you're thinking I think we are willing to listen to and consider and figure out a way to...

Council Member Davis: Because I think the more options we can give to their actuaries to make this work, I think, the better. And the more limiting obviously the harder it's going to be to get people to enroll to the numbers they want. And potentially for the success of the program. So, I think to the extent that we can within the regulations give them some latitude to give different options I think would be a great thing.

And then the only thing I would add to this list is a statement somewhere that clearly says that there'll be no impact on the existing CCRC if we go to this program. Whether it's in their healthcare services or whatever else they're delivering. Because my concern with this always has been can the CCRC handle the load that this could present to the CCRC. So, I would just a statement that says there'll be no impact on the CCRC if we go forward I think would be useful to have in the application.

Council Member Hennessy: And I would just check to see if any other Council Members have comments that they want to make or questions. No?

The only thing I'd like to see is a structured oversight plan. And it's kind of speaking I think to the issues that were talked about by a couple different Council Members and then also in the discussion we had earlier. And really what I'm looking for is looking at it from the patient safety, or the resident safety or member safety depending on how you want to look at it, perspective to understand the lines of responsibility.

So, that's really, I think we'll need to maybe explore that a little bit. I think the model is very different than the model in a traditional CCRC in the way that that works and I just want to make

sure that we have a clear understanding of the pathways there. So, that's one thing I'd like to see.

Second thing is, I'd like to see in any application that comes before us a specific listing of the either licensed entities or other operating entities that are going to provide the services that are affiliated with this at home option. I think that'll be very helpful.

I think you guys were wonderful today in giving us, I think, a good understanding of that. And I think you have a good plan in place. So, it's not so much of an issue for your application hypothetically. But as we move into the other ones I think it's going to be important that those agreements be in place before moving forward with something rather than player to be named in the future or something like that. So, that's my input.

Anybody else have anything else they want to say on this topic right now? No?

Okay, so as we're getting closer to the end of today's meeting the Department of Health wanted to mention briefly a few policy issues that are being considered for being addressed by the Council. The Council reviews policy statements that are issued by the Department. And it is anticipated that some of the current policy statements may require revision or new policy statements need to be issued to reflect the current environment in the New York State CCRC program.

For that I'll turn the microphone over to Mr. Heeran, CCRC Program Director for the Department of Health, to lead us through a list of policy issues that the Department is working on and may be presented to the Council at upcoming meetings. Mr. Heeran.

Mike Heeran: Okay, so on your agenda. I don't have a PowerPoint presentation or anything but I did list on your agenda. There are some policy issues that are starting to come to light that we would like to bring to the Council in the near future. The program itself is aging. It's a mature program now. And the previous Council, when they dealt with it, it was more of a program in development and startup phase. And there's some issues that aren't addressed in the law or clearly addressed in the law that we're finding in practice. We want to come to the Council for clarification so they're handled consistently across the state and fairly with the CCRCs. So, I'm going to read through a couple right now and just kind of explain why we're contemplating this.

And again, the intent is over the summer, it will be our summer homework so to speak, we'll be reaching out to stakeholders and others to gather information and input on these and then bring them to you guys as a formal policy statement. That was what was done with previous Councils. Those policy statements developed, presented to the Council, and then issued to the CCRC community.

The first is relevant to what we're talking about here. We will have to develop a CCRC Care at Home submission guidelines. So, we'll have to come up with a policy statement on what needs to be submitted in a Care at Home application. And we've already started talking about that

today and hopefully we'll get that all hammered out with the Summit at Brighton if they choose to go forward.

One issue that's becoming very controversial a little bit right now is marketing incentives. And I think it's over the term marketing incentives itself. And I think we need a policy statement to be developed to clarify that.

There seems to be some discrepancy over the term marketing incentive versus pricing incentives. And under DFS regulations any change to an entrance fee price or a monthly fee price is actually required by DFS regulations to be approved by the Department of Financial Services. That's how the structure works currently. And the term marketing incentives has been used a little loosely. This has been going back for years now. So, we're going to work with the industry on this and try to clarify the difference between just general marketing incentive versus what we consider to be pricing incentives.

Again, we don't want to be too restrictive and over regulating. The communities, we want to give them the flexibility of if they want to offer somebody an upgrade in appliances or help with a moving person to help them organize versus discounting. We've seen some discounting in a case we've been talking about here in the Council over the past couple times and what a certain community discounting without approval can actually be harmful. So, we want to make sure that we clarify what a marketing incentive is versus a pricing incentive.

Remote campus requirements. We've recently had a CCRC under its current certificate of authority, Canterbury Woods out in Buffalo, offer a remote campus ILU. This is something that was determined to be allowable under Article 46 and not prohibited. But we think that it's important for the Council and the Department of Health and the Department of Financial Services to weigh in with a policy statement on this. How far can a campus be away from the main campus and still be a cohesive, the law states, a cohesive community? So, we think we need to discuss this issue with the Council as well so we can just define what is allowed under an existing certificate of authority and what requires a new certificate of authority as far as when the campuses are built.

And again, the one in, it's the Gate Circle project I'm referring to at Canterbury Woods which is ten miles. It's actually Williamsville is the main campus in Buffalo and Gate Circle is more in the City of Buffalo. So again, the community was required as part of that application to show how the services would be provided but at some point, it will be a challenge. You're talking about Potomac Landing on the north fork of Long Island trying to provide having a campus in Manhattan. So again, we have to kind of figure out what the limits are there as well.

Fee-for-service contract submission guidelines. We've had a lot of, there's an existing policy in place that needs to be looked at again. There are some issues there. We have a lot of communities now looking at the Type C contract offering and submitting it. We'd like to go over that with the Council and discuss some concerns we have with that offering and maybe tweak the contract submission guidelines there.

And kind of in the same light there was an existing policy that talked about what happens when someone moves through the continuum of care. So, CCRC in non-life care settings. So, non-life care contracts we think we need to look at the policy that talks about how residents are treated when they go through that continuum of care. And that we're going to probably bring that forward as well to make sure that CCRCs are consistently applying that. And specifically, as that relates to the refund requirement of the contract as well. We've seen some inconsistencies across CCRCs in how that's done.

So, again these are just policy issues that we think need to be looked at. We'll do that and hopefully bring some stuff to you in the near future.

Council Member Hennessy: Does anyone from the Council have questions for Mr. Heeran?

Council Member Laible-Kenyon: Just more of a comment. Obviously, I don't want to, I don't want us to rush this or miss the opportunity to also be very deliberate on how we handle the CCRC Care at Home submission guidelines. So, knowing that we're sort of going on break, there's a lot to unpack here. There's a lot to do. There's an entity interested in moving forward with it. Do we want to entertain the idea of sending this to a subcommittee or even tasking it with our current subcommittee to move forward with something?

It's just that I don't want it to be rushed, you know. And I don't, it seems like it's something that is, it's pretty big. I mean this is a pretty big lift. There's a lot to handle here.

Council Member Hennessy: Do any of the other Council Members have an opinion on the idea?
Council Member Barnett?

Council Member Barnett: I just thought the timeline was a little ambitious when there's all this to be done.

Mike Heeran: We've expressed that concern to someone at Brighton as well. That that's their timeline and we...

Council Member Barnett: It's rather ambitious.

Mike Heeran: It's theirs to present. The Department has, the Department of Health and Department of Financial Services have not committed to that timeline. We really can't commit to that timeline at this time. Because we don't have anything in front of us. They obviously are still working through a few things. That's the timeline they would like to achieve.

I think we've discussed with them and we'll discuss with the Department of Financial Services ways to work to move forward more quickly. I think there's going to be certain elements that are more difficult. I think the contract portion of it is going to be extremely difficult to work the language out. And there's been some willingness I think on their part that they can have that developed sooner. I think the actuarial study comes later. So, certain elements, usually we like to review everything as a package. We may have to look at certain things a little out of order or

non-sequential when things are being worked on as well. But that's something we can work on with the applicant.

But again, I'm really concerned about the contract language aspect. This is new law. It's never been tested and we're really going to have to work at that, I think. I'm not a lawyer. But I just think that's going to be difficult.

Council Member Hennessy: So, I think Council Member Laible-Kenyon had a pretty good idea in this idea of maybe side loading. I'm not a big fan of offloading. But side loading some of these issues off to the subcommittee that's already looking at some ways to move through CCRC changes and ways to revise the process. I'm actually amenable to doing it that way. Does anyone else have an opinion on that?

Council Member Stubblebine: Yeah, I think that's a good idea.

Council Member Hennessy: Okay.

Council Member Stubblebine: [Inaudible] it's going to require a lot of careful thought looking through this.

Council Member Hennessy: Okay, do we actually have to take a motion in order to effectuate this. Okay, alright. Okay, so I'll make a motion to assign the task of reviewing these policy statements to the subcommittee.

Council Member Laible-Kenyon: I don't even, it's such a long name [laughter].

Council Member Hennessy: Yeah, I know. That's why, I can't do that from memory folks.

Mike Heeran: Regulatory and Framework Improvement Committee.

Council Member Laible-Kenyon: There you go.

Mike Heeran: I think that's it.

Council Member Hennessy: Alright, so I would make a motion to have these matters considered by the Regulatory and Framework Improvement Committee. Did I do that correctly?

Mike Heeran: I think that's it.

Council Member Hennessy: Can I just say to the, well forget it. Okay that's good enough.

Male: Come up with an acronym.

Council Member Hennessy: Yeah.

Council Member Davis: The committee members understand what you're talking about.

Council Member Hennessy: Okay, fair enough. So, I will make that motion. Can I have a second? Council Member Laible-Kenyon, second. Any discussion?

Council Member Davis: Just one point. I'm sure Mr. Heeran will find a creative way to get that group together without having to come to Albany. I think in this case I think you can do it for this committee. That would be appreciated.

Mike Heeran: I will try.

Council Member Laible-Kenyon: That would be lovely.

Mike Heeran: My FIPIT people aren't here but we've had challenges in Manhattan recently. We're trying. I don't think Buffalo is a challenge. I think New York City has been a challenge. But we'll try to remotely, we'll try.

Council Member Hennessy: Any other discussion by Council Members? No? All in favor say aye [chorus of ayes].

Any opposed? The motion carries. Okay, so we've taken care of that business.

That really concludes all of our business for today. Can I have a motion to adjourn? Moved by Council Member Stubblebine. Can I have a second? Council Member Barnett. All in favor say aye [chorus of ayes].

Aye, sorry. Anyone opposed? The meeting is adjourned.

The next meeting of the Council is scheduled for October 18th, 2018 here in OGS meeting room seven. As of right now we anticipate the need to reschedule this meeting due to conflicts in schedules. We'll be reaching out to members shortly with potential dates for a meeting later this year.

If an ad hoc meeting is held prior to that date the notice will be posted to the Department of Health Public Meetings website which you again can see at www.health.ny.gov. An email will be sent out to people who signed up for list serve. So, if you haven't please sign up. If you need instructions to sign up for list serve please see staff after the meeting or email CCRC@health.ny.gov.

And thanks so much for your time. Thanks especially to you for coming here today, we appreciate it.